



# Acknowledgements

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## Pathfinder Partners



**Standing Together** was founded 20 years ago with the ambition to eradicate domestic abuse by transforming the way organisations and individuals think about, prevent, and respond to it. Operating in various operational settings including health, housing, criminal justice and community work, Standing Together works with partner agencies to ensure a Coordinated Community Response (CCR) to domestic abuse by improving their understanding and response to survivors and perpetrators. Standing Together's aim is to stop survivors falling through gaps via these improved responses within and between voluntary and statutory organisations, and ultimately eradicate domestic abuse.



**AVA** (Against Violence and Abuse) is a feminist charity committed to creating a world without gender-based violence and abuse. Their mission is to work with survivors to end gender-based violence by championing evidence-based change. They are an expert, independent and groundbreaking national charity particularly recognised for their specialist expertise in expert-by-experience-led approaches, multiple disadvantages and children and young people's work. Our core work includes training, policy, research and consultancy.



**Imkaan** is a UK-based, intersectional, black feminist organisation dedicated to addressing violence against women and girls. As a second-tier, social justice and human rights organisation with national membership, Imkaan represents the expertise and perspectives of frontline specialist black and minoritised women's services that work to prevent and respond to violence against women and girls.



**IRISi** is a social enterprise established to promote and improve healthcare's response to gender-based violence. Their flagship intervention is the IRIS programme (Identification and Referral to Improve Safety) which is a domestic violence and abuse training, support and referral programme for general practices. The IRIS programme is a collaboration between general practice and specialist domestic abuse services. It is commissioned and running in areas of England, Wales and Northern Ireland.



**SafeLives** is the UK-wide charity dedicated to ending domestic abuse, for everyone and for good. SafeLives works with organisations across the UK to transform the response to domestic abuse. They want what you would want for your best friend. They listen to survivors, putting their voices at the heart of their thinking. They look at the whole picture for each individual and family to get the right help at the right time to make families everywhere safe and well. And they challenge perpetrators to change, asking 'why doesn't he stop?' rather than 'why doesn't she leave?' SafeLives is the originator of the Independent Domestic Violence Advocate (Idva) role, and of Multi-Agency Risk Assessment Conferences (Maracs).

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# Foreword

## by Nicole Jacobs, Designate Domestic Abuse Commissioner for England and Wales



Nicole Jacobs, Domestic Abuse Commissioner for England & Wales, discusses the need to make best practice common practice.

Health settings are trusted environments, used by everyone. Because of this, they are places we can reach those from every background and walk of life subjected to domestic abuse, especially those who may not feel confident seeking help from other professionals. That is why it is critical to ensure awareness about domestic abuse is embedded into the safeguarding policy and practices of all health settings.

For too long we have depended on people going above and beyond to make a difference. In health, there are many incredible examples of this from exceptional individuals, and I salute their work. Or we have depended on charitable trusts to fund what has been seen as 'additional' work. But, as good as they are, neither of these approaches is sustainable in the long-term.

Pathfinder shows what is possible when tackling domestic abuse is seen as core business for a health setting, when the exceptional practice of a few becomes the common practice of all. This is not just about staff training or even co-location of specialist practitioners. Transformation requires clear and consistent commitment from senior leaders supporting policy development, data collection, patient voice, and other mechanisms to promote practice improvements as part of the core safeguarding work of the Trust.

This is the kind of sustainable, systemic change that is needed everywhere. The current covid-19 context has demonstrated that the healthcare system is capable of accelerated progress when provided with clear and defined targets and strategic direction. Pathfinder provides a clear structure and set of targets to support the implementation of this model of good practice.

Before becoming the Domestic Abuse Commissioner, I was CEO at Standing Together, one of the Pathfinder partners, and I am a strong proponent of the model, which aims to raise the ambition for the health sector to combat domestic abuse across all settings, from GP surgeries to mental health Trusts to acute hospital Trusts.

I have seen first-hand the incredible transformation in practice that can take place with committed leadership within a Trust, working with specialist partners in the domestic abuse sector. Staff become confident to talk about potential signs of abuse directly with their patients and their co-workers, meaning abuse is identified earlier. Health professionals then act as a bridge to specialist services, which can provide the additional support a patient needs.

As Domestic Abuse Commissioner, part of my role will be to oversee and monitor domestic abuse provision, including specific work in health settings. This information will help leaders and decision makers in health to target their efforts and ensure there is greater consistency of practice. As we learn more from the evaluation of efforts such as Pathfinder, I aim to amplify and promote effective practice. And if and when there are opportunities in legislation and statutory guidance to make improvements, health must be central to our strategic thinking.

Thanks to the Home Office, Department for Culture, Media and Sport and Department of Health and Social Care for your support of Pathfinder. And thank you to the Pathfinder team and the eight Pathfinder sites for all of your work and the difference you are making in the lives of so many. You have shown us all what is possible when we aim high and work hard for systemic change.

A handwritten signature in black ink that reads 'Nicole Jacobs'.

**Nicole Jacobs is the Designate Domestic Abuse Commissioner for England and Wales.**



# Executive Summary

The Pathfinder project was a 3-year national pilot project, working across eight sites in England to transform Health's response to domestic abuse. The project was led by Standing Together alongside expert partners AVA, Imkaan, IRISi and SafeLives. It brought together the expertise of specialist domestic abuse organisations through its consortium of experts and the experience and good practice of professionals working at the local sites.

Pathfinder was unique in its whole-system approach to health and domestic abuse. Its ambition was to create an innovative, comprehensive and sustainable model responding to domestic abuse across the health economy. This model response is the result of emerging promising practice at our pilot sites coupled with the expertise of the Pathfinder consortium. The key components of the whole health model response are outlined as part of this Toolkit.

Domestic abuse is a public health issue and health professionals play a critical role in its response. Repeated findings from domestic homicide reviews have highlighted that health professionals can offer patient survivors a safe place to disclose and seek support at an earlier opportunity.

Evidence tells us that 80% of women experiencing domestic abuse seek help from health services and these are often their first, or only, point of contact<sup>1</sup>, with general practice often being an access point for many survivors. It is therefore essential that health services are equipped and supported to respond appropriately and safely to domestic abuse.

A number of key principles frame the work of Pathfinder and its Toolkit. Coordination and effective information sharing are key aspects of a coordinated community response. The work of Pathfinder is also based on the understanding that domestic abuse disproportionately affects women and children. This is the result of gendered societal norms and historical discrimination. Pathfinder is mindful of the additional barriers that survivors from particular groups often face when accessing services. Survivors may experience multiple discrimination based on their intersecting identities. For example they may face barriers to services based on their disability and their ethnic background or sexual orientation. It is paramount that survivors' diversity of experiences and access needs are at the forefront of the planning and delivery of services.

Pathfinder and its Toolkit promote a trauma-informed approach that is strengths-based and grounded in an understanding of the impact of trauma. The work of Pathfinder is survivor-led and reflects the lived experiences and needs of survivors. Finally, this work is underpinned by an understanding of the barriers faced by survivors experiencing multiple disadvantages, defined as the concurrence of homelessness, substance use, poor mental health and domestic abuse.

A robust strategic framework and governance structure is essential in setting the foundation for the implementation of this work and to ensure a coordinated and integrated approach both at a strategic and operational level.

To establish a governance structure for each level of the whole-health response to domestic abuse, operational steering groups should be set up within acute health Trusts, mental health Trusts and Clinical Commissioning Groups (CCGs) or IRIS areas where IRIS exists. These groups should report to an overarching health and VAWG/domestic abuse strategic group. Such structures will facilitate a consistent and integrated response across services; they will support the monitoring of progress, identification of gaps and ensure accountability.

An overarching domestic abuse/VAWG strategy will support this work by consolidating commitment and by clearly outlining the strategic direction of the local response, including the provision of training.

Standalone domestic abuse patient and staff policies are also paramount in ensuring that an appropriate environment is created for staff to feel supported and confident in identifying and safely responding to domestic abuse. This Toolkit includes a Policy Checklist and Policy Template to support services in developing comprehensive and effective policies to be adapted to suit local needs.

In order to deliver an effective service it is critical that an "intersectional" approach is embedded throughout the response. This means that meaningful equality and diversity structures and procedures need to be established to ensure quality of services, accessibility, inclusivity and ultimately to better respond to the needs of all patients and staff.

The Toolkit provides an overview of the different interventions and models of good practice focusing on the areas of general practice, acute and mental health.

IRIS is highlighted here as the model response to domestic abuse in general practice. IRIS is an evidence-based intervention to improve the general practice response to domestic abuse. It is nationally recognised as good practice and has informed NICE guidance.

The co-location of a Health Based Idva, the establishment of a Domestic Abuse Coordinator and Domestic Abuse Champions Networks are all integral parts of a whole health response to domestic abuse in acute and mental health settings. The Toolkit provides a suite of useful resources including a template business case, a working agreement and job description to support with the implementation of this model.

Detailed guidance on how to improve the operational implementation of a response to domestic abuse is also provided. Key practical steps around when and how to enquire about domestic abuse are offered. In addition, specialist guidance around how to respond to the particular needs of BME, LGBT+, older and disabled survivors is also included as part of the practical appendices as an aid to support health professionals to address any barriers faced by patients when disclosing and seeking support.

It is vital that every health service has established links with the specialist services in their local area to build an integrated response to domestic abuse. A clear and easily accessible referral pathway is important for professionals to feel confident in their response. Knowing what services are available to survivors, how they can support them and how one can refer in to them makes a professional more likely to enquire and offer survivors the support they need.

<sup>1</sup> Department of Health (2010) Responding to Violence against women and children – the role of the NHS. Accessible at: [www.health.org.uk/sites/default/files/RespondingtoViolenceAgainstWomenAndChildrenTheRoleofTheNHS\\_guide.pdf](http://www.health.org.uk/sites/default/files/RespondingtoViolenceAgainstWomenAndChildrenTheRoleofTheNHS_guide.pdf)

Regular, current and comprehensive training is essential when embedding a consistent, safe and effective response. The Toolkit provides an assessment framework to help Trusts assess their training provision and ensure it is of good quality, identifying any areas for improvement.

Data collection and analysis are important mechanisms to monitor and understand the effectiveness of health services' response to domestic abuse. Data monitoring is vital when demonstrating the positive impact of local interventions. It supports the identification of areas for improvement and how best to target resources to meet the needs of the local population. The Toolkit provides guidance on the sort of information that should be collected and recorded, and how it can be used actively to inform practice improvement.

An effective response to domestic abuse should also include a strategy detailing how survivors will be made aware of the support options available to them. This includes raising awareness among staff, as well as the public. Publicising information about local domestic abuse specialist services that patients can self-refer to, as well as the national domestic abuse helplines, helps alert survivors to the support that they can access themselves. The Toolkit offers some key practical considerations when planning an awareness strategy. It also includes reference to pathways for perpetrators of abuse too, though this was not the primary goal of Pathfinder.

Local commissioning strategies that reflect the diversity and multiple needs of the local population are vital in ensuring the accessibility of an effective domestic abuse response across the health system.

To conclude, this Toolkit brings together all elements of good practice into a comprehensive and sustainable model response to domestic abuse in health. The interventions and approaches pioneered and tested across Pathfinder sites highlight the benefits of a whole-health approach. Ultimately, this approach goes beyond individual specialist interventions and training; it requires a change in culture within a health service. Strategic commitment and leadership around the VAWG/domestic abuse agenda are essential in effecting systemic change.

## Pathfinder Recommendations

**The following recommendations are made within this Toolkit. The recommendations are based on the learning from the Pathfinder Project pilot sites and reflect the elements of a whole health model approach to responding to domestic abuse in healthcare settings.**

### Local Authorities and Clinical Commissioning Groups:

- Establish a commissioning strategy that integrates health with specialist local VAWG/domestic abuse, substance use, mental health, and other relevant services such as services run by and for BME, disabled and LGBT+ survivors.
- Any specialist services commissioned by a health service should be working to the VAWG sector's shared core standards<sup>2</sup> and be subject to ongoing assurance processes. Services which include perpetrator response should hold or be working to the Respect accreditation standard<sup>3</sup>.
- Roll out IRIS in every GP surgery across the UK.
- Have a VAWG/domestic abuse and health strategic group that is attended by the local acute health Trust, mental health Trust, representatives from general practice and the local domestic abuse/VAWG specialist services with clear links to existing local authority domestic abuse or VAWG governance structures to oversee the local response to domestic abuse in health.

**See Chapter 14: Funding, Commissioning and Sustainability for more information**

**See Chapter 5: General Practice: The IRIS Model for more information**

**See Chapter 1: Health and Domestic Abuse Governance Structure for more information**

<sup>2</sup> Sector Sustainability Shared Standards (2013) [www.womensaid.org.uk/what-we-do/i-commission-work-survivors/violence-women-girls-sector-shared-core-standards](http://www.womensaid.org.uk/what-we-do/i-commission-work-survivors/violence-women-girls-sector-shared-core-standards)

<sup>3</sup> The Respect Standard (2017) [https://hubble-live-assets.s3.amazonaws.com/respect/redactor2\\_assets/files/105/Respect\\_Standard\\_FINAL.pdf](https://hubble-live-assets.s3.amazonaws.com/respect/redactor2_assets/files/105/Respect_Standard_FINAL.pdf)

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**Acute Health Trusts, Mental Health Trusts and Clinical Commissioning Groups should:**


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- Have a VAWG/domestic abuse steering group which oversees the service's response to domestic abuse and the implementation of a domestic abuse strategy.

**See [Chapter 1: Health and Domestic Abuse Governance Structure](#) for more information**

- Assign a Lead for Domestic Abuse to represent them at steering group meetings. This responsibility should be recognised in their job description.

**See [Chapter 1: Health and Domestic Abuse Governance Structure](#) for more information**

- Have a VAWG/Domestic Abuse Strategy detailing the service's commitment to improving their response to patients and staff experiencing domestic abuse and outlining the practical action it will take to achieve this.
- Every VAWG/Domestic Abuse Strategy should include details of the service's commitment to providing training to staff in line with NICE guidelines.
- Every VAWG/Domestic Abuse Strategy should be aligned with the service's Equality, Diversity and Inclusion Strategy and Safeguarding Policies.

**See [Chapter 2: Domestic Abuse Strategy & Appendix 2: Domestic Abuse Strategic Action Plan Template](#) for more information**

- Have a policy for patients experiencing/perpetrating domestic abuse and a policy for staff experiencing/perpetrating domestic abuse.
- Every domestic abuse policy should be aligned with the service's Equality, Diversity and Inclusion Strategy and Safeguarding Policies.

**See [Chapter 3: Policies and Procedures, Appendix 7: Domestic Abuse Policy Assessment Tool & Appendix 8: Domestic Abuse Policy Template](#) for more information**

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**Acute Health Trusts and Mental Health Trusts should:**


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- Employ a full-time Domestic Abuse Coordinator to be responsible for the roll-out of the Trust's domestic abuse strategy, data collection and the coordination and delivery of domestic abuse training.

**See [Chapter 6: Domestic Abuse Coordinator & Appendix 9: Domestic Abuse Coordinator Job Description](#) for more information**

- Employ at least two co-located Health Based Idvas, depending on the size of the Trust, and embed them effectively within the NHS staff team. All Idvas should be qualified to undertake the work having attended the full SafeLives' accredited Idva training course.

- When co-locating a Health Based Idva service, a service level agreement should be written up between the NHS Trust and local specialist service hosting the role, to ensure the operational details of the role are agreed.

- Every newly appointed Idva working in hospital settings for the first time should undertake Pathfinder e-learning to understand the specifics of the Health Based Idva role in the NHS which can be accessed for free [here](#). This is additional and complementary to full Idva training, not a substitute.

**See [Chapter 7: Health Based Idvas & Appendix 10: Business Case for Health Based Idva Service Provision & Appendix 11: Health Based Idva Service Service Level Agreement Template](#) for more information**

- Embed a domestic abuse champions network to support the retention of expertise across departments.

**See [Chapter 8: Domestic Abuse Champions Network](#) for more information**

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### All NHS Services (Including all NHS Trusts, Clinical Commissioning Groups, General Practices, Ambulance Services etc) should:

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→ Undertake a range of diversity accreditations and schemes to promote positive equality, diversity & inclusion standards in the workplace and to better respond to the needs of all patients and staff.

#### See Chapter 4: Equality, Diversity and Inclusion for more information

→ Set up effective staff networks for staff members to promote diversity. As a minimum networks should exist for staff who are black and minority ethnic, disabled, LGBT+ and allies.

#### See Chapter 4: Equality, Diversity and Inclusion for more information

→ Ensure NHS employees and patients have access to an independent service for British Sign Language (BSL) and other translation services.

#### See Chapter 4: Equality, Diversity and Inclusion for more information

→ Ensure all health staff have access to the facilities they need to ensure that any domestic abuse enquiry is done in private and family members and friends are not used as interpreters.

#### See Chapter 9: Enquiry and Disclosure for more information

→ Ensure all health staff are equipped with the knowledge and skills they need to enquire about domestic abuse sensitively and supportively through an explorative conversation.

#### See Chapter 9: Enquiry and Disclosure for more information

→ Ensure all health staff understand the impact of trauma and consider how to ask and respond in a way that takes into account and acknowledges trauma responses.

#### See Chapter 9: Enquiry and Disclosure for more information

→ Ensure all health staff know how to record any disclosure of domestic abuse in the survivor's own words and offer specialist support.

#### See Chapter 9: Enquiry and Disclosure for more information

→ Embed clear and effective referral pathways into local specialist services.

#### See Chapter 10: Referral Pathways for more information

→ Have designated Marac<sup>4</sup> representatives and ensure that staff are aware of who they are including any appropriate internal referral procedures<sup>5</sup>.

#### See Chapter 10: Referral Pathways for more information

→ Have a sustainable training strategy in place to ensure all staff receive the relevant level of domestic abuse training in line with NICE guidelines.

#### See Chapter 11: Domestic Abuse Training & Appendix 12: Domestic Abuse Training Assessment Tool for more information

→ All domestic abuse training should be rooted within an equalities framework and cover the experiences of people who experience unique forms of discrimination due to the intersection of their gender with other identity characteristics including race, class, poverty, disability, age and sexual orientation

#### See Chapter 4: Equality, Diversity and Inclusion & Appendices 3, 4, 5 & 6: Specialist guidance for Health Professionals Responding To LGBT+ (Appendix 3), Older (Appendix 4), Disabled (Appendix 5) and BME (Appendix 6) Survivors of Domestic Abuse for more information

→ Collect data on:

→ Domestic abuse training attended by staff

→ Enquiry into domestic abuse to understand gaps in training

→ Disclosures of domestic abuse in the words of the survivor

→ Disaggregated data on protected characteristics

→ Referral pathways

#### See Chapter 12: Data Collection, Monitoring, Analysis and Practice Improvement for more information

→ Ensure that patient medical records are able to capture the data we suggest clinicians collect around domestic abuse

#### See Chapter 12: Data Collection, Monitoring, Analysis and Practice Improvement for more information

→ Have a clear strategy for how data on domestic abuse is put together with other relevant data, such as safeguarding and equalities monitoring with a clear framework for how data collection will be rooted in the need for practice improvement.

#### See Chapter 12: Data Collection, Monitoring, Analysis and Practice Improvement for more information

→ Have a clear awareness raising strategy for ensuring that patients and staff are aware of health professionals' role in responding to domestic abuse.

#### See Chapter 13: Awareness Raising for more information

<sup>4</sup> SafeLives Resources for Marac meetings <https://safelives.org.uk/practice-support/resources-marac-meetings>

<sup>5</sup> Marac referral form <https://safelives.org.uk/node/507>



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### Mental health Trusts should:

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- Ensure staff understand how experiences of domestic abuse contribute to current presentations of mental distress.

See [Chapter 9: Enquiry and Disclosure & AVA's Complicated Matters Toolkit for more information](#)

- Ensure domestic abuse questions are embedded into assessment documentation and in clinical audit.<sup>6</sup>

See [Chapter 9: Enquiry and Disclosure & AVA's Complicated Matters Toolkit for more information](#)

# About this Toolkit

This Toolkit has been designed as a stand-alone practical guide for commissioners and strategic professionals in the health sector, to support the delivery of a robust and coordinated response to domestic abuse. It complements existing literature about IRIS<sup>7</sup> and Idva provision<sup>8</sup> and brings together good practice responses to domestic abuse in the health system from across England.

Local authorities and CCGs are encouraged to commission a local area response to domestic abuse that incorporates all of the recommendations made within this Toolkit. Each chapter offers an overview of each element of this response, giving recommendations as well as providing tools and templates to facilitate implementation.

The Toolkit should be used to assess and improve existing responses to domestic abuse. The resources and templates provided can be adapted to fit your local context and needs.

## Who is this Toolkit for?

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Pathfinder has focused on enhancing responses to domestic abuse across acute health, mental health and general practice. The Toolkit is aimed primarily at strategic level professionals with influence over local health strategies and commissioning decisions from:

- CCGs
- Local authorities
- NHS Trusts

The Toolkit also includes a 'Best Practice Implementation' section and several tools that are also relevant to professionals with responsibility for domestic abuse within Trusts such as:

- Safeguarding Leads
- Health Based Idvas
- Domestic Abuse Coordinators
- HR Professionals

The content of this Toolkit speaks primarily to the role of professionals in responding to adult survivors of abuse, but references are included throughout to the needs of child survivors and to the need for appropriate response to perpetrators, recognising health professionals will come into contact with all family members, and be in a position to act for each of them.

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<sup>6</sup> Sally Macmanus (2015), 'Guidance for Trust managers Responding effectively to violence and abuse' (REVA project) Briefing 2. Implementing and sustaining routine enquiry about violence and abuse in mental health services, available online [www.dmss.co.uk/pdfs/REVA-Brief-2-Guidance-for-Trust-managers-FINAL-071015.pdf](http://www.dmss.co.uk/pdfs/REVA-Brief-2-Guidance-for-Trust-managers-FINAL-071015.pdf) (accessed March 25 2020), p.7.

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<sup>7</sup> IRISi Research, <https://irisi.org/all-resources/research/>

<sup>8</sup> SafeLives (2016) A Cry For Health [https://safelives.org.uk/sites/default/files/resources/SAFJ4993\\_Themis\\_report\\_WEBcorrect.pdf](https://safelives.org.uk/sites/default/files/resources/SAFJ4993_Themis_report_WEBcorrect.pdf)

# Domestic Abuse: A Health Issue

## What is Domestic Abuse?

Domestic abuse is defined in England and Wales as:

**“any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial, emotional.**

It includes coercive control, which is ‘an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.’<sup>9</sup>

The UK government definition of domestic abuse conflates violence or abuse committed by intimate partners with that by family members.

While both forms of violence and abuse are gendered, there are clear differences in the dynamics and motivations underpinning Intimate Partner Violence (IPV) and Adult Family Violence (AFV). It should also be noted that there is a significant dearth in research around AFV.

This guidance will reflect those differences and primarily focus on IPV where there is a more established body of evidence around what promising practice looks like.

Pathfinder recognises that domestic abuse disproportionately affects women and considers domestic abuse as a form of violence against women and girls (VAWG) which is defined by the UN as an ‘act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.’



## 2 million

**In the year ending March 2018, an estimated 2 million adults aged 16 to 59 years experienced domestic abuse (1.3 million women, 695,000 men)<sup>10</sup>**

The Crime Survey for England and Wales (CSEW) shows in the year ending March 2018, an estimated 2 million adults aged 16 to 59 years experienced domestic abuse (1.3 million women, 695,000 men)<sup>10</sup>. These figures are likely to be an underestimate, as domestic abuse largely goes under-reported and the current CSEW has artificial age limits which exclude some survivors from the data.

Evidence shows that men perpetrate abuse more often and more severe in nature than women and that the negative impact of experiencing abuse is greater for women than men.<sup>11</sup> While figures such as the ones from the Crime Survey can be useful in providing a glimpse into the extent of the issue, it is important to keep in mind that measuring individual acts of violence or aggression can be deceiving and does not provide an accurate picture of domestic abuse or its impact. It fails to consider important contextual factors which create significant differences in the experiences of survivors.

UK reports suggest the prevalence of partner abuse is similar, if not higher, between same-sex couples, occurring in approximately 25% to 38% of relationships. Transgender individuals may be at even higher risk, as research demonstrates 80% of transgender people have experienced emotionally, sexually, or physically abusive behaviour by a partner or former partner<sup>12</sup>.



## 25–38%

**The prevalence of partner abuse is similar, if not higher, between same-sex couples, occurring in approximately 25% to 38% of relationships.**

Public Health England also shows that disabled women experience disproportionately higher rates of domestic abuse. They experience domestic abuse for longer periods of time, and more severe and frequent abuse than non-disabled women.<sup>13</sup>

<sup>10</sup> [www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2018](https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2018)

<sup>11</sup> Hester, M (2009) Who does what to whom? Gender and domestic violence perpetrators, *European Journal of Criminology*, 10 (5).

<sup>12</sup> Spotlight LGBT+ and domestic abuse <https://safelives.org.uk/knowledge-hub/spotlights/spotlight-6-lgbt-people-and-domestic-abuse>

<sup>13</sup> Public Health England (2015), Disability and domestic abuse [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/480942/Disability\\_and\\_domestic\\_abuse\\_topic\\_overview\\_FINAL.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480942/Disability_and_domestic_abuse_topic_overview_FINAL.pdf)

Older women have often been a hidden group in the context of domestic abuse. Yet, older women account for one in four victims of domestic homicide in England and Wales<sup>14</sup>. Older women are also often invisible when considering other forms of Violence against Women and Girls too, including sexual violence<sup>15</sup>.

Throughout this Toolkit, we will strive to show how a tailored response to abuse is most likely to work best. Individuals' experiences and backgrounds will have an impact on their needs; it is crucial for professionals to listen to each individual and shape their responses on the basis of individual need.

Where an individual's needs are not identified and supported in a holistic way, this often contributes to them staying in a relationship with an abuser for longer periods of time, with negative implications for their safety and physical and mental health. For example, BME women are likely to stay in a relationship with an abuser longer than white women<sup>16</sup> and disabled women are twice as likely to experience domestic abuse than non-disabled women<sup>17</sup>. Unfortunately, survivors often find that domestic abuse services and health services do not work together, leading to individuals with protected characteristics being at risk of falling through the gaps and being further marginalised.



## One in four

Older women account for one in four victims of domestic homicide in England and Wales<sup>14</sup>. Older women are also often invisible when considering other forms of Violence against Women and Girls too, including sexual violence<sup>15</sup>.



2x

Disabled women are twice as likely to experience domestic abuse than non-disabled women<sup>17</sup>

## Why is domestic abuse a health issue?



Kathryn Bonney, former Head of Safeguarding for East Lancashire NHS Trust, talks about the role of health in responding to domestic abuse.

Domestic abuse is a public health issue. It can seriously affect physical, emotional, mental and sexual health and can be both chronic and acute in impact.

Every year nearly half a million survivors of domestic abuse seek assistance from medical professionals. Given that just one in five survivors call the Police, it is vital that health professionals have the tools to respond to domestic abuse and that survivors can access a non-criminal justice-based route to effective support.<sup>18</sup>

A report analysing 84 Domestic Homicide Reviews (DHRs) across London found that of the 354 resulting recommendations, 110 (31%) were exclusively related to the health sector.<sup>19</sup> DHRs consistently show the critical role that health professionals have in intervening earlier by providing a window of opportunity for survivors to disclose.



31%

Analysis of 84 London DHRs found 31% of resulting recommendations were related to the health sector.

14 Bows, H. (2018) Domestic Homicide of Older People. (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK. *The British Journal of Social Work*, 49 (5): 1234-1253.  
 15 Solace Women's Aid (2016) *The Silver Project: Domestic Abuse Service for Women Over 55*. Available at: [www.solacewomensaid.org/get-informed/professional-resources/silver-project-evaluating-our-domestic-abuse-service-women-over](http://www.solacewomensaid.org/get-informed/professional-resources/silver-project-evaluating-our-domestic-abuse-service-women-over).  
 16 Patel, P. (2003) *Third wave feminism and black women's activism*. London: Routledge: 255-268.  
 17 Spotlight: Disabled people and domestic abuse <https://safelives.org.uk/knowledge-hub/spotlights/spotlight-2-disabled-people-and-domestic-abuse>

18 Office for National Statistics-[www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwales/yearendingmarch2018](http://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwales/yearendingmarch2018)  
 19 Standing Together (2020) *London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process* [Unpublished]



## 80%

**of women experiencing domestic abuse seek help from health services and these are often a woman's first, or only, point of contact<sup>20</sup>.**

80% of women experiencing domestic abuse seek help from health services and these are often a woman's first, or only, point of contact<sup>20</sup>, with general practice often being an access point for many survivors.

As well as its human cost, domestic abuse has huge financial implications for the NHS. It is estimated that every year domestic abuse costs health services over £2.3 billion<sup>21</sup>.

The healthcare system is an effective setting to identify survivors of domestic abuse. Health professionals are uniquely placed in their ability to respond to domestic abuse. They have expert knowledge in identifying patterns of health service use – whether primary, acute or mental health – which might indicate abuse is happening or has happened.

Health professionals are likely to have opportunities to speak with patients in confidential and private settings. They have access to a vast electronic system, allowing them to record all manner of concerns relating to patients' medical and welfare needs. They are trusted professionals, both by agencies and their patients. They are well connected, and have an extensive network of support mechanisms for survivors to access. Broadly, health professionals will have opportunities that are not always available to other public sector workers. Domestic Homicide Reviews reveal that health services are often the only statutory service to have consistent contact with survivors of domestic abuse<sup>22</sup>. Maximising all of these opportunities will go a long way in tackling domestic abuse.



## £2.3 billion

**It is estimated that every year domestic abuse costs health services over £2.3 billion<sup>21</sup>.**

## Domestic Abuse and Acute Health Settings

Domestic abuse has severe and detrimental health implications. The physical and often more obvious implications can be short-lived, or long-lasting. These can include: broken bones, sprains, cuts, bruises, digestive issues, eating problems, pain of the back, neck, abdomen, stomach or genital area, headaches, fainting, seizures, hypertension, urinary tract or vaginal infections, sexually transmitted diseases and sexual dysfunction.

Research has also found that women who have been subjected to domestic abuse are at an increased risk of developing cardiometabolic diseases such as cardiovascular disease and type 2 diabetes. The same research has shown that women who have experienced domestic abuse appear to be 40% more likely to die from any cause compared to the general population.<sup>23</sup> Acute health settings, particularly Emergency Departments, maternity services and sexual health services, are crucial in responding to domestic abuse.



## 40%

**Women who have experienced domestic abuse appear to be 40% more likely to die from any cause compared to the general population.<sup>23</sup>**

Survivors of domestic abuse have high attendance rates within Emergency Departments. Homeless women in particular are unlikely to access a GP service and will often only ever have contact with Emergency Departments<sup>24</sup>. SafeLives' Cry for Health report<sup>25</sup> found that in the year before getting effective Idva support, nearly a quarter of survivors at high risk of serious harm or injury and one in ten survivors at medium risk, went to an Emergency Department due to their injuries. It is therefore crucial that Emergency Department staff are adequately trained in responding to domestic abuse.

20 Department of Health (2010) Responding to Violence against women and children – the role of the NHS [www.health.org.uk/sites/default/files/RespondingtoViolenceAgainstWomenAndChildrenTheRoleofTheNHS\\_guide.pdf](http://www.health.org.uk/sites/default/files/RespondingtoViolenceAgainstWomenAndChildrenTheRoleofTheNHS_guide.pdf)

21 Home Office (2019) The economic and social costs of domestic abuse [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/772180/horr107.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772180/horr107.pdf)

22 Standing Together (2016) Domestic Homicide Review Case Analysis, [www.standingtogether.org.uk/sites/default/files/docs/STADV\\_DHR\\_Report\\_Final.pdf](http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf)

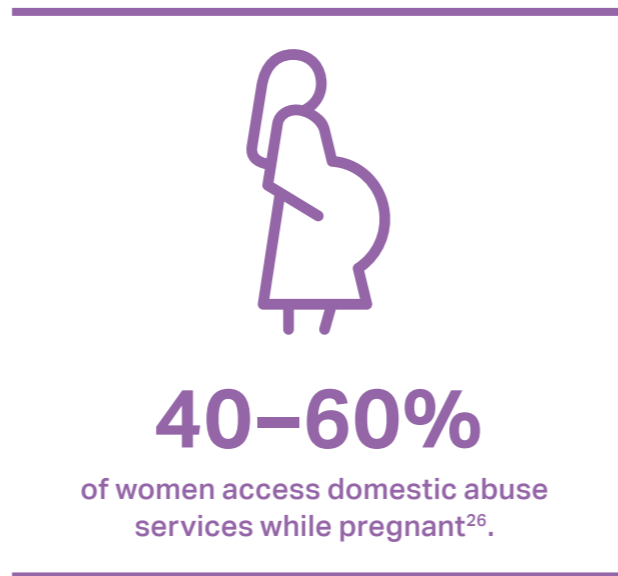
23 Singh Chandan et al. (2020) The Risk of Cardiometabolic Disease and All-Cause Mortality in Female Survivors of Domestic Abuse, the Journal of the American Heart Association, DOI: 10.1161/JAHA.119.014580

24 Groundswell (2020) Women, Homelessness and Health <https://groundswell.org.uk/wp-content/uploads/2020/02/Womens-Health-Research-Report.pdf>

25 SafeLives (2016) A Cry for Health <https://safelives.org.uk/cry-for-health>



Evidence shows that pregnancy can be a significant risk factor with 40–60% of women accessing domestic abuse services while pregnant<sup>26</sup>. Maternity services offer frequent check ups and extended levels of contact with their patients. Survivors can rely on these appointments as a stable support system during a potentially dangerous time. If survivors are unable to see any other professionals, maternity services become their only opportunity to seek help or support. In addition, multiple terminations, miscarriages or repeated pregnancies can all indicate the presence of control within a relationship. These specific signs may only be noticed by a maternity professional, and as such they are critical in identifying and responding to domestic abuse. It is paramount that maternity services are equipped to respond effectively to survivors of domestic abuse.



Survivors of domestic abuse are also at high risk of poor sexual health. Many will experience sexual abuse and rape. Sexual health professionals are likely to come into regular contact with survivors and therefore have a key role to play in responding to domestic abuse. Sexual health settings offer high levels of confidentiality, and patients will expect to be asked sensitive questions relating to their sexual health. It is therefore vital that sexual health professionals are equipped to identify and respond to domestic abuse.

## Domestic Abuse and General Practice Settings

The prevalence of domestic abuse is substantially higher in a general practice population than that found in the wider population<sup>27</sup>. For women who later access support from an Idva service, nearly half had visited their GP in the twelve months prior to accessing the service, and in that period had, on average, visited their GP 4.6 times<sup>28</sup>. There is extensive contact between women and primary care clinicians with 90% of all female patients consulting their GP over a five-year period<sup>29</sup>. This contrasts starkly with the virtual invisibility of domestic abuse within general practice, where in fact the majority of women experiencing domestic abuse and its associated effects are not identified<sup>30</sup>.

Creating an environment in which patients are more likely to feel safe to disclose domestic abuse will make a real difference. A case in point is provided by the IRIS programme in Cardiff and the Vale, where just seven patients were referred from general practices to specialist domestic abuse services in the three years prior to the commissioning of the IRIS programme. In the three years after the commissioning of the IRIS programme, 773 patients were referred from general practices to specialist domestic abuse services<sup>31</sup>.



27 Richardson et al. (2002) Identifying domestic violence: cross sectional study in primary care, British Medical Journal, 324

28 SafeLives (2016) A Cry for Health <https://safelives.org.uk/cry-for-health>

29 Wisner, C. L. et al. (1999) 'Intimate partner violence against women: do victims cost health plan's more?', Journal of Family Practice. 48(6), pp. 439 – 443.

30 Richardson et al. (2002) Identifying domestic violence: cross sectional study in primary care, British Medical Journal, 324

31 BAWSO and Cardiff Women's Aid (2018). Statistics from the IRIS programme in Cardiff and the Vale, jointly delivered by BAWSO and Cardiff Women's Aid. Internal figures. Unpublished.

Survivors of domestic abuse trust health care professionals with their disclosures and believe their doctor is one of the few people to whom they can disclose. However, many will not disclose violence and abuse without being directly asked. They report wanting to be asked and expect an appropriate response<sup>32</sup>. Women have reported wanting health services and professionals to have a duty to identify and respond to violence and abuse against women and girls, and felt it was more appropriate for health professionals to receive mandatory training to meet their needs effectively than it was for criminal justice professionals<sup>33</sup>.



## Domestic Abuse and Mental Health

Domestic abuse is a key cause of women's mental distress and there are high prevalence rates of experiences of abuse amongst those that use mental health services.<sup>34</sup> For example:

- Analysis of the Adult Psychiatric Morbidity Survey has shown that over half of women (54%) experiencing sexual and physical abuse – and a third (36%) experiencing extensive physical violence – meet the diagnostic criteria for at least one common mental disorder.<sup>35</sup>
- Women who experience domestic abuse are three times more likely to be diagnosed with a mental health problem and women who are experiencing domestic abuse are also nearly three times more likely to have a history of diagnosed mental health problems.<sup>36</sup>
- The rate of physical and sexual violence is also 3.8 times more likely for mental health service users than the general population.<sup>37</sup>

32 Feder, G (2006) Responding to intimate partner violence: what role for general practice? *British Journal of General Practice*, 56(525), 243-244

33 Women's National Commission (2010) A bitter pill to swallow: Report from WNC focus groups to inform the Department of Health Taskforce on the health aspects of Violence Against Women and Girls. Available at: <https://thewomensresourcecentre.org.uk/wp-content/uploads/ABitter-Pill-to-Swallow.pdf> (Accessed: 27th July 2018).

34 Sally Macmanus (2015), 'Guidance for Trust managers Responding effectively to violence and abuse (REVA project) Briefing 2. Implementing and sustaining routine enquiry about violence and abuse in mental health services, available online, [www.dmss.co.uk/pdfs/REVA-Brief-2-Guidance-for-Trust-managers-FINAL-071015.pdf](http://www.dmss.co.uk/pdfs/REVA-Brief-2-Guidance-for-Trust-managers-FINAL-071015.pdf) (accessed March 25 2020), p. 3.

35 <https://weareagenda.org/wp-content/uploads/2015/11/Hidden-Hurt-full-report1.pdf>

36 Chandan, J.S., Thomas, T., Bradbury-Jone, C., Russell, R., Bandyopadhyay, C., Nirantharakumar, K., and Taylor, J. (2019). 'Female survivors of intimate partner violence and risk of depression, anxiety and serious mental illness,' *The British Journal of Psychiatry*, 7:1-6. doi: 10.1192/bjp.2019.124.

37 Hughes, K., Bellis, M.A., Jones, L., Wood, S., Bates, G., Eckley, L., McCoy, E., Mikton, C., Shakespeare, T., Officer, A. (2012) Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies. *Lancet*, 379 (9826): 1621-1629.

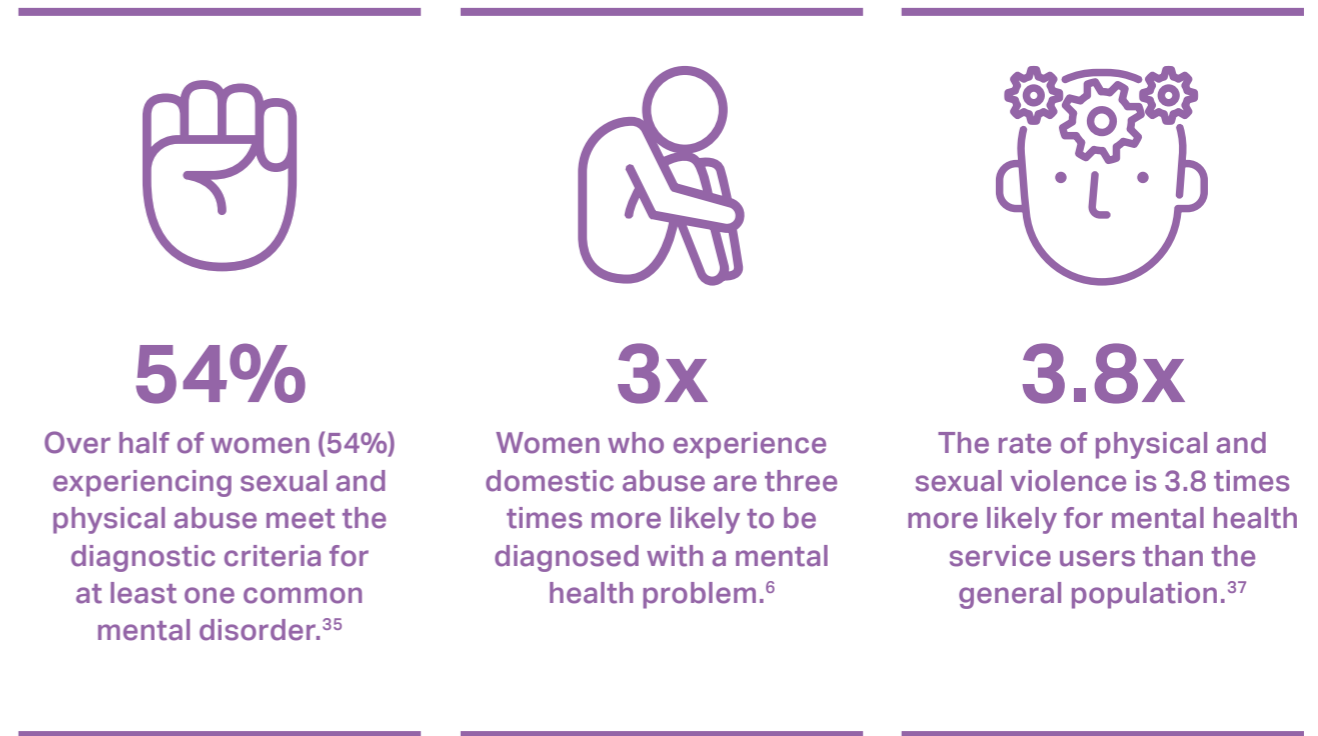
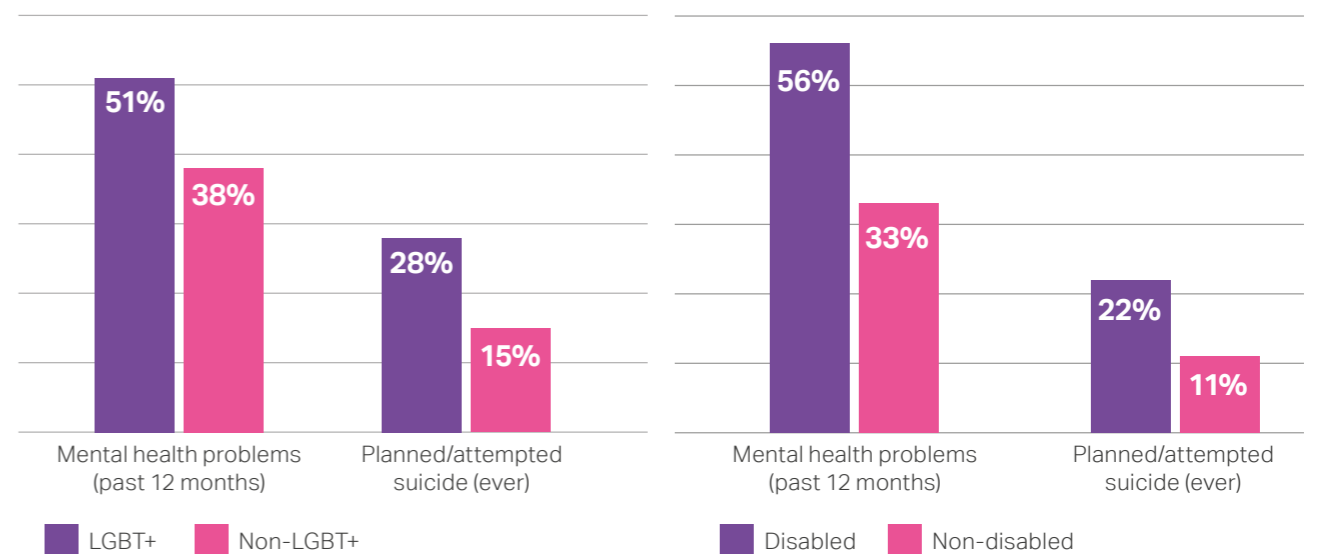


Figure 1: LGBT+ and disabled survivors are more likely to have mental health problems





Diagnosed mental health problems are more prevalent and severe amongst certain groups of survivors and intersecting oppressions can compound women’s experiences of mental distress. SafeLives have found that those identifying as LGBT+ and those who have a disability are more likely to have mental health needs at the point of accessing domestic abuse services – as highlighted by the graph above.<sup>38</sup> Indeed, those who face oppression as a result of being in marginalised or minoritised groups may face worse mental health outcomes due to those experiences of oppression and inequality.<sup>39</sup> In turn, women experiencing mental health problems may experience violence and abuse from those that care for them and are at greater risk of institutional violence if they are living in institutional settings.<sup>40</sup>

Evidence from the Women’s Mental Health Taskforce highlighted how mental health services could retraumatise women, playing out the behaviours associated with domestic and sexual violence: the use of restraint, particularly prone restraint; comments by male staff and fear of harassment by staff and other patients.<sup>43</sup> Mental health Trusts not only need to address domestic abuse but consider how their environments, processes and practices could retraumatise women. The Women’s Mental Health Taskforce made a clear recommendation that mental health services should be gender and trauma-informed at all levels and set out a model for taking this approach.<sup>44</sup>

Mental health services have a key role in responding to domestic abuse. **Since 2003 it has been Department of Health policy that all adult service users should be asked about experiences of violence and abuse in mental health assessments.**<sup>41</sup> As with other areas of health, research has found that while this is recommended practice, frontline practitioners will not ask about abuse unless they feel confident dealing with disclosures.<sup>42</sup> Thus, it is vital mental health Trusts follow the guidance in this document, in order to meet the recommendations under national policy guidelines.



Mental health Trusts should address service user experiences of domestic abuse in several different ways:

- 1** ask about and acknowledge the experiences of domestic abuse that patients/survivors have faced
- 2** take actions to keep service users safe from current and future abuse
- 3** acknowledge how experiences of abuse may have contributed to current presentations of mental distress and create treatment plans that address the impacts of abuse on mental wellbeing
- 4** review their own policy and practice to reduce – or better eliminate – the possibility of re-traumatisation.

Pathfinder endorses the use of the Drayton Park Model. Drayton Park is a women-only crisis house at Camden and Islington NHS Foundation Trust that is based on trauma-informed practice and seeks to be an alternative to acute admission. See [Appendix 1: Drayton Park Model](#) for more information.

38 SafeLives (2017). Disabled Survivors Too: Disabled people and domestic abuse. Spotlight. [online] London: SafeLives.  
 39 Cabinet Office (2017). 'Race Disparity Audit,' available online [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/686071/Revised\\_RDA\\_report\\_March\\_2018.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/686071/Revised_RDA_report_March_2018.pdf) (accessed, March 27 2020), pp. 49-50; Kalathil, J, Collier, B., Bhakta, R., Daniel, O., Joseph, D., and Trivedi, p., 'Recovery and Resilience: African, African Caribbean and South Asian Women's Narratives of Recovering from Mental Distress. London: Survivor Research and Mental Health Foundation, 2011. [www.mentalhealth.org.uk/sites/default/files/recovery\\_and\\_resilience.pdf](http://www.mentalhealth.org.uk/sites/default/files/recovery_and_resilience.pdf) (Accessed May 1 2017)  
 40 SafeLives (2017). Disabled Survivors Too: Disabled people and domestic abuse. Spotlight. [online] London: SafeLives.  
 41 Sally Macmanus (2015). 'Guidance for Trust managers Responding effectively to violence and abuse (REVA project) Briefing 2. Implementing and sustaining routine enquiry about violence and abuse in mental health services, available online, [www.dhss.gov.uk/pdfs/REVA-Brief-2-Guidance-for-Trust-managers-FINAL-071015.pdf](http://www.dhss.gov.uk/pdfs/REVA-Brief-2-Guidance-for-Trust-managers-FINAL-071015.pdf) (accessed March 25 2020).  
 42 Rose, D., Trevillion, k., Woodall, A., Morgan, C., Feder, G., and Howard., L. (2011), 'Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study,' British Journal of Psychiatry, 198(3), pp. 189-94.  
 43 Department of Health, Agenda (2018), The Women's Mental Health Taskforce Final report, [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/765821/The\\_Womens\\_Mental\\_Health\\_Taskforce\\_-\\_final\\_report1.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765821/The_Womens_Mental_Health_Taskforce_-_final_report1.pdf) (accessed March 25 2020).  
 44 Department of Health, Agenda (2018), The Women's Mental Health Taskforce Final report, [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/765821/The\\_Womens\\_Mental\\_Health\\_Taskforce\\_-\\_final\\_report1.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765821/The_Womens_Mental_Health_Taskforce_-_final_report1.pdf) (accessed March 25 2020).

**Trauma & Mental Health**

Significantly increased risk of mental health problems in those who have experienced trauma

Highest risk for development of mental disorder amongst those who are re-victimised

Trauma, MH & DVA are interrelated (Khalifeh et al. 2015)

- Sexual abuse in childhood 3-5x risk of common MH disorder
- Significantly increased rates of DV & SA amongst those who access MH services (lifetime and in the last year)
- More likely to report to health professionals

DVA ↔ Mental Disorder

Shirley McNicholas discusses the need for a trauma informed approach – taken from association with suicide

2020-04-29 10:11:20

## NHS staff as survivors and perpetrators of domestic abuse

The prevalence of domestic abuse within the UK means no workplace or set of employees is immune. An estimated 51,355 NHS staff (44,825 female and 6,530 male) will have experienced domestic abuse in the last 12 months<sup>45</sup>. A recent survey from the Royal College of Midwives' members found that 82% of midwives had experienced domestic abuse in their working lifetime and, of them, only 33% asked for workplace support. The Safe Places report<sup>46</sup> found that 29% of midwives surveyed reported that they received no support or had a poor experience of support for the abuse in the workplace. During the life of the Pathfinder project, 25 NHS staff received specialist domestic abuse support from our funded Health Based Idvas.



**Over 51,000**

An estimated 51,355 NHS staff (44,825 female and 6,530 male) will have experienced domestic abuse in the last 12 months<sup>45</sup>.



**82%**

of midwives had experienced domestic abuse in their working lifetime and, of them, only 33% asked for workplace support.



**29%**

midwives surveyed reported that they received no support or had a poor experience of support for the abuse in the workplace.



**25**

During the life of the Pathfinder project, 25 NHS staff received specialist domestic abuse support from our funded Health Based Idvas.

45 Department of Health, Agenda (2018), The Women's Mental Health Taskforce Final report, [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/765821/The\\_Womens\\_Mental\\_Health\\_Taskforce\\_-\\_final\\_report1.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765821/The_Womens_Mental_Health_Taskforce_-_final_report1.pdf) (accessed March 25 2020)

46 The Royal College of Midwives (2018) Safe Places? Workplace support for those experiencing domestic abuse

## Domestic Abuse and Children

Domestic abuse is not only experienced by adults. There is a large body of evidence to show that the impact of a perpetrator's coercive control on the mother or non-abusive parent has an equally devastating effect on children within the family<sup>47</sup>.

Whether present in the house during particular incidents of domestic abuse or not, children and young people will be experiencing the effects of the perpetrator's everyday patterns of controlling and coercive behaviour.

The isolation from family and friends, the tension and fear within the home and lack of access to financial independence for the non-abusive parent will all directly impact on the child/children's development and quality of life.<sup>48</sup> It is important to recognise children as direct victims of domestic abuse rather than merely collateral damage.

SafeLives' analysis of their Children's Insights database found that domestic abuse causes serious physical and psychological harm to children. As measured by the children's caseworkers, at intake:

- 52% had behavioural problems
- 60% felt responsible for the negative events
- 52% had problems with social development and relationships
- 39% had difficulties adjusting at school.

NHS staff have a duty to safeguard children at risk of harm. A Health Based Idva service is well placed to help with identification, referrals and support and to enable hospitals to fulfil their duties, not least by ensuring mothers at risk are identified early on.

47 <https://safelives.org.uk/insights-national-briefing-children>

48 Katz, Emma. (2016). Beyond the Physical Incident Model: How Children Living with Domestic Violence are Harmed by and Resist Regimes of Coercive Control. Child Abuse Review 25(1), 46–59.

49 <https://safeandtogetherinstitute.com/about-us/founders-statement/>

50 Radford and Hester (2006) Mothering through Domestic Violence



Support for adults and children should not be artificially separated. A child's experience of abuse is intimately connected to the experience of their non-abusive parent, and vice versa, and so best practice responses will recognise the need for a holistic, inclusive approach responding to needs of the non-abusive parent and child. Evidence shows that providing support to keep the non-abusive parent safe is often the best way to safeguard children in the context of domestic abuse.<sup>50</sup>



**60%**

of children felt responsible for the negative events



# The Pathfinder Project

Pathfinder was a national project aimed at addressing the links between domestic abuse and health and improving the capacity of health professionals to respond to survivors effectively by establishing comprehensive health practice in relation to domestic abuse in three distinct areas; acute hospital Trusts, mental health Trusts and GP practices.

The project ran from 2017 to 2020 and was led by Standing Together as part of a consortium of expert partners including Against Violence and Abuse (AVA), Imkaan, IRISi, and SafeLives.

Over the three years, the project engaged nine CCGs and 18 NHS Trusts across England to implement wide-ranging and sustainable interventions in eight local areas.

We did this by:

- Working with health stakeholders across these eight sites to identify and share good practice
- Turning guidance into practice and providing interventions where a gap in provision was identified
- Embedding local health and domestic abuse governance structures linking the parts of each local health economy to each other and to their local specialist domestic abuse services to promote a coordinated community response to survivors and perpetrators of domestic abuse
- Sharing learning and guiding national dissemination of good practice to inform future policy work and data collection

This Toolkit has been informed by the existing good practice we have identified and the learning we have accumulated through improving the response to domestic abuse in our sites. Each chapter includes details of the governance structures, interventions and best practice we promoted on our sites and how to go about implementing these.

The project is being independently evaluated by Cardiff University and the findings will be published in August 2020.

The Pathfinder project was funded by:



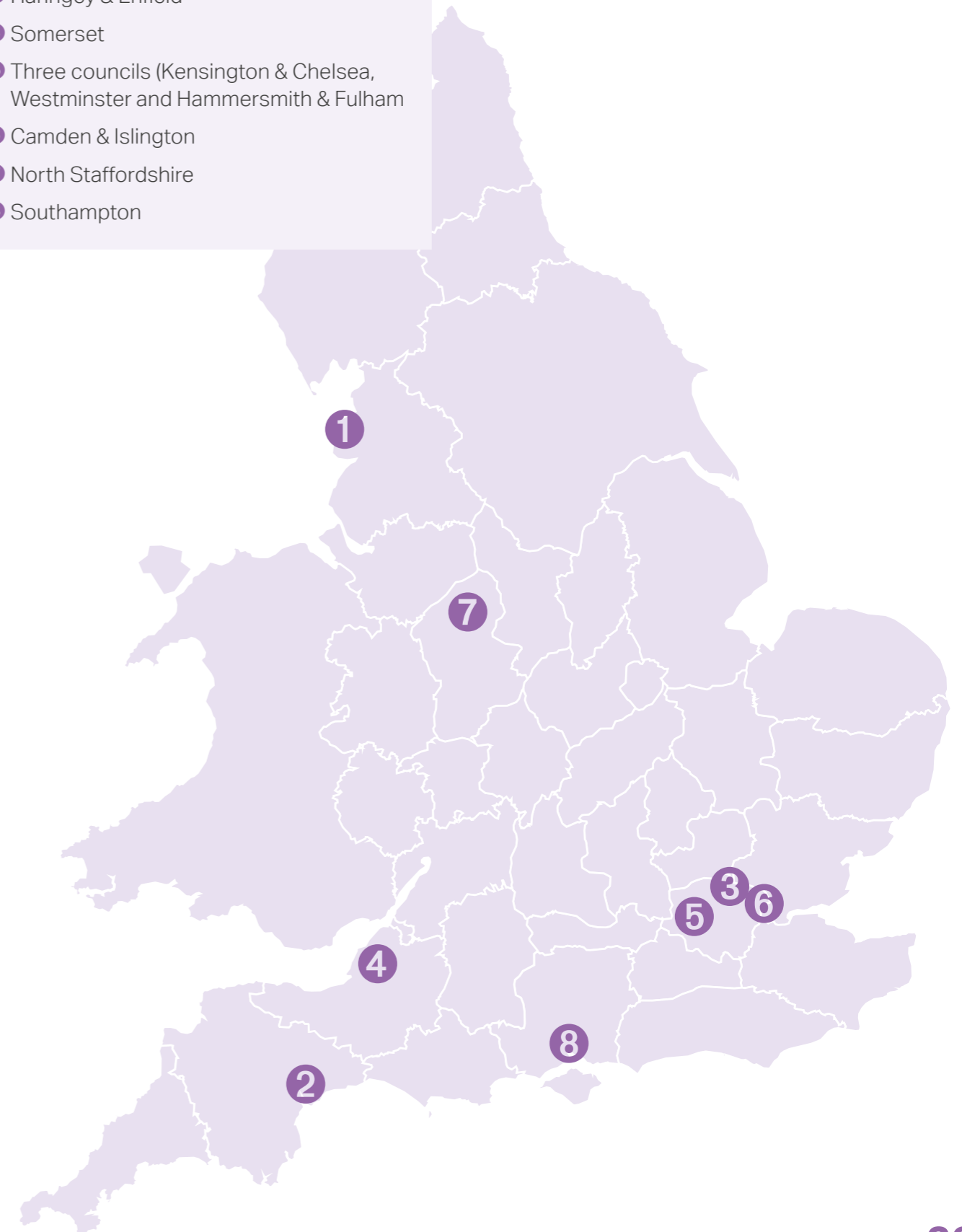
**Department for  
Digital, Culture,  
Media & Sport**



**Department  
of Health &  
Social Care**

## Pilot sites

- 1 Blackpool
- 2 Exeter & North Devon
- 3 Haringey & Enfield
- 4 Somerset
- 5 Three councils (Kensington & Chelsea, Westminster and Hammersmith & Fulham)
- 6 Camden & Islington
- 7 North Staffordshire
- 8 Southampton



# Key Achievements of the Pathfinder Project

"I... feel confident that we have significantly raised the profile of Domestic Abuse within Health's Safeguarding Agenda and I believe that our strategic partners recognise the importance and intrinsic value of health embedding a universal response to domestic abuse"

-Pathfinder Domestic Abuse Project Lead

- £** Ten Health Based Idvas, three Domestic Abuse Coordinators and two IRIS programmes across 64 GP practices were funded
- 2,738** Approximately 2,738 health professionals have had domestic abuse training since the start of the Pathfinder project
- 15x** 15 NHS Trust Domestic Abuse Policies have been reviewed
- 8** 8 NHS Trust Domestic Abuse Training Packages have been reviewed
- 9x** 9 Domestic Abuse Champion Networks in NHS Trusts have been setup and supported
- Each Pathfinder site now has a steering group and an operational group to focus on the NHS Trusts response to Domestic Abuse

## The Whole Health Model

A whole health model takes a systemic approach to responding to domestic abuse across the health economy. It brings together national promising practice to ensure effective and sustainable change. This model builds on the knowledge and expertise tested and recorded nationally as part of the Pathfinder project.

A whole health model goes beyond the implementation of individual initiatives such as training; it requires systemic change and the strategic commitment of services.

The diagram below illustrates the key components of this model. A robust strategic framework and governance structure is essential in creating the foundations for the implementation of this work and to ensure a coordinated and sustainable approach.



## Our Approaches

The Pathfinder consortium used a range of approaches to thinking about domestic abuse and systems change throughout the design and implementation of the Pathfinder Project. These approaches are embedded throughout the recommendations made in this Toolkit and Pathfinder recommends that health services use them in thinking about their own response to domestic abuse.

### The Coordinated Community Response (CCR) Approach

The Coordinated Community Response approach enables a whole system response to a whole person. It highlights that responsibility for safety should not rest with individual survivors but with the community and services they come into contact with and is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor. Instead, it emphasises that a successful response to domestic abuse requires agencies to share information and work together effectively and systematically to increase the safety of survivors. This allows a professional to understand the full risk the perpetrator(s) pose to a survivor, and how fast this needs to be acted on.

It is important to remember that a CCR model supports organisational responses, it does not, however, replace them. Organisations remain responsible and accountable (to survivors, to their own agencies and to the partnership) for their own responses to domestic abuse, within a context of multi-agency working.

If you are interested in learning more about this approach and how you can embed it locally read [In Search of Excellence](#) or contact [Standing Together](#) to learn more about CCR Leaders training.

### Gendered Approach

One in every 20 women have experienced extensive physical or sexual violence and abuse across their life course, compared to one in every 100 men. At the same time, perpetrators are overwhelmingly male<sup>51</sup>.

In order to appropriately respond to and fully understand the source of the issue of domestic and sexual abuse, it is essential to take a gendered approach. The abuse women face is tied to historical discrimination and the patriarchal structures in society whereby gender inequality creates barriers that limit women's choices and services<sup>52</sup>. Over the years, this has resulted in systems and services often being designed without women's experiences taken into account.

This is not to exclude the abuse that men also face, whether from other men or from women, or to exclude other forms of abuse such as intimate partner abuse in same sex relationships, and child to parent abuse. However crucially, it recognises that the sexual and domestic abuse women face is more frequent and more extensive, and tied to broader social and structural barriers. We do this by using gendered language and using examples which typically refer to the survivor as female.

Pathfinder has taken a gendered approach, acknowledging the gender dynamics at play in both sexual and domestic abuse, and the extent to which victims are primarily female. This approach is evidence-based and has been endorsed nationally & internationally by bodies such as NICE, the UN and WHO<sup>53</sup>.



### Trauma-informed approach

**"I remember when I took an overdose, I woke up, and there was a man just sitting on the chair in front of me just watching me... I remember I passed out and fainted. They thought it was because I hit my head, it was because I was in that much panic in my brain. It was like I had a mental overload and it was too much, but I couldn't even explain it to them because there were men there"**  
 –Rosa<sup>54</sup>, survivor consulted as part of the Pathfinder survivor consultation process

Given what is known about the severe impact of domestic abuse on individuals, it is not surprising that many survivors suffer from trauma as a result of their experiences. Certain factors mean that often survivors suffer from complex trauma including the trauma (abuse) occurring in an environment that is supposed to be safe and perpetrated by an individual who is known to them and over long periods of time. One study evidences that 80% of women accessing domestic abuse services had PTSD<sup>55</sup>. Symptoms of trauma vary for the individual, but may include depression, anxiety, guilt, loss of concentration, loss of appetite, feelings of fear, hyper-arousal, avoidance and flashbacks.

A trauma-informed approach (TIA) is a: 'survivor-centred, considered way to engage respectfully and safely with trauma, and aims to promote healing and restore survivors' wellbeing. TIA is a strengths-based practice moving away from what's wrong with you to what's strong with you, recognising survivors' capabilities for resistance and resilience. Work is heart driven with relationships built on the basis of collaboration, mutuality, honesty and transparency. The emphasis on survivor-led practice provides options and choices, promoting empowerment to secure survivors' autonomy. TIA practice is grounded in an Intersectional perspective, providing a holistic frame to acknowledge and embrace survivors' socio-political reality.' –Dr Akima Thomas OBE

It is essential to understand that survivors' experiences of abuse are traumatic, and to ensure that responses to survivors are trauma-informed. Taking a trauma-informed approach is essential in order to safely, effectively and appropriately support survivors.

Pathfinder endorses the use of the Drayton Park Model. Drayton Park is a women-only crisis house that is based on a trauma-informed model and seeks to be an alternative to acute admission. See Appendix 1: Drayton Park Model for more information.

51 Scott, S & McManus, S (2016) Hidden hurt: violence, abuse and disadvantage in the lives of women, Available at: <https://weareagenda.org/>

52 Dobash, R.P. and Dobash, R.E. (2004) 'Women's violence to men in intimate relationships. Working on a Puzzle', British Journal of Criminology, 44(3), pp. 324–349

53 WHO (2012) Understanding and addressing violence against women [https://apps.who.int/iris/bitstream/handle/10665/77432/WHO\\_RHR\\_12.36\\_eng.pdf;jsessionid=995C6D8C652B434F75950BA983330C85?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf;jsessionid=995C6D8C652B434F75950BA983330C85?sequence=1); UN Women [www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures](http://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures)

54 All names have been changed to protect the anonymity of the survivors.

55 Ferrari, Giulia; Agnew-Davies, Roxane; Bailey, Jayne; Howard, Louise; Howarth, Emma; Peters, Tim J; Sardinha, Lynnmarie; Feder, Gene; (2016) Domestic violence and mental health: a cross-sectional survey of women seeking help from domestic violence support services. Global health action, 7 (1)





### Intersectional approach

**“Intersectional paradigms remind us that oppression cannot be reduced to one fundamental type, and that oppressions work together in producing injustice”<sup>56</sup>**

Intersectionality provides a framework for thinking about and responding to the ways that different women and girls are subjected to oppression. Taking this approach allows us to recognise that women’s and girls’ identities and social positions are uniquely shaped by several factors at the same time, creating unique experiences and perspectives. These factors include among others ‘race’, ethnicity, sexuality, gender identity, disability, age, class, immigration status, caste, nationality, indigeneity, and faith. For example, a black woman may experience sexism and racism at the same time. Her experiences of discrimination cannot be separated out into either of these distinct categories as she will experience

sexism differently to her white counterpart due to her race and racism differently to her male counterpart due to her sex. This has an effect, not only on how she will experience and understand violence, but also on how and where she can access support and justice.<sup>57</sup>

An intersectional approach also recognises that historic and ongoing experiences of discrimination will impact on a woman’s sense of trust. It is therefore the responsibility of the organisation to ensure that a sensitivity to the gendered dynamics of VAWG does not ignore other areas of inequality that a woman may encounter. An effective, intersectional approach is not limited to interactions with individual women, but should be at the core of each aspect of an organisation’s work, from governance through to evolution. An intersectional approach should be at the heart of an organisation’s broader commitment to anti-discriminatory practice.<sup>58</sup>

### Survivor-led approach

**“Whether it’s coercive, physical, mental or whatever the abuse is, no one really understands it who hasn’t been through it themselves, I mean why should they, and that’s fair enough. But, there are services we approach, if they put up barriers, then you feel like you’re being abused by everybody”**

–Sophie<sup>59</sup>, survivor consulted as part of the Pathfinder survivor consultation process

Survivors of domestic and sexual abuse should be at the heart of all responses to domestic abuse. The term survivor reflects that those who have faced violence and abuse have employed a range of strategies to cope and protect themselves and aims to be a term of empowerment.

A survivor-led approach means involving those who have faced abuse as partners in the creation of the systems and services for which they are intended beneficiaries. Survivor-led means giving agency to be involved in everything from the design, commissioning and delivery of services as well as in policy, influencing and campaigns work. In health settings, co-production and involvement is a vital part of good patient outcomes and consideration should be given as to how survivors of abuse are able to participate. Survivor involvement is also a key component of a trauma-informed approach.

To find out how best to involve survivors in your own work Pathfinder recommends following the principles of effective and safe survivor-led work included in the survivor’s charter [here](#).

<sup>56</sup> Collins, Hill Patricia (2000) Black Feminist Thought: Knowledge, Consciousness and the Politics of Empowerment. New York and London: Routledge

<sup>57</sup> Imkaan (2017) Safe pathways? Exploring an intersectional approach to addressing violence against women and girls – Good Practice Briefing. London: Ascent (London VAWG Consortium)

<sup>58</sup> Imkaan, Rape Crisis England and Wales, Respect, SafeLives and Women’s Aid (2016) Sector Sustainability Shared Standards

<sup>59</sup> All names have been changed to protect the anonymity of the survivors.



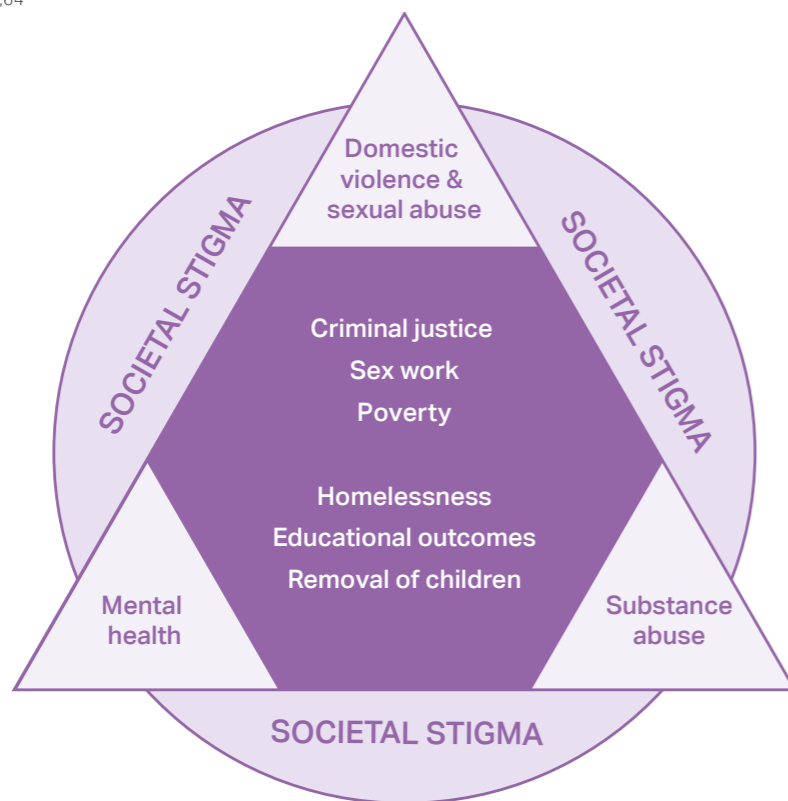
**Multiple disadvantage approach**

Multiple disadvantage refers to the interaction and inter-connectedness of people’s experiences, with domestic and/or sexual abuse, mental-ill health and the use of substances forming a triangle of common experiences<sup>60</sup>. Other experiences and outcomes that may interact include poverty, contact with the criminal justice system, prostitution, removal of children, homelessness, and poor educational outcomes.

This diagram, produced by AVA’s peer researchers, demonstrates what we mean by multiple disadvantage and its application as a lens through which to understand survivors’ experiences.<sup>61,62,63,64</sup>

This is not to say that women and girls who don’t have these experiences cannot be affected by abuse; indeed research has shown that health settings can be a more conducive environment for women of real or notionally higher economic status and educational attainment to disclose their experiences. The need to look at multiple disadvantage is therefore applicable for some women, but not all women who have experienced or who may be vulnerable to abuse.

AVA’s work on multiple disadvantage identifies the need for services to be set up and/or available to support women experiencing multiple disadvantage<sup>65</sup>.



60 SafeLives (2019). Mental Health and Domestic Abuse. Spotlight. [online] SafeLives. Available at: <http://safelives.org.uk/sites/default/files/resources/Spotlight%20-%20Mental%20health%20and%20domestic%20abuse.pdf> [Accessed 8 Nov. 2019].

61 AVA (2019) Breaking Down the Barriers, Accessible at: <https://avaproject.org.uk/wp-content/uploads/2019/03/Breaking-down-the-Barriers-full-report-.pdf>

62 National Drug Treatment Monitoring System: [www.ndtms.net/viewit/Adult/ExecutiveSummary.aspx](http://www.ndtms.net/viewit/Adult/ExecutiveSummary.aspx)

63 Wall-Weiler, E., Roos, L., Bolton, J., Brownwell, M., Nickel, N. and Chateau, D. (2017). Maternal health and social outcomes after having a child taken into care: population-based longitudinal cohort study using linkable administrative data. *Journal of Epidemiological and Community Health*, 71, pp.1145-1151

64 Homeless Link (2014). The Unhealthy State of Homelessness. [online] London: Homeless Link. Available at: [www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf](http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf) [Accessed 12 Dec. 2019].

65 AVA & Agenda (2017) Mapping the Maze [Online] Available at: <https://avaproject.org.uk/wp/wp-content/uploads/2017/09/Mapping-the-Maze-final-report-for-publication.pdf>

## A

# Section A: Governance and Strategy

This section covers the importance of embedding a robust structure to govern your local health areas' response to domestic abuse.

## This section is aimed at:

- Local Authority Domestic Abuse/VAWG Leads
- Clinical Commissioning Group Domestic Abuse/Safeguarding Leads
- Anyone responsible for commissioning domestic abuse interventions within health or coordinating a local area's response to domestic abuse or VAWG
- Leads for domestic abuse in NHS Trusts

## The following chapters are included in this section:

- [Chapter 1: Health and Domestic Abuse Governance Structure](#)
- [Chapter 2: Domestic Abuse Strategy](#)
- [Chapter 3: Policies and Procedures](#)
- [Chapter 4: Equality, Diversity and Inclusion](#)

## Appendices relevant to this section include:

- [Appendix 2: Domestic Abuse Strategic Action Plan Template](#)
- [Appendix 3: Specialist guidance for Health Professionals Responding To LGBT+ People Experiencing Domestic Abuse](#)
- [Appendix 4: Specialist guidance for Health Professionals Responding To Older Women Experiencing Domestic Abuse](#)
- [Appendix 5: Specialist guidance for Health Professionals Responding To Disabled Women Experiencing Domestic Abuse](#)

- [Appendix 6: Specialist guidance for Health Professionals Responding To BME Women Experiencing Domestic Abuse](#)
- [Appendix 7: Domestic Abuse Policy Assessment Tool](#)
- [Appendix 8: Domestic Abuse Policy Template](#)

## Throughout this section the following recommendations are made:

- Every local authority should have a VAWG/ domestic abuse and health strategic group that is attended by the local acute health Trust, mental health Trust, representatives from general practice and the local domestic abuse/ VAWG specialist services with clear links to existing local authority domestic abuse or VAWG governance structures to oversee the local response to domestic abuse in health.
- Every NHS Trust and CCG should have a VAWG/domestic abuse steering group which oversees the services' response to domestic abuse and the implementation of a domestic abuse strategy.
- Every NHS Trust and CCG should assign a Lead for Domestic Abuse to represent them at steering group meetings. This responsibility should be recognised in their job description.
- Every NHS Trust and CCG should have a VAWG/Domestic Abuse Strategy detailing the service's commitment to improving their response to patients and staff experiencing domestic abuse and outlining the practical action it will take to achieve this.
- Every VAWG/Domestic Abuse Strategy should include details of the service's commitment to providing training to staff in line with NICE guidelines.
- Every VAWG/Domestic Abuse Strategy should be aligned with the service's Equality, Diversity and Inclusion Strategy and Safeguarding Policies.
- Every NHS Trust and CCG should have a policy for patients experiencing/perpetrating domestic abuse and a policy for staff experiencing/perpetrating domestic abuse.
- Every domestic abuse policy should be aligned with the service's Equality, Diversity and Inclusion Strategy and Safeguarding Policies.
- Every NHS service should undertake a range of diversity accreditations and schemes to promote positive equality, diversity & inclusion standards in the workplace and to better respond to the needs of all patients and staff.
- Every NHS service should set up effective staff networks for staff members to promote diversity. As a minimum networks should exist for staff who are black and minority ethnic, disabled, LGBT+ and allies.
- Every NHS service should review their existing training offer regularly and aim to create an interactive training package that covers the experiences of people who experience unique forms of discrimination due to the intersection of their gender with other identity characteristics including race, class, poverty, disability, age and sexual orientation, as part of the course.
- All NHS Services should ensure NHS employees and patients have access to an independent service for British Sign Language (BSL) and other translation services.

## A

# Chapter 1: Health and Domestic Abuse Governance Structure

## Pathfinder recommendations:

- Every local authority should have a VAWG/ domestic abuse and health strategic group that is attended by the local acute health Trust, mental health Trust, representatives from general practice and the local domestic abuse/ VAWG specialist services with clear links to existing local authority domestic abuse or VAWG governance structures to oversee the local response to domestic abuse in health
- Every NHS Trust and CCG should have a VAWG/domestic abuse steering group which oversees the services' response to domestic abuse and the implementation of a domestic abuse strategy
- Every NHS Trust and CCG should assign a Lead for Domestic Abuse to represent them at steering group meetings. This responsibility should be recognised in their job description.

**'Health partners play a vital role in ending domestic abuse as part of our wider coordinated community response. The Pathfinder project has provided us with a robust framework to ensure that local authorities, specialist services and health approaches are aligned and effectively coordinated. Building on existing good practice, we have adopted a partnership approach on both a strategic and operational level in a range of health settings to be able to better meet the support needs of victims and survivors of domestic abuse.'**

–Shabana Kausar, Strategic Lead: Violence against Women and Girls London Boroughs of Westminster, Hammersmith & Fulham and Kensington & Chelsea

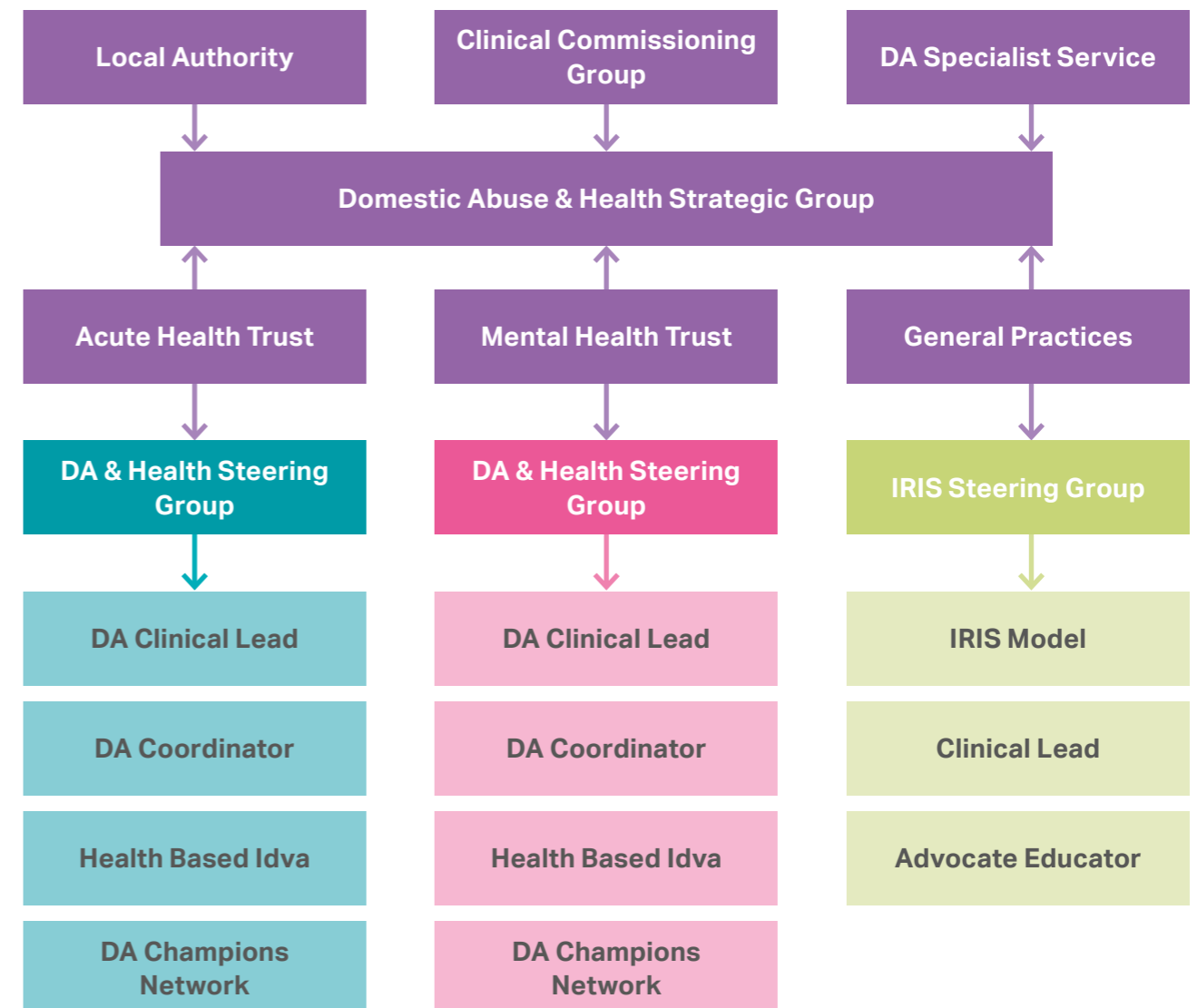


Shabana Kausar, VAWG Strategic Lead, discusses the importance of partnership working.

It is important to establish a robust governance structure for each level of the whole-health response to domestic abuse; strategic and operational, to support a consistent response to domestic abuse across health services where any survivor will receive the same level of support from health professionals irrespective of the health issues they present with (sexual health, mental health, burns, pregnancy etc).

Every local authority area will have different existing arrangements, strategic lead responsibilities and governance structures for addressing domestic abuse. Your local authority may have an existing standalone domestic abuse strategy and governance structure or domestic abuse may fall under a VAWG or domestic and sexual abuse strategy.

Pathfinder recommends that any strategic groups and governance structures set up to respond to domestic abuse and health should fit appropriately into the existing remit led by the local authority. For example, if your local authority has a VAWG strategy then you should look to set up a VAWG and health strategic group which would address domestic abuse as part of it. Any new strategic groups should be set up in consultation with the local authority to ensure it fits appropriately within this established local structure. Throughout this chapter we will refer to these strategic groups as VAWG/domestic abuse strategic groups, however, as outlined, you should adapt this model and language to fit your own local context.





## VAWG/Domestic Abuse and Health Governance Structures

To establish a robust governance structure for each level of the whole-health response to domestic abuse, Pathfinder recommends that operational steering groups should be set up within acute health Trusts, mental health Trusts and CCGs or IRIS areas where IRIS exists. These groups should be accountable to an overarching health and VAWG/domestic abuse strategic group, as shown below.

This should ensure that all local NHS services are held to account for their response to domestic abuse. It will also ensure the response is embedded at a strategic level and joined up across local health services.



## VAWG/Domestic Abuse and Health Strategic Groups

The VAWG/Domestic Abuse and Health Strategic Group should hold strategic oversight of the response to domestic abuse across all local health settings (mental health, acute health and general practice). The focus of this group should be on implementing a coordinated community response by providing a platform to optimise multi-agency partnerships to achieve safe responses for survivors across the health system.

The steering group should agree to a clear Terms of Reference which outlines the commitment of each agency and the specific aims of the group.

Pathfinder recommends that these meetings take place quarterly with a focus on:

Using appropriate data, analysis and survivor input to get a full picture of need across the local area, including an understanding of additional barriers that might be faced by certain groups

Mapping provision of domestic abuse support across the local health economy and identifying gaps when placed alongside the robust assessment of needs

Providing a platform to optimise multi-agency partnerships to achieve safe responses for survivors

Supporting the implementation of promising practice across all health areas including the identification of funding opportunities

- Sharing learning, good practice and resources across partners including policies and procedures, training strategies, data sharing protocols and agreements with local domestic abuse or VAWG specialist services.

In order to do this it is vital for the group to have regular attendance from:

- 1 All local acute and mental health Trusts
- 2 The local CCG or a representative from general practice
- 3 The local authority domestic abuse or VAWG Lead
- 4 Local domestic abuse or VAWG specialist services
- 5 An IRIS representative (if IRIS is commissioned in the local area)
- 6 BME, LGBT+ and Disabled specialist services or representatives

Services 4–6 mentioned above should be consulted for ideas about how survivors of abuse can be brought into a process of co-production and analysis of the local response to domestic abuse. This makes no assumption about the experiences of the professionals in the room, who of course might also have their own lived experience of abuse, but will not be able to advise from a position of independence.



Sharing learning, good practice and resources across partners

## The Role of a Lead for Domestic Abuse

It is important to consider which staff member is best placed to represent your organisation at the VAWG/Domestic Abuse and Health Strategic Group. Pathfinder recommends that every NHS Trust and CCG should nominate a Lead for Domestic Abuse to champion the service's domestic abuse response at a decision making level and represent the service at multi-agency meetings. The responsibility for identifying and appointing these roles should sit with senior officials at Trust Board level.

The Lead for Domestic Abuse should be a senior member of staff with a professional responsibility or interest in domestic abuse. We know that in many NHS services around the country there are champions of domestic abuse who already fill this role unofficially, often on top of their existing clinical responsibilities (it is likely you are the one reading this Toolkit!). It is vital that this responsibility is formally acknowledged by the service by including it in their job description.

The Lead should **not** be responsible for creating or implementing the organisation's domestic abuse strategy, this is a full-time role that a Domestic Abuse Coordinator should undertake within the Trust. Instead the Lead should be responsible for:

- Raising awareness of the domestic abuse agenda with the executive board
- Submitting business cases to employ a Domestic Abuse Coordinator and Health Based Idva and overseeing the embedding of these roles
- Ensuring the organisation is engaged in the local coordinated community response to domestic abuse via the local governance structure and steering group meetings.

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If there is no Lead appointed yet, the executive board should assign a colleague with strategic oversight of the organisation's response to attend. This may be someone at director level such as a Director of Nursing responsible for Safeguarding or Head of Safeguarding.

### NHS Trust VAWG/Domestic Abuse Steering Groups

Pathfinder recommends that every NHS Trust (both acute and mental health Trusts) should set up a domestic abuse steering group which feeds into the VAWG/Domestic Abuse and Health Strategic Group to implement and maintain good practice in relation to domestic abuse across the Trust. It is vital that the local specialist VAWG or domestic abuse service attends these meetings.

We recommend that these meetings take place monthly or bi-monthly with a focus on:

- Developing and implementing the Trust's domestic abuse strategy (please see Chapter 2: Domestic Abuse Strategy & Appendix 2: Domestic Abuse Strategic Action Plan Template for more information)
- Ensuring the Trust's domestic abuse strategy is delivered in line with the Equality, Diversity and Inclusion strategy (Please see Chapter 4: Equality, Diversity and Inclusion for more information)
- Developing and maintaining a data set to monitor practice in relation to domestic abuse (please see Chapter 12: Data Collection, Monitoring, Analysis and Practice Improvement for more information)
- Developing and maintaining excellent partnerships in order to ensure a joined-up response to survivors (please see Chapter 10: Referral Pathways for more information)

- Creating and refreshing policies and procedures for staff and patients (Please see [Chapter 3: Policies and Procedures & Appendix 7: Domestic Abuse Policy Assessment Tool](#) & [Appendix 8: Domestic Abuse Policy Template](#) for more information)
- Capturing and responding to the needs of staff and patients appropriately and in a trauma-informed way
- Raising awareness of domestic abuse (please see [Chapter 13: Awareness Raising](#) for more information)
- Providing and promoting capacity building opportunities
- Connecting identified Domestic Abuse Champions (please see [Chapter 8: Domestic Abuse Champions Network](#) for more information)

To ensure that this steering group is as effective as possible it is important to ensure that all key decision makers are around the table. Steering groups with buy in from change makers and Board level representatives will be more effective, however, implementing a good response to domestic abuse will involve buy in and input from all areas of the Trust. Indeed, research in mental health Trusts found that there must be strategic leadership to support staff in addressing domestic abuse. However, staff often identify with their own discipline – leadership must therefore be multidisciplinary, in mental health Trusts this should include representation across nursing, psychology, social work, occupational therapy and psychiatry.

Having someone around the table who can advise on the feasibility of your ideas will save valuable time and resources. For example, you may need to know whether it is possible to adjust electronic medical records to record more substantial data around domestic abuse or whether it is possible to alter an e-learning module and having representatives with this knowledge will speed up decision making processes.

The group should have regular attendance from representatives of the following roles/ departments:

- 1 The Clinical Lead for Domestic Abuse or any colleague with responsibility for domestic abuse in the organisation
- 2 The Domestic Abuse Coordinator
- 3 The Health Based Idvas
- 4 Learning and Development
- 5 Safeguarding
- 6 Substance Use
- 7 Learning disability
- 8 IT Department (someone with responsibility for data collection)
- 9 HR team
- 10 Equality and Diversity Lead
- 11 Communications team
- 12 Data or auditing team
- 13 Patient involvement representative

To ensure the Trust's response to domestic abuse is survivor-led and caters to the needs of all patients, you should consider who else you could invite to attend these meetings.

### Survivor/patient voice groups

It is vital that the Trust's response to domestic abuse reflects the needs and priorities of the local patient population. Inviting your local domestic abuse specialist service and your Health Based Idva to attend your steering group will go some way toward doing this. However, you should consider how you can go further to ensure all survivors are represented at this level.

Pathfinder recommends that every Trust invite representatives and input from local relevant patient voice groups, domestic abuse survivor networks and women's support groups. If existing survivor/patient voice groups do not exist locally you should liaise with your local VAWG or domestic abuse service to set up a group funded by the Trust to ensure the Trust's response to domestic abuse is considered with direct survivor input and consultation.

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Furthermore, the Trust should recognise that not all women have equal access to the support and services they need. The Trust should recognise that nuanced and specific responses may be required to adequately address VAWG and respond effectively and safely to all survivors. In order to achieve this, the Trust should invite representatives from any local BME, LGBT+ or disability specialist services to attend your steering group and represent the needs and experiences of these survivors.

It is important to note that any survivor involvement in this forum should be done in an appropriate way considering the potential re-traumatisation of the survivor. You should be led by survivors themselves and ask them how they would like to participate. Pathfinder recommends that you do this in consultation with your local VAWG or domestic abuse service, even if participating survivors have never accessed a specialist domestic abuse service (voices that are also vitally important to include). Local services should support you to meaningfully incorporate survivor voices and be given the resource to do so.

## Staff networks

Some NHS Trusts will have existing staff networks to provide a platform for staff with particular identity characteristics to voice their opinions and support the Trust to improve working practices and services. These may include networks for LGBT+, BME or disabled staff, among others. If these networks exist then consider inviting a representative to the steering group to support you to meet the needs of specific patient and staff populations.

If these networks do not already exist in your Trust, you should consider whether this would be a useful resource to help your Trust respond effectively to patients and staff and meet your statutory duty around equality and diversity. See [Chapter 4: Equality, Diversity and Inclusion](#) for more information on how to go about setting these up.

## Promising practice example

As part of the Pathfinder project in the **London Boroughs of Camden and Islington**, a strategic group was set up to create a space for key strategic decision making, sharing learning and best practice and enabling cross-health partnership working across the lifespan of the project.

This group included representatives from the respective Local Authority VAWG strategy and commissioning teams, CCGs, Acute health, Mental health, local IRIS intervention, and third sector organisations (including Idvas funded through the project). The group membership built on pre-existing partnerships and relationships across the local areas – a fundamental factor in the ease of setting-up the group.

The Camden and Islington strategic group met every two months over the course of the project. The regulation of meetings, alongside commitment from all representatives, were key enablers for the successes of the Pathfinder project in this site, and key to informing and driving developments in health responses to domestic abuse and a coordinated community response. The group offered opportunities for greater partnership working and multi agency network building both within and across the local areas.

Through the group meetings, members were able to organise and streamline efforts for a more coordinated response for survivors. This included identifying and addressing gaps in service provision and service responses – for example, the strategy group enabled key decisions to be made in regards to the allocation of resources, a commitment to long term implementation of specialist interventions in health settings; access to training opportunities and resources that members circulated with the rest of the group.

Meeting others making a commitment to prioritising domestic abuse was considered by all as an incentive for agencies to continue this work, as well as providing a level of accountability. Some members also found that the knowledge of good practice they gained from other agencies provided them with leverage for calling for improvements in their own agency.

Due to the successes, benefits and outcomes of the strategy group over the life of the Pathfinder project, the group intends to continue meetings on a long term basis, opening up to a broader range of agencies. The group highlighted that persistence, patience, commitment from relevant agencies, using previous networks for membership and keeping realistic objectives in mind have been crucial to the effective running of such a group.

When asked, steering group members commented that:

**'The benefits have been a joint partnership working and commitment by different organisations to work together post project'**

**'Without a group and buy in from different partners, you are one service trying to make a difference. Like the clients we support, we need a coordinated response, everyone's knowledge, contacts and guidance.'**

**'This group has been very useful. It's about having an insight into what other people are doing, sharing the information with the CCGs and different partners.'**



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## Chapter 2: Domestic Abuse Strategy

### Pathfinder recommendations:

- Every NHS Trust and CCG should have a VAWG/domestic abuse strategy detailing the service's commitment to improving their response to patients and staff experiencing domestic abuse and outlining the practical action it will take to achieve this
- Every VAWG/domestic abuse strategy should include details of the service's commitment to providing training to staff in line with NICE guidelines
- Every VAWG/domestic abuse strategy should be aligned with the service's Equality, Diversity and Inclusion strategy and Safeguarding Policies.

Once a clear governance structure has been agreed and all key decision makers are around the table, the next step is to ratify a VAWG/ domestic abuse strategy to ensure the aims of the steering group are clearly and concisely mapped out.

As highlighted in [Chapter 1: Health and Domestic Abuse Governance Structure](#), each local authority will have different existing arrangements, strategies and governance structures for addressing domestic abuse. Your local authority may have an existing standalone domestic abuse strategy and governance structure or domestic abuse may fall under a VAWG or domestic and sexual abuse strategy.

Pathfinder recommends that your organisation's strategy reflects the remit of your local authority's governance structure. For example, if your strategic group focuses on VAWG or sexual violence your strategy should reflect this. Throughout this chapter we will refer to these strategies as VAWG/ domestic abuse strategies, however, as outlined, you should adapt this model and language to fit your own local context.

Furthermore, each local authority area will have different expectations about the geographical remit of VAWG/domestic abuse strategies. It is important that the remit of your service's strategy is led by the local authority and the local context. For example, some local authorities advocate for a county-wide approach to VAWG and in this case it may be appropriate for all local health services to share a VAWG/domestic abuse strategy that is led by the CCG rather than the individual services. Regardless of what level your VAWG/ domestic abuse strategy sits at, the principles of the strategy should be considered and reflected by each NHS service and every Trust or CCG should have a clear action plan outlining the practical actions it will take to meet the aims of the strategy.

Please see [Appendix 2: Domestic Abuse Strategic Action Plan Template](#) for an easy to use guide to creating an action plan for your service.

### The purpose of a VAWG/ domestic abuse strategy

Having a VAWG/domestic abuse strategy is important to:

- 1** Evidence your organisation's commitment to improving your response to domestic abuse
- 2** Establish the overarching aims and priority areas for change
- 3** Detail how your aims will be achieved by producing a clear action plan for the work that needs to be undertaken
- 4** Stipulate a timeline for achieving your aims
- 5** Define accountability for the strategy and encourage commitment at all managerial levels
- 6** Make clear how your own responsibilities and approach will fit with, and reinforce, the action of other agencies and statutory/voluntary sector partners, locally.

Assigning clear actions and responsibilities to staff members ensures accountability and effective monitoring of the success of the strategy.

Some specific things for you to consider when producing a domestic abuse strategy include:

#### The gaps in your current response to domestic abuse

Prior to writing your strategy, the domestic abuse/VAWG steering group should undertake a full review of your organisation's current response to domestic abuse. You should consider circulating a survey to staff members to get an idea of:

1. How many feel comfortable responding to domestic abuse
2. Whether they are happy with the level of training they receive
3. If they are aware of the domestic abuse policy and where to find it

You should also consult with patients who have experienced domestic abuse to understand how they experienced your service, and what improvements they would like to see. You can do this through consultation with the Health Based Idva, the local specialist domestic abuse service or any local patient voice groups as outlined in the [Chapter 1: Health and Domestic Abuse Governance Structure](#).



Consult with patients who have experienced domestic abuse

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### The content of your strategy

Once you have identified gaps in your response, your VAWG/domestic abuse strategy should outline exactly how you will plug them. [Appendix 2: Domestic Abuse Strategic Action Plan Template](#) should be used as a guide for what to include in your VAWG/domestic abuse strategy. The strategy should clearly speak to the following questions:

#### → Who is responsible for domestic abuse within the organisation?

The strategy should name anyone with a clinical or strategic responsibility for domestic abuse within the service. The strategy should include a clear action plan with named people responsible for delivering each action.

#### → How will you build and maintain multi-agency relationships?

The strategy should outline the ways your organisation will interact and share information with other agencies. This should include who will be representing your organisation at Marac and local domestic abuse steering groups. To find out more about Marac please see [Chapter 10: Referral Pathways](#). Please remember that participation in Marac is about more than attendance; it is vitally important that health professionals are also actively engaged in the referral process and onward safety and support planning agreed at meetings, as well as contributing expertise to considering other cases.

#### → How will you build structural capacity to ensure a safe response to domestic abuse?

This may include:

- producing or updating the Trust's domestic abuse policy for patients and staff
- ensuring processes and managers allow staff sufficient time to respond to domestic abuse
- ensuring staff have access to quiet, confidential areas to enquire about domestic abuse
- producing clear referral pathway guidance that staff have easy access to
- discussing staff confidence in responding to domestic abuse in supervision sessions

#### → What domestic abuse models and interventions will you invest in?

If your service already employs a Health Based Idva service, Domestic Abuse Coordinator or other practice/governance leads, the strategy should outline the key aims of those roles and any actions necessary to ensure the funding of the roles is sustainable long-term. If your service does not have these roles embedded as standard, the domestic abuse strategy should outline the actions you will take to fund these roles. If you have or are looking to set up a Domestic Abuse Champions Network the strategy should also include details of how you plan to achieve this.

#### → How will you improve your ability to respond effectively to staff who are survivors or perpetrators of domestic abuse?

This should include the ratification of a staff domestic abuse policy, tools for managers responding to domestic abuse within their staff team and training that managers and HR will receive.

#### → How will you monitor your response to domestic abuse?

Your domestic abuse strategy should state the importance of improving data collection around domestic abuse in order to monitor your response and evidence the success of your domestic abuse strategy. It should outline the steps you will take to collect data in line with Pathfinder recommendations, and how you will actively use this data to improve practice – data collection is never a goal in its own right.

#### → How will you increase staff confidence to respond to domestic abuse

If your organisation does not currently fulfill NICE recommendations on teaching staff how to enquire about and respond to domestic abuse, the VAWG/domestic abuse strategy should outline the actions you will take to improve the training offered to staff. This should include simple 'rehearsals for change' – opportunities for staff members to practice asking questions they find difficult. See [Chapter 11: Domestic Abuse Training](#) for more information on how to implement a robust domestic abuse training strategy as part of your overarching VAWG/domestic abuse strategy.

### How often the strategy will be reviewed

The VAWG/domestic abuse strategy should form the basis of the organisation's action plan for improving their response to domestic abuse. For this reason the strategy should be reviewed informally by the Domestic Abuse Coordinator and Clinical Lead for Domestic Abuse on an ongoing basis. It should inform their individual work plans and the content of the Trust's Domestic Abuse Steering Group meeting. The strategy should be formally reviewed every 2 years and all new actions should be allocated to individuals and departments as necessary.

#### Links to other strategies

It is important to ensure your organisation's VAWG/domestic abuse strategy is produced in line with other strategies including Equality, Diversity and Inclusion and the Safeguarding strategy, as well as policies which speak directly to the experiences of your own workforce, amongst which there will also be survivors and perpetrators of abuse.

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## Chapter 3: Policies and Procedures

### Pathfinder recommendations:

- Every NHS Trust and CCG should have a policy for patients experiencing/perpetrating domestic abuse and a policy for staff experiencing/perpetrating domestic abuse
- Every domestic abuse policy should be aligned with the service's Equality, Diversity and Inclusion Strategy and Safeguarding Policies

All NHS Trusts and CCGs should have a domestic abuse policy clearly detailing guidance for all staff, students and volunteers on initiating questions about domestic abuse within the context of their holistic assessment and undertaking routine/selective enquiry as appropriate. Pathfinder recommends that, while this policy should be in line with existing safeguarding policies, it should sit as a separate document. This is to ensure that domestic abuse is considered as a distinct issue and not just part of the wider safeguarding agenda.



All NHS Trusts and CCGs should have a domestic abuse policy

Most NHS Trusts and CCGs will already have a domestic abuse policy ratified and updated on a regular basis or domestic abuse may be covered in the remit of an existing VAWG or domestic and sexual abuse policy. If this is the case, you can use our [Domestic Abuse Policy Assessment Tool in Appendix 7](#) to ensure that domestic abuse is adequately addressed and considered in the existing policy.

If your organisation does not already have a domestic abuse policy, this should be identified as a gap in your response to domestic abuse at the VAWG/domestic abuse steering group and in the corresponding strategy and action plan you produce. Please see our [Domestic Abuse Policy Template in Appendix 8](#) which provides a template domestic abuse policy that can be easily modified to fit your local context and need.

### The purpose of a domestic abuse policy

Policies clearly set the tone and standard for employees and reflect the core values of the organisation. A comprehensive, clear domestic abuse policy that all staff can easily access will go some way to demonstrating the organisation's commitment to addressing domestic abuse, supporting patient and staff survivors and holding perpetrators to account.

We know that staff are more likely to ask patients and colleagues about their experiences of domestic abuse if they feel supported by their employer to do so. This is particularly important in relation to domestic abuse as it is a complex area, which can result in increased risk to survivors if handled inappropriately. A clear policy outlining how to inquire about domestic abuse and the steps involved in appropriately handling a disclosure will help to improve the confidence of staff.

### How to make sure your domestic abuse policy is successful

#### 1 The content of the policy

Use our Domestic Abuse Policy Checklist and Domestic Abuse Policy Template tools to ensure the content of your policy is comprehensive and gives clear guidance on how employees are expected to respond to survivors and perpetrators. You can also refer to the NHS guide on developing a domestic abuse policy, which can be found [here](#).

Fundamentally the policy should outline a standardised approach for the assessment and management of domestic abuse. It should set out three minimum standards:

- i. Patients/service users should be asked about their experiences of domestic abuse.
- ii. Information regarding domestic abuse must be recorded in the health profile/health records.
- iii. Appropriate action must be taken in all cases where domestic abuse is identified.

#### 2 Responsibility for updating the policy

Ensure the domestic abuse policy states how often it should be reviewed and updated. This should include details of who is responsible for doing this. Pathfinder recommends that a Domestic Abuse Coordinator should be funded to undertake this role. Please see [Chapter 6: Domestic Abuse Coordinator](#) to find out more about this role and how to implement it.

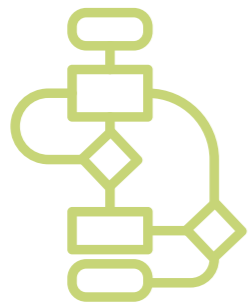


### A 3 Making the policy accessible

Consider how to make your policy as accessible to staff as possible. Is the policy on the Trust intranet and on your service's website? Ensure that managers are aware of the policy and discuss it with staff during supervision. The policy should include practical information that staff can use in their day to day practice. This should include:

- External and internal referral pathways
- Risk assessment tools (such as SafeLives DASH Ric<sup>67</sup>)
- The Duluth power and control wheel
- A list of signs and symptoms for professionals to be aware of
- Actions which can be undertaken as part of support for the employee e.g. being moved to a different department, the alleged perpetrator being banned from the premises and security being made aware of the situation

In our experience including visual aids such as flowcharts and diagrams ensures this information is as accessible as possible to all staff.



In our experience including visual aids such as flowcharts and diagrams ensures this information is as accessible as possible to all staff.

### 4 Links to other policies

The policy should link effectively to all other relevant policies including:

- a. Allegations Against Staff Policy
- b. Confidentiality Code of Practice
- c. Dignity and Respect Policy
- d. Disciplinary Process and Procedure Policy
- e. Equality and Diversity Policy
- f. Lone Working Policy
- g. Safeguarding Children and Young People Policy
- h. Safeguarding Adults Policy

### The importance of having a distinct staff domestic abuse policy

Pathfinder strongly recommends that every NHS Trust and CCG has a distinct policy dedicated to dealing with staff members as survivors or perpetrators of domestic abuse. We know that when staff experience domestic abuse it is likely to impact their safety, attendance, performance and job security. It can also affect other colleagues who may experience negative behaviours from the perpetrator especially if the perpetrator works within the same organisation as the survivor.

Having a dedicated procedure on how the organisation will respond to staff who are experiencing abuse will encourage staff to ask for support by reassuring them that they will not be judged and their situation will be handled sensitively.

Although we recommend having a stand-alone policy for staff, Pathfinder have not created a template staff policy as, at the time of writing, NHS England were in the process of producing their own Staff Domestic Abuse Policy Template. However, our [Domestic Abuse Policy Assessment Tool in Appendix 7](#) offers guidance on what should be included in a staff policy. Some important considerations include:

- Consideration of staff members' access to records
- Disciplinary action for alleged perpetrators
- Sick leave and compassionate leave arrangements
- Discrete support options for survivor staff members

Staff members experiencing domestic abuse may require support from their manager and HR and it is important that other staff members are clear on how to approach this. This is a highly sensitive issue, there needs to be a level of confidentiality and ability for staff to approach dedicated line managers, HR, safeguarding, or senior staff members where needed.

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## Chapter 4: Equality, Diversity and Inclusion

### Pathfinder recommendations:

- Every NHS service should undertake a range of diversity accreditations and schemes to promote high equality, diversity & inclusion standards in the workplace and to better respond to the needs of all patients and staff.
- Every NHS service should set up effective staff networks for staff members to promote diversity. As a minimum, networks should exist for staff who are black and minority ethnic, disabled, LGBT+ and allies.
- All NHS Services should ensure NHS employees and patients have access to an independent service for British Sign Language (BSL) and other translation services.

**"I personally feel just as an African... I fail to find something I can identify with. I shut down and fail to express myself, you know, why I'm there in the first place. Personally, I know probably this is impossible, but it would be amazing in all of these services to have some diversity in it you know. When we go, even in the office, I may not be talking to that black woman there, but she's just there. It lifts up a lot of weight... Somehow we are always left behind"**  
– Zahra<sup>68</sup>, survivor consulted as part of the Pathfinder survivor consultation process

All NHS patients and staff can experience abuse regardless of race, sexual orientation, ability, religion or age. Women who access healthcare are not a homogeneous group but are from diverse communities, ages, abilities, sexual identities and more. It is vital that the NHS responds to survivors of domestic abuse with diverse experiences by ensuring services are accessible to a range of people.



## One in four

victims of domestic homicides in England and Wales are over 65<sup>69</sup>

There are various myths and stereotypes about domestic abuse that can be a barrier to recognising and responding to it, for example that domestic abuse only happens in heterosexual relationships. These can affect peoples' perception of domestic abuse, making professionals less likely to consider abuse when a patient with a certain identity characteristic presents with unexplained injuries or mental health issues. It can also make it hard for survivors to recognise their experience as domestic abuse and make a disclosure. This in turn means that they may be less likely to be offered support or referred into specialist agencies.

For example, the 'public story' and perception of domestic abuse tends to exclude the experiences of older survivors and in some cases, when an older survivor may be cared for by an intimate partner or family member, incidents of violence or abuse can be wrongly attributed to a carer's stress. For this reason domestic abuse amongst older people is significantly underreported. Whilst one in four victims of domestic homicides in England and Wales are over 65<sup>69</sup>, over 61s make up only 3.4% of services users accessing domestic abuse support in the community with this falling to 1.4% in refuges<sup>70</sup>.

Historically, systems have been designed without the experiences of women, LGBT+, disabled and BME people in mind. This means that services may be harder for certain groups to access. Past experiences of racism, bi/homo/transphobia, ableism or agism may lead to a 'gap of trust' whereby survivors fear they will not get a sympathetic response and will face discrimination<sup>71</sup>.

Furthermore, it is important to remember that individuals do not fit neatly into labelled boxes and that someone who experiences a range of discrimination due to their intersecting identities may struggle to access services and disclose abuse due to a multitude of access needs. For example, a black lesbian woman with hearing loss may fear accessing support due to past experiences of sexism/racism/homophobia as well as a difficulty accessing information due to her disability. If she did access services effectively, the abuse she was experiencing may not be picked up on if the professional assumed that domestic abuse did not happen in same-sex relationships or that her female partner was a close friend or sister.



**Historically, systems have been designed without the experiences of women, LGBT+, disabled and BME people in mind.**

69 Bows, H. (2018) Domestic Homicide of Older People. (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK. The British Journal of Social Work, 49 (5): 1234-1253.

70 Women's Aid (2020) The Domestic Abuse Report 2020: The Annual Audit. Available at: [www.womensaid.org.uk/research-and-publications/the-domestic-abuse-report](http://www.womensaid.org.uk/research-and-publications/the-domestic-abuse-report)

71 Donovan, C. and Hester, M. (2014) Domestic violence and sexuality: what's love got to do with it? Bristol: Policy Press



Sarah Hughes, Mental Health Coordinator at Standing Together, discussing the need to respond better to survivors from marginalised groups.

In order for NHS services to adequately meet the needs of all survivors, they must consider the experiences of a wide range of survivors and how the intersection of these various identities may contribute to the service failing to respond to them. This approach to domestic abuse should be taken as par for the course, rather than as an afterthought or a tokenistic consideration of the equalities agenda.<sup>72</sup> In order to respond to all survivors of domestic abuse effectively, all processes must be free from discrimination, value the differences between people and aim to make it easier for everyone, regardless of differences, to access suitable and effective support.

Pathfinder has produced specialist guidance for health professionals on how to respond appropriately to:

- [LGBT+ survivors – See Appendix 3](#)
- [Older survivors – See Appendix 4](#)
- [Disabled survivors – See Appendix 5](#)
- [BME survivors – See Appendix 6](#)

## What is equality, diversity and inclusion (EDI)?

**Equality** of opportunity is about ensuring that everyone has an equal chance to take up opportunities, make full use of the opportunities on offer and fulfil their potential. By promoting equality, the aim is to remove all equality and diversity issues including discrimination, bullying, harassment or victimisation. The [Equality Act 2010](#) outlines who is protected from discrimination on these grounds:

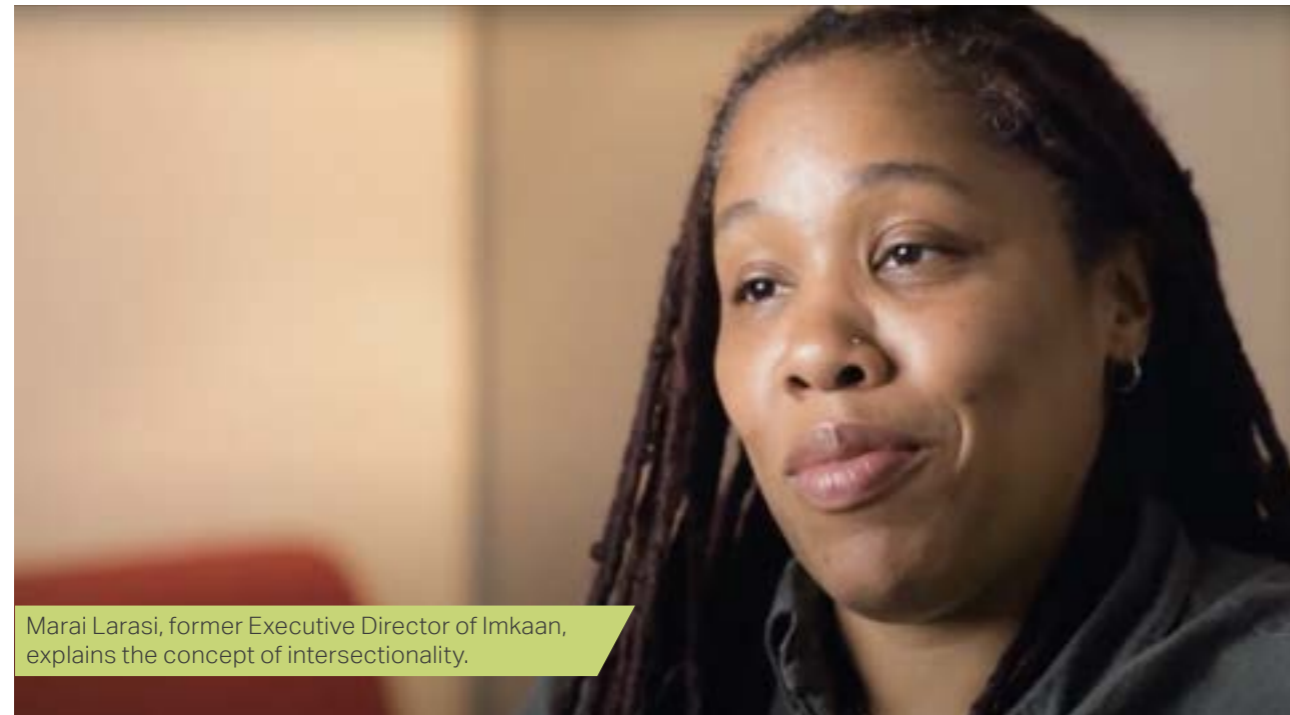
- Ethnicity
- Sex
- Gender reassignment
- Disability
- Religion and belief
- Age
- Sexual orientation
- Pregnancy and maternity
- Marriage and civil partnerships

**Diversity** is about celebrating and valuing how different we all are. This is strongly linked with promoting human rights and freedom, based on principles such as dignity and respect. Diversity is about recognising, valuing and taking account of people's different backgrounds, knowledge, skills, and experiences, and encouraging and using those differences to create a productive and effective workforce. Diversity is something that applies to everyone, and should be part of everything we do. It is an important part of our work and not just a side issue. It requires everyone to play a role in recognising that none of us fit neatly into separate 'packages' which can be easily labelled or discriminated against.

**Inclusion** refers to an individual's experience within the workplace and in wider society, and the extent to which they feel valued and included. It is about allowing everyone equal access to services and resources. Inclusion involves eliminating discrimination and promoting equality.

<sup>72</sup> Imkaan, Positively UK and Rape Crisis England and Wales, (2017) Taking A Forward View On Women And Mental Health: Key Messages For Government. London: Women's Health and Equality Consortium





Marai Larasi, former Executive Director of Imkaan, explains the concept of intersectionality.

Pathfinder promotes taking an **intersectional approach** to thinking about domestic abuse and equality, diversity and inclusion. Intersectionality calls on us to recognise that women's and girls' identities and social positions are shaped by several factors at the same time, creating unique experiences and perspectives. These factors include among others 'race', ethnicity, sexuality, gender identity, disability, age, class, immigration status, caste, nationality, indigeneity, and faith. For more information on intersectionality, see [Our Approaches section](#) at the beginning of the Toolkit or [watch the video above](#).

## Equality, diversity and inclusion statutory requirements for NHS employers

As one of the largest employers in the world, and the largest in Europe, it is vital that the NHS leads the way in its response to equality, diversity and inclusion and the four key laws relating to equality and diversity which all employers in the UK should be familiar with:

- 1 The Equality Act 2010** – The Act provides a legal framework to protect the rights of individuals from discrimination and places specific duties on public bodies, such as the NHS, to advance equality of opportunity for all. NHS England have created resources which include templates to assist Trusts to achieve good practice and to perform better<sup>73</sup>.
- 2 The Human Rights Act 1998** – this legislation outlines the basic human rights and principles of equality. The 'FREDA' acronym helps you to remember what is covered by the Act: Fairness, Respect, Equality, Dignity and Autonomy.
- 3 The Mental Capacity Act 2005** – this legislation outlines the Deprivation of Liberty Safeguards (DoLS), among other things, which aim to aid vulnerable individuals to maintain their right to independence, dignity and freedom.
- 4 The Care Act 2014** – this legislation provides six key principles which should underpin all work with adults at risk. This includes ensuring that adults receive support that's personal to them, chosen by them and has their consent.

On top of the legislative EDI requirements that all employers should abide by, the NHS has a number of statutory requirements that it must consider and respond effectively to. These include:

- 1 The NHS Equality Delivery System (EDS2)** – this is designed to measure how well NHS services are applying the requirements of the Public Sector Equality Duty 2011. It is made up of 18 outcomes, against which organisations are graded as 'excelling', 'achieving', 'developing' or 'underdeveloped.' The EDS is not a self-assessment; rather the gradings are agreed by the Trust with local stakeholders, such as staff, service users and the public. Pathfinder recommends that every NHS Trust should engage with local third sector domestic abuse/VAWG services as part of the implementation of EDS2 as they will have links and expertise with specific domestic abuse/VAWG services that health services may have difficulties engaging with.
- 2 The Workforce Race Equality Standard (WRES)** – this was announced in 2014 for the NHS to use as an assessment tool of race equality based on a series of indicators to ensure that BME staff have equal access to career opportunities and receive fair treatment in the workplace. Each Trust will have implemented a WRES which is a requirement for NHS commissioners and NHS healthcare providers including independent organisations<sup>74</sup>. From 2015/16 onwards, all NHS healthcare providers must publish their workforce race equality data annually. This allows each Trust to monitor how well they are performing and meeting the needs of a diverse workforce which includes creating a strategy, plans, data monitoring and also publishing their performance. NHS providers are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation.

<sup>73</sup> [www.england.nhs.uk/about/equality/equality-hub/equality-standard/resources](http://www.england.nhs.uk/about/equality/equality-hub/equality-standard/resources)

<sup>74</sup> [www.england.nhs.uk/about/equality/equality-hub/equality-standard](http://www.england.nhs.uk/about/equality/equality-hub/equality-standard)

**3 Workforce Disability Equality Standard (WDES)** – this was implemented by NHS England in spring 2019 and consists of ten specific metrics that enable NHS organisations to compare the experiences of their disabled and non-disabled staff. The findings are then used to create a supporting action plan to enable the service to demonstrate progress being made to enhance disability equality.

**4 Accessible Information Standard (AIS)** – The standard aims to ensure people who have an impairment or sensory loss are able to access the information and communication they need in a style which benefits and supports them. There are five elements which make up the consistent approach and these are identifying, recording, flagging, sharing and meeting of needs of people using their services and their relatives and/or carers. This has been a legal requirement since August 2016.

**5 Gender Pay Gap Reporting (GPG)** – this became an annual requirement as of April 2017. It requires employers with more than 250 employees to publish a number of statutory calculations. Annual reports for each Trust should be available on the equality, diversity and inclusion pages of the Trust website along with a supporting action plan to close the gap.

## Key things to consider when implementing these statutory requirements:

### 1 Diversity awards and schemes in the workplace

Pathfinder recommends that every NHS service should undertake a range of diversity accreditations and schemes to promote positive EDI standards in the workplace and to better respond to the needs of all patients and staff.

The following are a handful of the schemes we recommend:

#### Stonewall Diversity Champions Programme

As Europe's largest lesbian, gay, bi and trans (LGBT) charity, the Diversity Champions programme is the leading employers' programme for ensuring all LGBT staff are accepted without exception in the workplace. Find out more [here](#).

#### The Disability Confident Scheme

This is a government scheme that supports employers to make the most of the talents disabled people can bring to the workplace. When your organisation signs up to become 'Disability Confident Committed', the scheme will provide advice and guidance to help you think differently about disability, and improve how you attract, recruit and retain disabled workers. Find out more [here](#).

#### The Mental Health at Work Commitment

This commitment involves meeting six standards that any organisation can follow to improve and support the mental health of their employees. Find out more [here](#).

#### Age Friendly Employer Scheme

The Centre for Ageing Better has produced an easy to use Toolkit for employers wanting to implement their five step process for becoming a better employer of older people. Find out more [here](#).

### The Business Disability Forum

This forum provides a number of services to members with pragmatic support by sharing expertise, advice and providing training and networking opportunities to help organisations become fully accessible to disabled customers and employees. Find out more [here](#).

### 2 Staff networks to promote diversity

As the largest employer of BME people in England, the NHS should show how committed it is to challenging discrimination by creating an environment that is inclusive for all staff and patients.<sup>75</sup>

Staff networks have been an important way of engaging and supporting staff in the workplace for many years. Networks promote diversity, encourage legal compliance and create better communication across the Trust. Pathfinder recommends that every NHS service should set up effective staff networks to support, as a minimum, staff members who are:

- Black and minority ethnic
- Disabled
- LGBT+

These networks should operate across the organisation and should have access to support and resources in order to be effective and fit for purpose.

For these networks to succeed they will require monitoring, reviewing, auditing and a commitment to share good practice and learning across services nationally on what has been challenging and what has worked well. The best network groups, and those that are most sustainable long term, have a defined role within the Trust and have received support from senior and executive staff.

It's important to develop a work programme that is linked to EDI within the Trust. The role should be supported by the Equality Lead to ensure that the networks meet and are linked to the Trust's EDI work. Staff should be supported to take part and this should not be seen as yet another meeting to attend or an add on. The networks should meet bi-monthly or quarterly, depending on the service, and have clear strategic aims and structures in place to ensure its success. This should include:

- Defined aims and objectives
- Terms of reference agreement
- Clear work plan
- Executive support and senior champions from the Board of Directors
- A defined structure and membership
- Access to resources
- A confidentiality policy

Example objectives could include:

- Raising awareness of BME diversity in the workplace
- Supporting the career development of BME employees
- Providing strategic advice to the Trust on the issues affecting BME staff and patients
- Social and networking events

75 [www.england.nhs.uk/publication/improving-through-inclusion-supporting-staff-networks-for-black-and-minority-ethnic-staff-in-the-nhs](http://www.england.nhs.uk/publication/improving-through-inclusion-supporting-staff-networks-for-black-and-minority-ethnic-staff-in-the-nhs)

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### Case Study: University College London Hospital NHS Foundation Trust Staff Networks

The Trust recognised the need to provide a platform for staff to contribute towards improving their practice and services for patients and staff with various protected identity characteristics.

There are currently four active staff networks within the Trust:

- Network for Change (black, Asian and minority ethnic) and allies – the network is working with the Trust on projects that aim to improve race equality, including the Workforce Race Equality Standard.
- Disability Network (mental and physical lived experience and carers) and allies – the network is working with the Trust on projects that aim to improve disability equality, including the Workforce Disability Equality Standard.

→ Rainbow+ Network (lesbian, gay, bisexual and transgender) and allies – the network is working with the Trust on projects that aim to improve LGBT+ equality, including working with Stonewall.

→ Women's Network (all who identify as women) and allies – the network is working with the Trust on projects that aim to improve gender equality, including the Gender Pay Gap Report.

Each staff network has an executive sponsor, whereby an executive director has committed to championing that group at Board level. They attend at least one meeting a year to understand the issues being raised by the group.

### 3 Promote a clear commitment to equality and diversity at all levels

Currently there is an over-reliance on diversity managers and HR directors to drive the equality agenda across NHS services. Pathfinder recommends that equality and diversity issues should be championed by the Executive Board. Commitment at Board level will facilitate real change and will be a clear statement of intent from the Trust to improve the care of all staff and patients.

Furthermore, effective diversity management policies, practices and procedures are vital to shape and reinforce equal employment and the experience of patient care. Taking a strategic approach to creating inclusion at all levels and an emphasis on the value of diversity within the workforce should come from senior management.

It is also vital for every service to clearly advertise their commitment to these values on their website and public facing information. For example, identifying any Equality Accreditations on the website would show the service's commitment and reassure patients and potential employees that they can expect to be treated with equality, dignity and respect. This will go some way to ensuring that services are welcoming, inclusive and accessible. This may be particularly important for women experiencing forms of VAWG who may be reluctant to disclose to your service out of fear of being discriminated against or not believed.

### 4 Robust equality training using an intersectional approach

Most NHS services will already provide various, often online, equality training packages. Pathfinder recommends that all NHS services should review their existing training offer regularly and aim to create an interactive training package that covers the experiences of people who experience unique forms of discrimination due to the intersection of their gender with other identity characteristics including race, class, poverty, disability, age and sexual orientation, as part of the course.

By taking this intersectional approach throughout the training package it will bring these unique perspectives and experiences to the forefront, making them central to a health professional's understanding of how to provide effective care that's responsive to the lived experiences of all patients rather than as an afterthought or a tokenistic consideration of the equalities agenda.

When reviewing and updating training, services should consider approaching a local specialist BME, LGBT or disability charity who will be able to offer valuable support and insight into the needs and experiences of the groups they represent.

Staff training must be delivered alongside an EDI Strategy which can create a wider inclusive working environment for staff and patient care.



Services should consider approaching a local specialist BME, LGBT or disability charity

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## 5 Clinical considerations for responding to all patients and staff with dignity and respect

Pathfinder recommends that every NHS service should have access to an independent service for BSL and other translation services. A translation service should always be used if the clinician does not speak the same language as the patient.

Friends and family members should **never** be used for translation as this may influence the information the patient shares with you or the friend or family member may alter the information they pass on. Furthermore, the friend or family member offering to provide translations may be abusing the patient or may pass on information to the abuser(s) increasing the risk to the patient if they were to disclose abuse. Furthermore, offering to translate on their partner or family member's behalf may be a technique for controlling and limiting the individual's interactions with professionals and they may be able to communicate better in English than previously thought.

It is paramount health professionals are mindful of the increased risk of domestic abuse in caring relationships between intimate partners and family members. Professionals should use their professional judgement and attempt to speak to the patient directly and alone when possible.

Where feasible, services should ensure that the independent translation service has a good understanding of domestic abuse and VAWG so that they can accurately communicate to you the risks and needs that the patient is describing.

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# B

## Section B: Models and Interventions

This section details the different domestic abuse interventions and models that Pathfinder recommends are commissioned in every health area.

### The section is aimed at:

- Local Authority domestic abuse/VAWG Leads
- Clinical Commissioning Group domestic abuse/Safeguarding Leads
- Anyone responsible for delivering and implementing domestic abuse interventions within health or coordinating a local area's response to domestic abuse or VAWG

### The following chapters are included in this section:

- [Chapter 5: General Practice: The IRIS Model](#)
- [Chapter 6: Domestic Abuse Coordinator](#)
- [Chapter 7: Health Based Idvas](#)
- [Chapter 8: Domestic Abuse Champions Network](#)

### Appendices relevant to this section include:

- [Appendix 9: Domestic Abuse Coordinator Job Description](#)
- [Appendix 10: Business Case for Health Based Idva Service Provision](#)
- [Appendix 11: Health Based Idva Service Service Level Agreement Template](#)

### Throughout the chapter the following recommendations are made:

- IRIS should be rolled out in every GP surgery across the UK.
- Every NHS Trust should employ a full-time Domestic Abuse Coordinator to be responsible for the roll-out of the Trust's domestic abuse strategy, data collection and the coordination and delivery of domestic abuse training.
- Every NHS Trust should employ at least two co-located Health Based Idvas, depending on the size of the Trust, and embed them effectively within the NHS staff team. All Idvas should be qualified to undertake the work having attended the full SafeLives' accredited Idva training course.
- When co-locating a Health Based Idva service, a service level agreement should be written up between the NHS Trust and local specialist service hosting the role, to ensure the operational details of the role are agreed.
- Every newly appointed Idva working in hospital settings for the first time should undertake Pathfinder e-learning to understand the specifics of the Health Based Idva role in the NHS which can be accessed for free [here](#). This is additional and complementary to full Idva training, not a substitute.
- Every NHS Trust should embed a domestic abuse champions network to support the retention of expertise across departments.

# B

# B Chapter 5: General Practice: The IRIS Model

## Pathfinder recommendations:

- IRIS should be rolled out in every GP surgery across the UK

**"I am now convinced that violence against women and children is a major public health problem with long term consequences for women and their families. As an experienced GP, the whole project has been nothing short of transformational."**

–IRIS GP

## What is IRIS?

IRIS (Identification and Referral to Improve Safety) is a domestic violence and abuse training, support and referral programme for general practices. The IRIS programme is a collaboration between general practice and specialist domestic abuse services.

Core areas of the programme include:

- Embedding a specialist domestic abuse worker within general practice
- Ongoing training and education for the clinical and non-clinical staff to support better identification and response to domestic abuse
- Support for those affected by domestic abuse
- Clinical enquiry and simple care pathways for clinicians
- An enhanced referral pathway for all female patients aged 16 and above.



Prof. Gene Feder from Bristol University discusses the role of GPs in responding to domestic abuse.

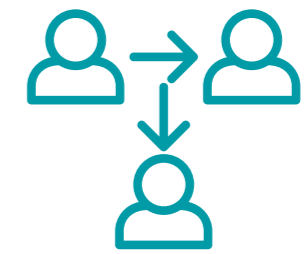
## Why IRIS?

The IRIS programme is an **evidence-based, effective** and **cost-effective** intervention to improve the general practice response to domestic abuse and is nationally recognised. It has been cited as best practice in general practice for responding to domestic violence and abuse by the Department of Health (2010, 2011, 2017), and has also informed the NICE guidance and standards on domestic violence and abuse.

IRIS has been evaluated in a randomised controlled trial which found it to be a very successful programme for addressing domestic abuse in general practice.

IRISi's most recent national report (data to 31–3–19) has highlighted that the IRIS programmes across England and Wales have consistently brought about substantial increased referrals into specialist services as well as improved the safety and quality of life for patients.

From April 2018 to March 2019 there were **3,195 referrals from 36 localities**, totalling over **15,500 referrals** from the beginning of the programme's launch in 2010 (IRIS national report, 2019).

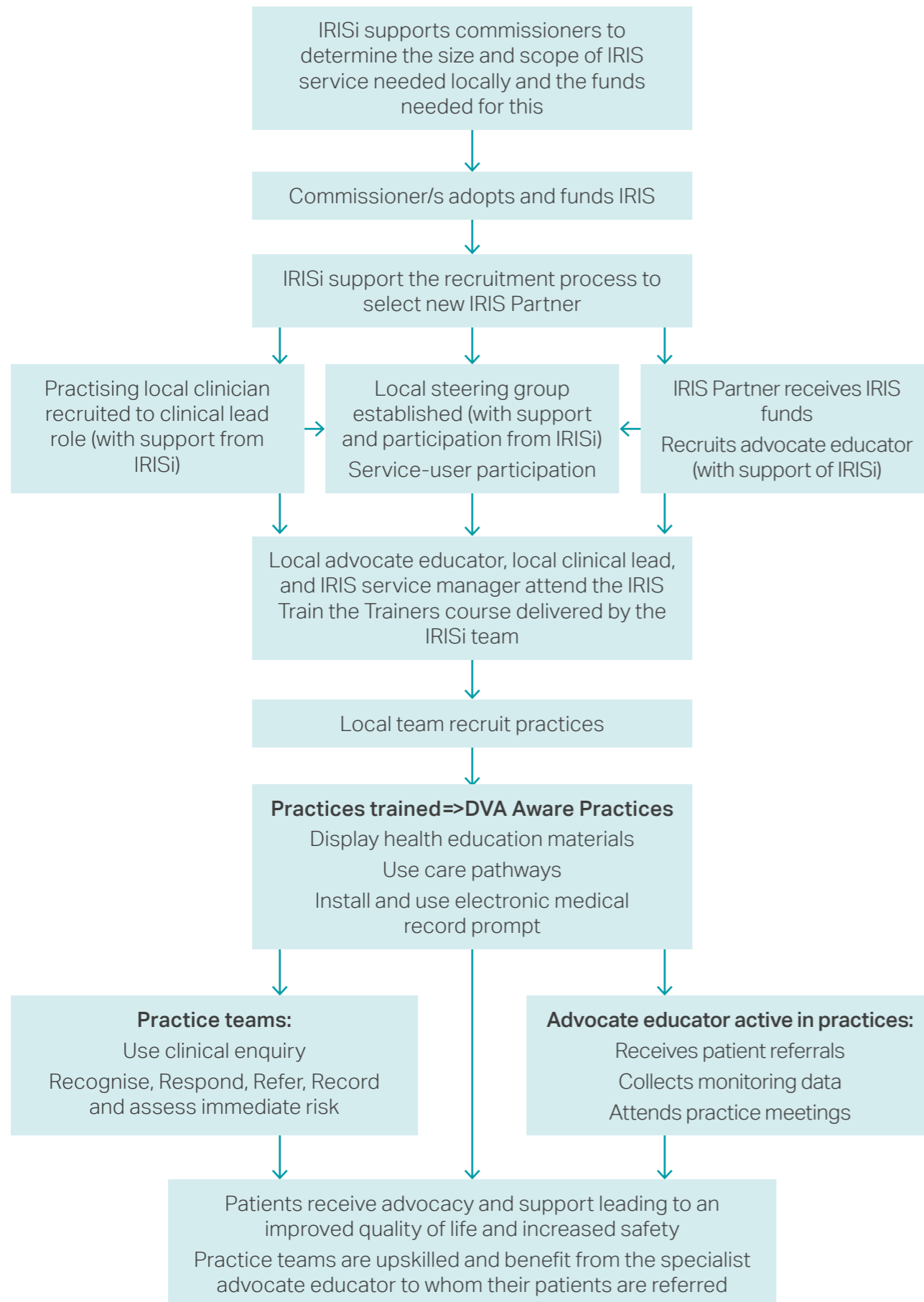


**3,195**

**3,195 referrals from 36 localities, totalling over 15,500 referrals from the beginning of the programme's launch in 2010**



## How does IRIS work?



## First steps to implementation:

- 1 Funding and commissioning** – The programme is predominantly funded and commissioned by health. The staff at IRISi, the national organisation responsible for the development of the IRIS programme, work with local commissioners to successfully establish, implement and maintain the programme in an area.
- 2 Recruiting your local IRIS team** – With IRISi input and support, a local VAWG domestic abuse specialist service is selected to deliver the programme, and the local IRIS team is recruited. The team consists of an Advocate Educator (AE) and a Clinical Lead, who is a local practising clinician. The AE and Clinical Lead work in partnership to deliver the training and offer continued support to practices. The AE also provides specialist domestic abuse advocacy to patients referred into the service.
- 3 Setting up your IRIS steering group** – The IRIS team is supported by a local IRIS steering group and by the IRISi Regional Manager, who provides ongoing expert advice and consultancy. IRISi would expect these meetings to be attended by:

- Local specialist domestic abuse service manager
- IRIS Clinical Lead
- Advocate Educator
- Commissioner
- IRISi Regional Manager (on semi-regular basis)

Other strategic allies and supporters (e.g. within health in the local area) may be part of the regular steering group or may be invited to attend particular meetings. It is also good practice for an IRIS steering group to have access to at least one IRIS service user/patient who can be consulted on relevant decisions

## Equality, Diversity and Intersectionality

IRISi recognises that equality, diversity and intersectionality should be a golden thread running through all work addressing domestic abuse. The IRIS national report of data up to March 2019 has found this to be true, with 60% of patients disclosing mental health issues and some localities having high rates of Black African and Caribbean survivors and/or Asian survivors accessing IRIS programmes. However, the IRIS programmes also recognise that many individuals are still not being acknowledged by health. Findings show that referral rates for patients from the LGBT+ community into IRIS programmes are lower than is proportionate to the national average (IRIS national report, 2019). Other research also highlights women with no recourse to public funds continuously being 'stuck' in relationships with abusers due to fear of destitution or deportation. We must recognise nationally that women need diverse support for domestic abuse that is sensitive to their needs and acknowledges their fear of stigmatisation, with more dedication to local specialist services.

For more information, see [www.irisi.org](http://www.irisi.org)

### Promising practice example

As part of Pathfinder, **Blackpool Teaching Hospitals NHS Foundation Trust** implemented the IRIS programme. The intervention was extremely successful and within just under 22 weeks, 73% of surgeries in Blackpool had received clinical training and training for their administrative staff: 133 clinical staff and 115 administrative staff were trained on identifying and responding to domestic abuse.

The Blackpool IRIS team received great feedback from those who attended the training with many staff using the local IRIS contact details to refer patients or to get some advice on cases. During the period, 46 patient referrals were made to the IRIS Advocate Educator – highlighting the success of the training in supporting general practices to identify and respond to domestic abuse.

Embedding IRIS in Blackpool highlighted a real need for this kind of support and the number of referrals were so high that Blackpool Teaching Hospital took the decision to recruit a second Advocate Educator.

In reflecting on why IRIS was so quick to embed and take effect, those who set up the programme felt that it helped that the Advocate Educators were co-located between health and the local domestic violence service (Fylde Coast Women's Aid). Unusually, the advocates had access to medical records which, together with having an NHS email, was invaluable in building trust with health professionals and patients. It was also important that the local CCG were invested in the programme from the beginning ensuring it was an 'everyday' part of work for Blackpool. At the same time the advocates had the support, knowledge and case management systems of a specialist service – enabling partnership working and linking them into the wider community responses to domestic abuse.

## Chapter 6: Domestic Abuse Coordinator

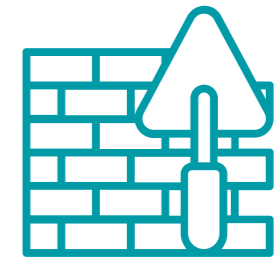
### Pathfinder recommendations:

- Every NHS Trust should employ a full-time Domestic Abuse Coordinator to be responsible for the roll-out of the Trust's domestic abuse strategy, data collection and the coordination and delivery of domestic abuse training.

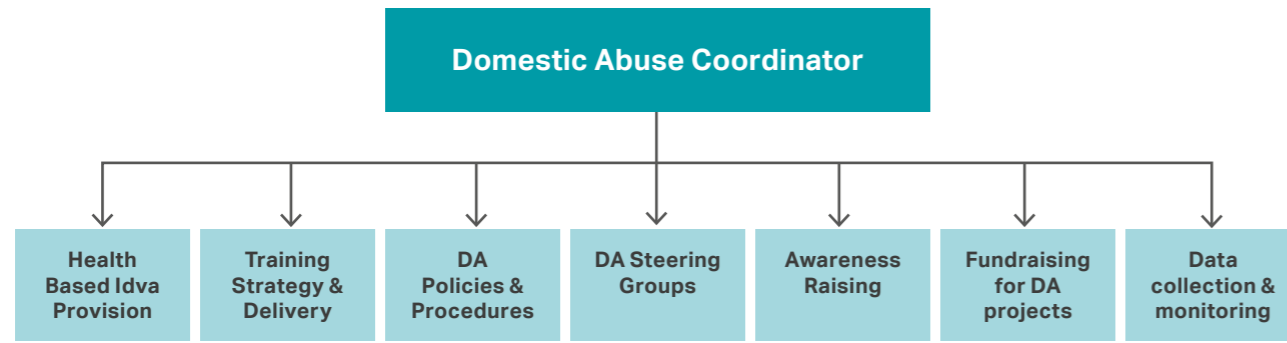
**'Coordination is a system, not a person, though the complexity of the task requires a dedicated person, or a team, to oversee the process... A good coordination team will be the difference between success and warm words that gradually cool.'**<sup>76</sup>

The coordination of a Trust-wide response to domestic abuse takes the effort and buy-in of many individuals at different levels. Without the support of the executive board, directors, HR and the Safeguarding Team, the changes needed to policies, procedures, strategies and the data collected via electronic medical records to affect real change would not be possible.

It is therefore important to remember that a coordinated community response to domestic abuse cannot happen without the crucial role of a dedicated Domestic Abuse Coordinator. The role of the Coordinator can sometimes be overlooked and undervalued, however, a Coordinator can build the capacity of the whole Trust to respond to domestic abuse and upskill workers efficiently and on an ongoing basis.



**A Coordinator can build the capacity of the whole Trust**



### What does a Domestic Abuse Coordinator do?

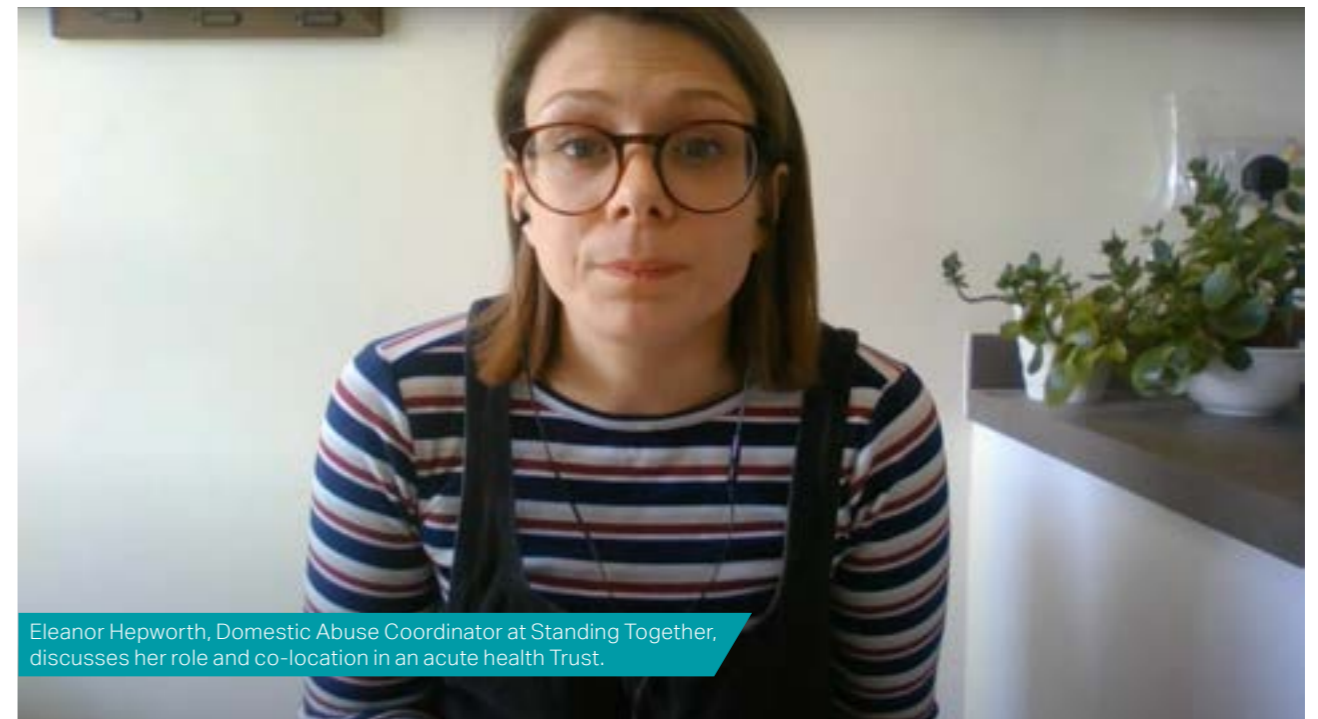
Instead of responding to patients and staff experiencing domestic abuse directly, the Coordinator's role is to:

- Lead on the coordination of a Trust-wide response to domestic abuse within acute/ mental/community health settings.
- Improve the safety and wellbeing of patients and staff experiencing domestic abuse and their dependents by creating an environment within the hospital where staff feel confident to respond effectively and are supported by managers, HR and the executive board to do so.
- Improve identification and responses to domestic abuse by engaging health professionals, developing an infrastructure of policies and procedures, and training staff within a Coordinated Community Response (CCR) framework.
- Build relationships with specialist services and contribute to identifying and securing funding and other resources necessary to implement projects including ensuring the sustainability of Idva provision.
- Collect data and monitor progress of the Trust's response and evidence the need for further actions and investment.

The Domestic Abuse Coordinator should be responsible for administering Trust VAWG/ domestic abuse steering group meetings, creating and implementing a domestic abuse strategy and engaging those who haven't yet engaged.

Oversight of the domestic abuse strategy is an on-going role and therefore the Domestic Abuse Coordinator should be a post funded by the Trust or CCG on a permanent basis. It is important to avoid thinking about the post as a short-term role to implement domestic abuse projects and then leave. Domestic abuse is an intrinsic and prevailing issue and the presence of a Coordinator ensures the issue is treated as part of the core business of the Trust long-term.

The Coordinator **should not** hold responsibility for a caseload as this will ultimately lead to their strategic work flagging. For example, if faced with the choice of responding to a survivor of abuse who has been identified by a clinical colleague or reviewing a training strategy, it is likely that the Coordinator would choose to respond to the survivor who needs immediate attention. Furthermore, the Coordinator should be a domestic abuse expert and non-clinical to avoid them picking up extra clinical responsibilities or shifts.



Eleanor Hepworth, Domestic Abuse Coordinator at Standing Together, discusses her role and co-location in an acute health Trust.

### Things to consider when implementing a Domestic Abuse Coordinator

#### 1 How to best achieve coordination?

The Domestic Abuse Coordinator should sit within the Trust they are working in, the CCG or a local specialist service as long as the coordinator has an NHS email address, access to a desk within an NHS building and the support to build lasting relationships with NHS staff. In most NHS Trusts, a full-time dedicated Coordinator is required in order to stay on top of the significant number of staff who need training and constant awareness raising of processes and referral pathways.

In some cases the type of domestic abuse coordination required will depend on the set up of the local health economy. In areas with smaller populations it may be possible to share a Domestic Abuse Coordinator across two NHS Trusts but the success of this will rest on having a clear plan of how the role will be split across both Trusts and clear communication between partners.

Partners need to be honest about their capacity to do joint work and to what extent it is possible for them to share a domestic abuse strategy and elements of a domestic abuse response. In this case, the post may work best operating out of the CCG.

#### 2 Domestic Abuse Coordinator management structure

Day to day management of the Coordinator's work load should be the responsibility of the Clinical Lead for Domestic Abuse at the Trust or CCG. If the Coordinator is employed on an honorary contract via a local specialist service, line management and supervision of the role should be the responsibility of the specialist service. Whilst the Domestic Abuse Coordinator should not hold responsibility for line managing the Health Based Idvas, they should have strategic oversight of the roles and help to solve any operational problems that occur.



### B 3 How will the post fit into the wider 'whole health' model?

The Domestic Abuse Coordinator should be responsible for orchestrating the Trust's operational domestic abuse steering group. They should be responsible for feeding into the local Health and Domestic Abuse Strategic Group, updating on the Trust's activities and accomplishments around domestic abuse and bringing back any good practice shared. The Coordinator should also be responsible for establishing strong links with local specialist organisations and maintaining effective and safe referral pathways.

### B 6 4 Who is best to fill the post?

It is vital that the post-holder has:

- A strong understanding of domestic abuse and wider-VAWG issues with experience of delivering support to survivors.
- A working knowledge of the NHS including internal governance structures and funding application procedures.
- Experience of creating and delivering a strategy within a large public body.

Please see [Appendix 9: Domestic Abuse Coordinator Job Description](#) for a full overview of the responsibilities of a Domestic Abuse Coordinator in health settings.

### Promising practice example

**Chelsea & Westminster NHS Foundation Trust** have successfully embedded a Domestic Abuse Coordinator. The Coordinator is employed by Standing Together, their local specialist service, but has an honorary NHS contract and is co-located in the Trust. The Coordinator is responsible for overseeing and delivering the Trust's suite of domestic abuse training options, the 300+ Domestic Abuse Champions network, monitoring data and updating referral pathways, policies and procedures.

The Coordinator is line-managed by Standing Together but works closely with and reports daily to the Chelsea & Westminster Hospital NHS Foundation Trust's Domestic Abuse Clinical Lead. She also works closely with the 3 Health Based Idvas problem solving to ensure their co-location is successful.

The role was initially resourced through Cabinet funding via Standing Together and was on a part-time basis covering only one of the hospital sites. When this ceased, the DA Clinical Lead secured 1 year funding through CW+ charity following a successful bid for a full-time position on the basis that thereafter the post would be match-funded by the Trust. The post is now funded by corporate safeguarding on a permanent basis. The Trust pays Standing Together to host the role, and the coordinator now covers both hospital sites.

### Promising practice example

Both **Central and North West London NHS Foundation Trust** and **West London NHS Trust** have recruited a Domestic Abuse Coordinator who will work over both Trusts for 12 months with the ambition to fund the role permanently after this initial period. The Coordinator will be employed by the NHS as a band 6 employee. They will lead on the coordination of a whole-Trust domestic abuse response and the roll out of the Domestic Abuse Champions networks to improve the safety and wellbeing of patients and staff members experiencing domestic abuse and their dependents.

# Chapter 7: Health Based Idvas

## Pathfinder recommendations:

- Every NHS Trust should employ at least two co-located Health Based Idvas, depending on the size of the Trust, and embed them effectively within the NHS staff team. All Idvas should be qualified to undertake the work having attended the full SafeLives' accredited Idva training course.
- When co-locating a Health Based Idva service, a service level agreement should be written up between the NHS Trust and local specialist service hosting the role, to ensure the operational details of the role are agreed.
- Every newly appointed Idva working in hospital settings for the first time should undertake Pathfinder e-learning to understand the specifics of the Health Based Idva role in the NHS which can be accessed for free [here](#). This is additional and complementary to full Idva training, not a substitute for it.

Survivors of domestic abuse in hospital are often in the immediate aftermath of a crisis: severe physical assault, drug/alcohol related medical needs, attempted suicide or self-harm. Health Based Idvas are able to provide immediate support to these survivors reducing risk and abuse earlier.

## The role of a Health Based Idva is:

- To provide immediate support and advice to survivors of domestic abuse, both hospital patients and staff
- To provide support and advice to staff responding to patients they believe may be experiencing abuse
- To link individuals and families to longer-term community-based support
- To provide ongoing support to a small caseload of survivors including patients and staff experiencing domestic abuse
- To participate in the domestic abuse steering group and operational meetings
- To raise awareness of domestic abuse and remain visible to staff
- To access continual professional development to maintain up to date expertise around domestic abuse and VAWG

**Lone working is not suitable for an Idva**, so two is the minimum any Trust should seek to employ.



Kathryn Bonney, former Head of Safeguarding for East Lancashire NHS Trust, discusses the importance of successfully embedding Health Based Idvas

## Why is it important to have Health Based Idvas in your Trust?

Reducing the risk of immediate harm to survivors presenting in health settings is vital; particularly when hospital release is imminent. The safety of the survivor is paramount, both in the short-term as well as the long-term, following discharge. Health Based Idvas, working in close coordination with clinical staff and other agencies, are best placed to increase adult and child survivors' safety and wellbeing.

As an intervention, Idvas in health settings and the community are highly effective. At the end of their case, the majority of survivors reported to Idvas a significant reduction in abuse and positive changes in their safety and quality of life<sup>77</sup>:

- 60% of survivors reported a cessation of abuse
- Over 70% of all Idva clients felt more confident, optimistic about the future and reported they had an improved quality of life and feeling of wellbeing
- Over 80% of survivors felt safer.

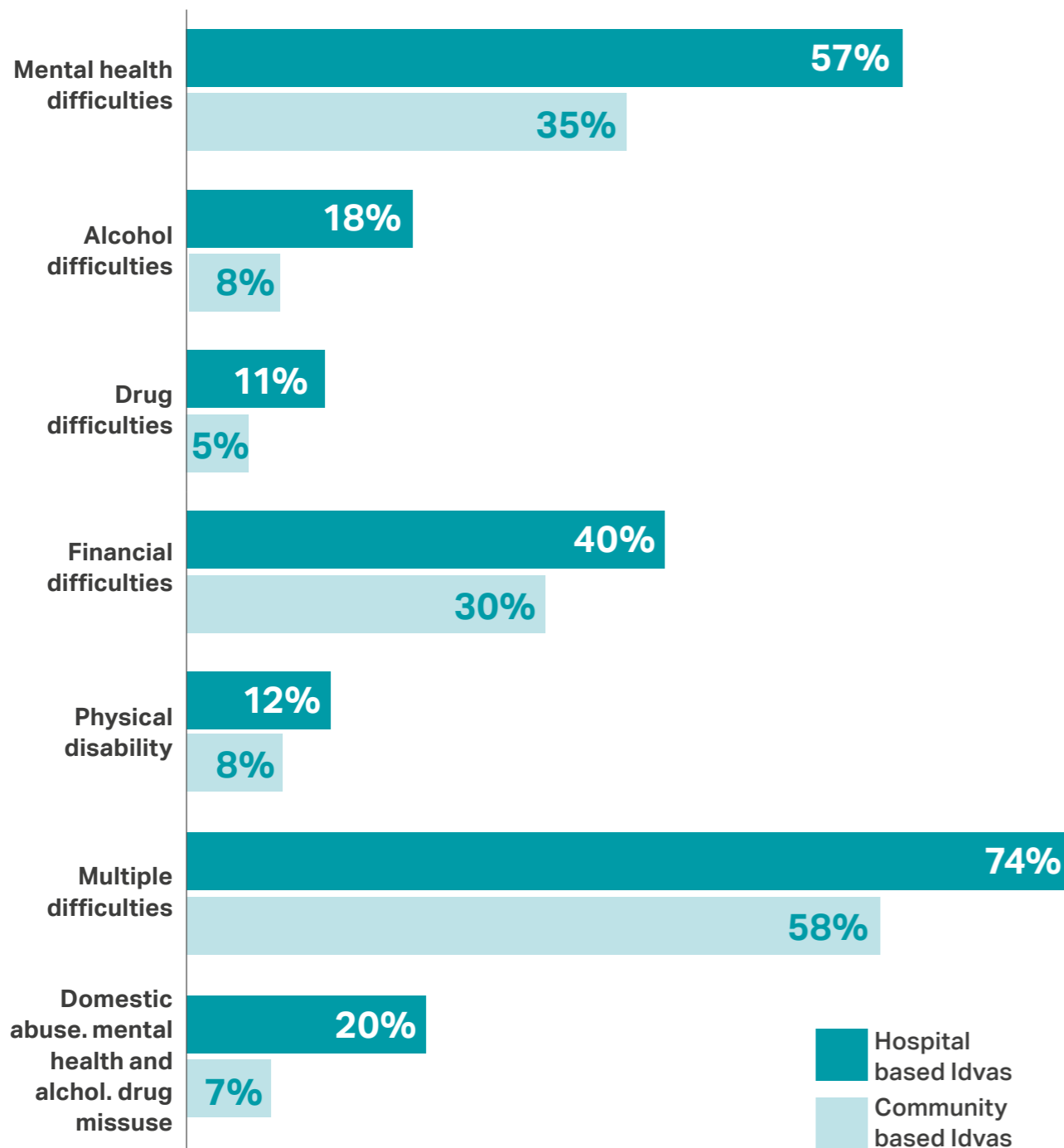
Health Based Idvas are quick to respond. Survivors engaging with Health Based Idvas are shown to be accessing effective support at an earlier point – survivors who accessed support from a Health Based Idva had experienced abuse for an average of 6 fewer months than survivors engaged with a local, community-based service.<sup>78</sup>

77 SafeLives, Insights Idva England and Wales dataset 2018-19 Adult Independent domestic violence advisor (Idva) services, <https://safelives.org.uk/sites/default/files/resources/Idva%20NDS%20201819.pdf>

78 SafeLives, Cry for health (2016)

A Health Based Idva has all the knowledge, skills and empathy of a local community service Idva as well as being confident in a health setting, good at networking with all levels of staff and are confident communicators. Strong multi agency work is crucial, as Health Based Idvas are more likely to work with survivors with additional needs. SafeLives' *Cry for Health* report found that survivors identified in hospitals were facing higher levels of multiple disadvantage than local Idva clients. More hospital clients had:

**Idvas help victims disclose other difficulties**



**Things to consider when implementing a Health Based Idva service**

**1 How many Idvas should you fund?**

Pathfinder recommends that every NHS Trust should have at least two co-located Idvas – a Health Based Idva should not work alone. This ensures that a seven-day week is covered in a hospital-setting, it also means that Idvas are able to consult with and learn from their colleagues. Research has shown that lone Idvas are more prone to burn-out and isolation, compared with services which employ more than one Idva.<sup>79</sup> Trusts should consider the needs of their specific patient population and embed an Idva who is better placed to meet these, such as an Idva who can speak a language commonly spoken in the area or a Idva specialising in responding to survivors experiencing homelessness, drug and alcohol and/or mental health issues in areas with high rates of these.

**2 Where the Idvas will be based**

Pathfinder recommends that Health Based Idvas should be co-located at the relevant health setting they are funded to support. Locating Idva services into the health settings increases identification rates, as Idvas are able to reach the survivor much quicker than a local community Idva. This ensures that the survivor is seen during the golden 'window of opportunity' – a short time period when they are most likely to disclose and be able to accept support.

**3 Idva management structure**

If the Idva is employed on an honorary contract via a local specialist service as recommended, line management and supervision of the role should be the responsibility of the specialist service. The Idvas should also report to the Domestic Abuse Coordinator and the Clinical Lead for Domestic Abuse at the Trust day to day. This hospital management structure for the Idva will help to embed them within the Trust, giving them a clear route to escalate operational issues they are experiencing and an on-site team with which they can discuss cases and the difficulties of the role.

**4 How to embed your Idvas successfully**

All operational details of the Idva's role must be clarified prior to them starting in the role, and reflected in a service level agreement between the Trust and specialist service that Idvas are employed by. This should include:

- How the Idvas should record their case notes.
- Who will provide line management and supervision to the Idvas.
- Any reporting requirements the Trust has.
- Who will provide cover for the Idva when they are sick or on annual leave.
- An agreement that the Idvas will not hold cases from the community as they should have more than enough case load generated from within the health setting. There should be a clear process in place for the Health Based Idvas to refer cases into the community Idva service when necessary.



- B**
- 7**
- A data sharing agreement between the Trust, specialist service and commissioning body.
  - Providing the Idvas with an honorary contract which would help them embed into the Trust and be recognised as an NHS colleague. This should involve the Idvas having an NHS email address, access to patient medical records and the Trust intranet.
  - Providing access to a permanent office space within the hospital – to maximise impact Idvas should have access to a private office space so they have a confidential space in which to conduct their work. This space should be close to the departments where their support will be most needed (e.g. Emergency Department, maternity etc) so they can respond quickly to requests from staff, enabling them to be seen and easily accessible to staff in time-pressured environments. It will also increase their face-time with the staff they will work with most closely, increasing the likelihood of staff asking for advice, making a referral or disclosing abuse they are experiencing themselves.

**Pathfinder funded Idvas who were located outside of patient-facing departments received far fewer referrals, due to their limited visibility within departments.**

Please see [Appendix 11: Health Based Idva Service Service Level Agreement Template](#) for more information on the operational detail of co-locating an Idva in health settings.

## **5 Idva referral process within the Trust**

The Idva referral pathways will be specific to each Trust. You should produce a clear referral form outlining the ways that Idvas will accept referrals which should be embedded within the Trust's electronic system for ease of access for staff. If it is agreed that referrals can be accepted verbally, this should be followed up later with a referral form for recording purposes. If referrals will be accepted over the phone, Idvas should be given access to a Trust phone so that staff can contact them. If referrals will be accepted over email, the referral form should be sent to the Idva's Trust email address so that the Trust can have oversight of all referrals.

It is important to ensure that the referral pathways are not reliant on the specialist service the Idva is employed by. This means that if there is a changeover of specialist services providing Idvas it will not disrupt the existing referral pathway and if Idvas are ever absent the referral pathway can still be monitored internally to ensure the safety of staff and patients at risk.

## **6 How to ensure all staff are aware of the Trust's Idva provision**

It is vital that Idvas are given the opportunity to introduce themselves to the staff and departments they will be working with during their induction. Consider asking the Idvas to attend regular team meetings to introduce their role and how to make a referral. This will ensure they meet as many staff as possible face to face which is particularly important due to high turnover rates within departments such as ED. Details of how to contact the Idva should be easily accessible on the Trust intranet and in the domestic abuse policy and managers should be advertising the Trust's Idva provision in supervision sessions with staff. Idvas should also introduce themselves to psychiatric liaison, homelessness and drug and alcohol services so they can build relationships with these services and effectively cater to the multiple disadvantages a survivor may face.

## **7 Health Based Idvas as an important resource for staff experiencing domestic abuse**

It is important to note that Idvas will also support staff experiencing domestic abuse, this should be recognised in assumptions about caseload and resourcing. Health Based Idvas are trained to recognise signs of abuse in staff and are able to sensitively and confidentially enquire and offer support to staff survivors. Staff should be able to self-refer to the Idva or be signposted by colleagues or managers. This leads to staff being safe, happier and able to stay in work and be more productive whilst at work.

Idvas should have access to a dedicated, private office space to protect the confidentiality of any staff experiencing abuse. It is important that the Trust has a staff domestic abuse policy so that your Idvas can support staff appropriately.

Please see [Appendix 10: Business Case for Health Based Idva Service Provision & Appendix 11: Health Based Idva Service Service Level Agreement Template](#) for more information. This Toolkit also contains e-learning for existing Idvas who plan to or have recently become health based. It is available for free [here](#).

### Promising practice example

With Pathfinder funding, the **London Boroughs of Camden and Islington** have invested in the provision of two specialist mental health Independent Domestic & Sexual Abuse Advisors (Idsvas), co-located in the **Camden and Islington Foundation Trust (CIFT)**.

Recruited from local specialist domestic abuse services, the Idsvas utilise their expert knowledge to work supporting survivors who have experienced domestic and/or sexual abuse across six teams within the Trust:

1. Early Intervention Team
2. Assertive Outreach Team
3. Personality Disorder service
4. Complex Depression anxiety and trauma service
5. iCope
6. Focus Homeless Outreach and Street Population

Referrals from these six teams increased dramatically as a result and in the last 12 months of the co-location Camden Safety Net received 77 referrals from these teams where previously the number received was much lower. These survivors may have gone unnoticed prior to Idsva intervention.

Furthermore the Idsvas were able to support mental health practitioners to respond appropriately and holistically to survivors who declined a referral to Camden Safety Net directly.

The Idsvas embedded themselves within the Trust's clinical and safeguarding teams, advising and supporting practitioners to increase their confidence in dealing with survivors. The Idsva's reported that being on site meant they were more able to:

- Develop trusting relationships with NHS colleagues
- Raise awareness of domestic abuse among NHS staff which resulted in an increased number of calls for advice from CIFT staff.
- Support survivors who walked in unannounced
- Arrange meetings face to face in an environment the client was familiar with
- Engage with survivors who may have otherwise not engaged through the rapport they had built with their care coordinators

### Promising practice example

The Health Based Idva post in **Royal Devon and Exeter NHS Foundation Trust** was initially funded by Pathfinder in 2018. In the first 18 months of the role the Idva supported 172 survivors of domestic abuse, 21 of which were staff members.

One of these survivors included an 81 year old woman who had been subjected to domestic abuse by her husband for 60 years. She had presented to the Emergency Department numerous times with injuries but had never

previously been asked about domestic abuse. The nurse made a referral to the Idva who was able to attend immediately and spend time exploring the abuse the woman has been subjected to. After 2 hours, she decided she did not want to return home and supported accommodation was found for her to move into that afternoon. She has not returned to hospital since.

It was recognised Trust-wide how beneficial the Health Based Idva service had been for staff and patients and in January 2020 it was confirmed that the CCG would continue to fund the role.

## Chapter 8: Domestic Abuse Champions Network

### Pathfinder recommendations:

- Every NHS Trust should embed a domestic abuse champions network to support the retention of expertise across departments

A major barrier to NHS Trusts improving their response to domestic abuse is the retention of specialist knowledge within staff teams. It is not possible to train all clinical staff to feel confident to respond to domestic abuse all the time, especially complex cases. Employing a Domestic Abuse Coordinator and Health Based Idvas will go some way toward solving this problem as staff will feel comfortable calling to ask for advice or referring the patient to the Idva. However, due to high caseloads, working hours and other responsibilities of the role, Idvas will not always be available to respond immediately to all inquiries or requests for support from Trust staff. Therefore, health professionals need to feel confident to respond in that moment regardless.

A way to mitigate this issue is to train a core team of clinicians, administration staff and HR to an enhanced level so that they can support their colleagues and offer advice when needed. Whilst it would remain all staff's responsibility to be aware of and respond to domestic abuse, upskilling staff to support colleagues would save time and help embed this expertise throughout the workforce. This in turn will have meaningful and positive changes for the Trust's patients and staff who are subjected to abuse.



**Upskilling staff to support colleagues would save time and help embed this expertise throughout the workforce.**

## Responsibilities and aims of the role may include:

- Having enhanced knowledge of domestic abuse, risk factors, good practice, support mechanisms and safety planning on site
- Being a lead and point-of-contact for domestic abuse issues in their area/ department and guiding their teams on the content of and access to, the domestic abuse resources on the Trust Intranet
- Guiding their teams/colleagues on the process of referring to the Safeguarding Team and Marac when appropriate
- Providing their teams with information on local and national domestic abuse services, checking the details for local services are up to date, displaying relevant posters/leaflets in their clinical area and providing access to resources for patients
- Providing support to appropriately document and share information
- Potentially co-delivering training to colleagues if they have been sufficiently trained to do so
- Feeding back to the Domestic Abuse Coordinator, attending steering groups, supervision and other relevant training for professional development, practical and emotional support
- Celebrating positive outcomes and good practice – making sure that clinicians are aware of what difference it made when they went the extra mile – as this might not be visible to them

## Domestic Abuse Champions should not:

- Replace the need for a specialist response and Idva provision within a hospital
- Hold responsibility for responding to all cases where domestic abuse is identified, rather they will support fellow practitioners through the process

## Considerations when setting up a Domestic Abuse Champions Network:

### 1 Who should be a Domestic Abuse Champion?

If possible, there should always be a champion around that staff can reach out to. Pathfinder recommends that when setting up a network you aim to train enough champions so that there will be one available on every shift in every department.

All staff should have the option to become a Domestic Abuse Champion to improve their own skills and confidence. Reception staff and Health Care Assistants can make some of the best Champions, however, you should aim to recruit all colleagues that staff regularly go to with questions or concerns, such as Senior Nurses in Charge and Matrons, and all staff with HR or line management responsibilities.

This may feel like a daunting task so, when starting out, concentrate recruitment on departments where domestic abuse presentation is most common e.g. Safeguarding, Maternity, Emergency Department, Sexual Health, Psychiatric Liaison and HR.

### 2 Who will oversee the maintenance and implementation of the network?

Pathfinder recommends that supervision sessions are delivered quarterly to champions in small groups. Group supervision enables champions to come together to discuss cases and get practical feedback from domestic abuse experts and their peers from other departments. It also gives champions an opportunity to debrief emotionally (although they should always be made aware of specialist emotional support available e.g. through occupational health). Champions should also be able to request 1–2–1 supervision on an ad hoc basis from the Domestic Abuse Coordinator or the Clinical Lead supported by a local specialist service if required. It should be made clear that supervision is to debrief and a learning opportunity and they should not wait for these sessions to manage risk of live cases.

All champions should also have access to continuous training and development opportunities which could take a variety of forms including training from specialist VAWG, BME, LGBT+ and disabled survivors services to training about trauma-informed practice. It is recommended that the person responsible for maintaining the network checks in regularly with the champions to scope their training needs so these can be met.

Regular supervision and enhanced training should not be mandatory but all champions should undertake supervision or training at least once a year to ensure that they remain confident to respond and up to date with good practice.

Coordinating a Domestic Abuse Champions Network takes time and commitment. We recommend that this maintenance of the network is undertaken by the Domestic Abuse Coordinator. If you do not have a Coordinator to undertake this work, the Clinical Lead should take responsibility for the network and be given adequate time and resources to do so and effectively involve the local specialist service for expertise, training and supervision. For the network to be successful there must also be buy in from senior members of staff and line managers.

### 3 How does this fit with your training strategy?

Pathfinder recommends that Domestic Abuse Champions are trained to NICE Level 3 in domestic abuse. Among other things, this should include how to identify survivors, conduct a risk assessment, safety plan on site and make appropriate referrals to Marac, specialist services and safeguarding. This training should be delivered by the Domestic Abuse Coordinator, a local specialist service or whoever is responsible for delivering the Trust's domestic abuse training.

**Please see Chapter 11: Domestic Abuse Training and Appendix 12: Domestic Abuse Training Assessment Tool for further information and recommendations around how to deliver domestic abuse training.**

### 4 Is the network written into your policies and procedures?

Ensure the network of Domestic Abuse Champions is recorded in your policies. Consider how you will make staff aware of who the Domestic Abuse Champions are. This could be via the intranet or Champions could wear badges that distinguish them from their colleagues.



### Promising practice example

**North Staffordshire Combined Healthcare NHS Trust**, set up a Domestic Abuse Champion Network with support from the local specialist service, Glow. Together they identified key 'front door' services to initially recruit champions from which included:

- Healthy minds
- Parent and baby unit
- Access team
- Mental Health Liaison Team
- Ashcombe Centre (integrated health and social care)
- Harplands Hospital (inpatient wards)
- North Staffordshire Wellbeing Services
- Education and Development (for staff)

They identified champions in each department who went on to attend a two day

domestic abuse training course provided by Glow. This included a train-the-trainer so that the champions could deliver domestic abuse training to other health professionals in their Trust.

After they received this training, each champion was given the aim to train every member of staff in their department. A trainer from the local specialist service co-trained with each champion for the first two sessions to ensure they felt comfortable delivering the training. It was agreed that the local specialist service would provide on-going support and feed into the Trust's internal quarterly domestic abuse forums for the champions. The role of Domestic Abuse Champion and trainer was acknowledged in each professional's job description and will be taken on by their successor once they leave to ensure sustainability.

Prior to Pathfinder, only two referrals were made into Glow via the Trust between October 2018 and March 2019. During the delivery of this intervention (between July 2019 and Feb 2020) 60 referrals were made to Glow by the Trust. Referrals to Marac from mental health services also increased.

### Promising practice example

**Central and North West London NHS Foundation Trust** and **West London NHS Trust** each set up a Domestic Abuse Champions network. The Champion role was advertised internally via a poster and newsletters.

Events were held to launch the networks where over 100 staff members registered their interest in becoming a Champion with 60 going on to attend the training. Some of the Champions also opted to attend a Train the Trainer course to enable them to deliver training to their colleagues.

Both Trusts committed to sustaining the networks by hiring a Domestic Abuse Coordinator to do this. They have also committed to providing time for additional training and supervision and hosting quarterly network forums for Champions to raise any issues and report on their progress.

# C

## Section C: Best Practice Implementation

This section gives practical recommendations on how to improve your service's operational response to patients experiencing domestic abuse.

### The section is aimed at:

- Commissioners
- Safeguarding leads
- Health Based Idvas
- Domestic Abuse Coordinators
- Any professionals with responsibility for domestic abuse in health settings

### The following chapters are included in this section:

- [Chapter 9: Enquiry and Disclosure](#)
- [Chapter 10: Referral Pathways](#)
- [Chapter 11: Domestic Abuse Training](#)
- [Chapter 12: Data Collection, Monitoring, Analysis and Practice Improvement](#)
- [Chapter 13: Awareness Raising](#)

### Appendices relevant to this section include:

- [Appendix 12: Domestic Abuse Training Assessment Tool](#)

### Throughout the section the following recommendations are made:

- All health staff should have access to the facilities they need to ensure that any domestic abuse enquiry is done in private and family members and friends are not used as interpreters.
- All health staff should be equipped with the knowledge and skills they need to enquire about domestic abuse sensitively and supportively through an explorative conversation.
- All health staff should understand the impact of trauma and consider how to ask and respond in a way that takes into account and acknowledges trauma responses.
- All health staff should know how to record any disclosure of domestic abuse in the survivor's own words and offer specialist support.
- Mental health Trusts should ensure staff understand how experiences of domestic abuse contribute to current presentations of mental distress.
- Mental health Trusts should ensure domestic abuse questions are embedded into assessment documentation and in clinical audit.<sup>80</sup>
- Every health service should embed clear and effective referral pathways into local specialist services.
- Every health service should have designated Marac<sup>81</sup> representatives and ensure that staff are aware of who they are including any appropriate internal referral procedures<sup>82</sup>.
- Every health service should have a sustainable training strategy in place to ensure all staff receive the relevant level of domestic abuse training in line with NICE guidelines and rooted within an equalities framework.
- Every health service should collect data on domestic abuse training attended by staff.
- Every health service should collect data on enquiry into domestic abuse to understand gaps in training.
- Every health service should record disclosures of domestic abuse in the words of the survivor.
- Every health service should collect disaggregated data on protected characteristics.
- Every health service should collect data on referral pathways.
- Every health service should ensure that their patient medical records are able to capture the data we suggest clinicians collect around domestic abuse
- Every health service should have a clear strategy for how data on domestic abuse is put together with other relevant data, such as safeguarding and equalities monitoring with a clear framework for how data collection will be rooted in the need for practice improvement.
- Every health service should have a clear awareness raising strategy for ensuring that patients and staff are aware of health professionals' role in responding to domestic abuse.

80 Sally Macmanus (2015), 'Guidance for Trust managers Responding effectively to violence and abuse (REVA project) Briefing 2. Implementing and sustaining routine enquiry about violence and abuse in mental health services, available online, [www.dmss.co.uk/pdfs/REVA-Brief-2-Guidance-for-Trust-managers-FINAL-071015.pdf](http://www.dmss.co.uk/pdfs/REVA-Brief-2-Guidance-for-Trust-managers-FINAL-071015.pdf) (accessed March 25 2020), p. 7.

81 <https://safelives.org.uk/practice-support/resources-marac-meetings>

82 <https://safelives.org.uk/node/507>

# C

## Chapter 9: Enquiry and Disclosure

### Key recommendations:

- All health staff should have access to the facilities they need to ensure that any domestic abuse enquiry is done in private and family members and friends are not used as interpreters.
- All health staff should be equipped with the knowledge and skills they need to enquire about domestic abuse sensitively and supportively through an explorative conversation.
- All health staff should understand the impact of trauma and consider how to ask and respond in a way that takes into account and acknowledges trauma responses.
- All health staff should know how to record any disclosure of domestic abuse in the survivor's own words and offer specialist support.
- Mental health Trusts should ensure staff understand how experiences of domestic abuse contribute to current presentations of mental distress.
- Mental health Trusts should ensure domestic abuse questions are embedded into assessment documentation and in clinical audit.<sup>83</sup>

**"Compassion, patience, understanding – sometimes it's all we need."**

–Francesca<sup>85</sup>, survivor consulted as part of the Pathfinder survivor consultation process

**"If they ask you more than once is everything ok, is everything ok at home and you feel that compassion, that oh they really care about me, you are prompted to open up. For someone that is a survivor, you just need that little window and everything comes crashing down."**

–Abi<sup>84</sup>, survivor consulted as part of the Pathfinder survivor consultation process

Healthcare professionals have a unique window of opportunity to respond to survivors of domestic abuse. Many survivors who would not feel comfortable or able to disclose abuse to the police will attend healthcare appointments and ED.



**Healthcare professionals have a unique window of opportunity to respond to survivors of domestic abuse.**

We know from domestic homicide reviews that in some cases health professionals will be the only statutory service in contact with both the survivor and perpetrator. For this reason, it is imperative that health professionals know how to enquire about domestic abuse safely, and to feel confident that it is a legitimate and important part of their role to do so.

The 'whole-health' model recognises that health professionals will be more effective in responding if a Health Based Idva is funded to handle cases of domestic abuse in the health service and if clear referral pathways and strong links are established with the local specialist domestic abuse agencies.

**NICE guidelines state that being trained to respond to disclosure (Level 1) and how to ask about domestic abuse (Level 2) is essential for safe enquiry about experiences of domestic abuse and a consistent and appropriate response.<sup>86</sup>**

### When to enquire

**NICE recommends that mental health services, reproductive care, sexual health, alcohol or drug misuse and children's and vulnerable adults' services routinely enquire about domestic abuse with every patient/service user.**

Routine enquiry means all women are asked about domestic abuse, but the method/question might vary according to the provider or the survivor's situation.<sup>87</sup> Routine enquiry is more than a tick box exercise and the aim of enquiry is to have a supportive and explorative conversation to help you better understand the needs of the patient. Do not force a disclosure and always adopt a non-judgemental approach.

Best practice routine enquiry should be accompanied by strategic leadership and commitment from Trust management but also across disciplinary teams. Routine enquiry must be accompanied by training at all levels – evidence from mental health Trusts is that routine enquiry is most effective when rolled out to all staff at all levels.

Routine enquiry is not recommended in General Practice, ED and most Outpatient Services. However, it is recommended that if a patient presents with indicators of domestic abuse then you should ask about their experiences in a private discussion. NICE and WHO both recommend a low threshold for health staff to ask about domestic abuse<sup>88</sup>.

Indicators will vary for adult and child survivors and perpetrators, however common conditions linked to survivors of domestic abuse are depression, anxiety, sleep and eating disorders, suicidal thoughts/plans or attempts, unexplained chronic gastrointestinal symptoms, adverse reproductive outcomes, including multiple unintended pregnancies or terminations, chronic unexplained pain, traumatic injury, particularly if repeated and with vague or implausible explanations and an intrusive 'other person' in consultations, including partner or spouse, parent, grandparent or an adult child.<sup>89</sup>

83 Sally Macmanus (2015), 'Guidance for Trust managers Responding effectively to violence and abuse (REVA project) Briefing 2. Implementing and sustaining routine enquiry about violence and abuse in mental health services, available online, [www.dmss.co.uk/pdfs/REVA-Brief-2-Guidance-for-Trust-managers-FINAL-071015.pdf](http://www.dmss.co.uk/pdfs/REVA-Brief-2-Guidance-for-Trust-managers-FINAL-071015.pdf) (accessed March 25 2020), p. 7.

84 All names have been changed to protect the anonymity of the survivors.

85 All names have been changed to protect the anonymity of the survivors.

86 National Institute for Health and Care Excellence (2016), Domestic violence and abuse

87 Taft A, O'Doherty L, Hegarty K, Ramsay J, Davidson L, Feder G. Screening women for intimate partner violence in healthcare settings. *Cochrane Database Syst Rev* 2013;4:CD007007

88 Feder G, Wathen CN, MacMillan HL (2013) An evidence-based response to intimate partner violence: WHO guidelines

89 National Institute for Health and Care Excellence (2016), Domestic violence and abuse





## Key considerations for how best to enquire

### Is the environment appropriate for you to enquire?

It is crucial that enquiring about domestic abuse is done sensitively in a private environment. Although it may not be possible to have access to a private office space in a busy Emergency Department, it is imperative that clinicians try to ensure the space is as private and confidential as possible before asking about experiences of abuse. The patient must be alone and you should not enquire about abuse if they are with their partner, a family member or friend. Furthermore, the patient should not be asked about abuse if their children are present unless the child is under the age of two and incapable of repeating what they have heard and thus increasing the risk to the survivor.

Remember, friends and family members should never be used for translation as this may influence the information the patient shares with you or the friend/family member may alter the information they pass on. Furthermore, the friend/family member offering to provide translations may be abusing the patient or may pass on information to the abuser(s), increasing the risk to the patient if they were to disclose abuse. If you do not speak the same language as the patient you should use an independent service with an understanding of VAWG for BSL and other translation services. Similarly, please do not make assumptions about two people of the same sex – they may be partners rather than friends or siblings. And someone presenting as a carer for a disabled person may also be someone who poses a risk to them.



### Consider the impact of trauma

It is essential to understand that survivors' experiences of abuse are traumatic, and to ensure that enquiry is trauma-informed. When thinking about when and how to ask, practitioners should consider how they make a person feel safe and comfortable in a room – ask if they want to sit or stand and where they want a chair to be, explain and show them how you are recording information and show them the forms or your computer screen, also be clear on how information will be shared. When someone does disclose, thank them for trusting you, showing empathy is vital. Trauma-informed practice is about working with someone and offering choice and support where you can so that they feel involved in the processes and clear on what is being asked and why.

### Avoid unhelpful assumptions

For all areas of health it is important that staff are professionally curious and open minded about what those experiencing and perpetrating abuse look like. Although domestic abuse research and services mainly focus on intimate partners, this type of violence and abuse takes many forms. Examples include: forced marriage, abuse perpetrated in the name of so-called 'honour', abuse of parents by their children, abuse of older people and other intra-familial abuse.

Remember that anyone can be subjected to domestic abuse regardless of race, gender, sexual orientation, ability, age or socioeconomic background and that everyone has the right to live free from abuse. Avoid unhelpful assumptions, for example, that two people of the same sex attending together must be friends rather than partners or that women with a particular cultural heritage choose to live under the control of their partner.

Pathfinder has produced specialist guidance for health professionals on how to respond appropriately to:

- LGBT+ survivors – See [Appendix 3](#)
- Older survivors – See [Appendix 4](#)
- Disabled survivors – See [Appendix 5](#)
- BME survivors – See [Appendix 6](#)



Dr Mary Hepburn OBE discussing how to frame enquiry about domestic abuse.

### Ask the right questions

Four questions have been developed as a framework for helping to identify survivors of domestic abuse which could be used in hospital and community settings, where it is safe to do so. The questions have been found to be a sensitive and accurate tool<sup>90</sup>. These will need to be adapted if you believe the abuse is inter-familial (for example abuse by parents or in-laws to adult children, or parent to child abuse) rather than by a partner or ex-partner. They will also need to be framed in a way that is age and learning-age appropriate for all survivors:

- Humiliation: "In the last year, have you been humiliated or emotionally abused in other ways by your partner/family member?" "Does your partner/family member make you feel bad about yourself?" "Do you feel you can do nothing right?"

- Afraid: "In the last year have you been afraid of your partner or ex-partner/family member?" "What does your partner/family member do that scares you?"
- Rape: "In the last year have you been raped by your partner or forced to have any kind of sexual activity?" "Do you ever feel you have to have sex when you don't want to?" "Are you ever forced to do anything you are not comfortable with?"
- Kick: "In the last year have you been physically hurt by your partner/family member?" "Does your partner/family member threaten to hurt you?"

It is not just about what questions you ask but also how you ask them. It is important that you are confident in your enquiry – being comfortable will send a message to the patient that this is not a shameful topic. So ask the questions in your own words that feel comfortable for you.

<sup>90</sup> Sohal H, Eldridge S, Feder G; The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: a diagnostic accuracy study in general practice. BMC Fam Pract. 2007 Aug 29;8:49



**Validate the patient's experience**

It is important to believe and respond to all disclosures of domestic abuse. After a patient discloses, take a moment to recognise how difficult it may have been for them to trust you and let you in on what they have been experiencing. It may be the first time they have told anyone about the abuse. For this reason, it is important to validate their experience and reassure them that you believe them and the abuse they are being subjected to is not their fault.

You could say:

- Thank you for telling me
- I believe you
- This is not your fault. You are not to blame for your partner's abuse...he/she alone is responsible, abuse is a choice he/she makes

- Your safety at home and that of your children is our priority
- Everyone has a right to live free from abuse
- I know someone you can talk to (a domestic abuse service)

Some people using health services, and particularly mental health services, may experience paranoid thoughts, delusions and hallucinations. Disclosures in this context should still be responded to as described. For example "Thank you for telling me that. It is not ok for somebody to treat you that way. I am going to do what I can to get you the support that you want"



Donna Allender discusses building rapport with survivors

**Responding to staff as survivors**

SafeLives research A Cry For Health estimates that over 51,000 NHS staff are likely to have experienced domestic abuse in the past 12 months<sup>91</sup>. It can be difficult to spot signs of abuse in colleagues and uncomfortable to enquire about it, but you have a unique opportunity to help someone, and domestic abuse survivors consistently say they wish someone had just asked them sooner what was going on.

Be aware of signs which can be indicative of experiencing abuse, such as frequent absence, lateness, obsession with time keeping, change in manner of dress and isolating themselves from other colleagues. If you have concerns you can speak to your HR department for advice, or your local Idva service will also be happy to give you practical tips. For further information on how to support colleagues, please read SafeLives' guidance paper on responding to colleagues experiencing domestic abuse<sup>92</sup>.

**Promising practice example**

Routine enquiry about domestic abuse was embedded in health visiting services across **Haringey and Enfield boroughs** and sexual health services across North Central London in 2016.

**North Middlesex University Hospital** also embedded routine enquiry in midwifery and gynaecology. In midwifery alone, after routine enquiry was embedded in 2016, there were 136 disclosures of domestic abuse.



**Over 51,000**

NHS staff are likely to have experienced domestic abuse in the past 12 months<sup>91</sup>



Lisa Lonsdale, Named Nurse Safeguarding at Blackpool Teaching Hospitals NHS Foundation Trust, discusses how to ask colleagues about their experiences of abuse.

91 SafeLives, A Cry For Health, [www.safelives.org.uk/sites/default/files/resources/SAFJ4993\\_Themis\\_report\\_WEBcorrect.pdf](http://www.safelives.org.uk/sites/default/files/resources/SAFJ4993_Themis_report_WEBcorrect.pdf)  
 92 SafeLives, Respond to colleagues experiencing domestic abuse: practical guidance for line managers, human resources and Employee Assistance



# C

## Chapter 10: Referral Pathways

**"Try to understand the complexities of support needs of the survivors with more compassion, more of a holistic and less clinical approach. They also can signpost you to other organisations but once referred, there is a waiting list, therefore the mental health provisions, in the interim, should offer temporary support for the victim. Early intervention is imperative."**

–Zoe<sup>93</sup>, survivor consulted as part of the Pathfinder survivor consultation process



**A clear, robust and easily accessible referral pathway is needed for professionals to feel confident in their response.**

### Pathfinder recommendations:

- Every health service should embed clear and effective referral pathways into local specialist services
- Every health service should have designated Marac<sup>94</sup> representatives and ensure that staff are aware of who they are including any appropriate internal referral procedures<sup>95</sup>

A clear, robust and easily accessible referral pathway is needed for professionals to feel confident in their response. Knowing what services are available to survivors, how they can support them and how one can refer in to them makes a professional more likely to enquire and offer survivors the support they need.

Pathfinder strongly recommends that a clear referral pathway that all staff are aware of is in place before implementing enquiry. Inviting your local specialist service to present on their work at large gatherings of colleagues in the service will also help to break down lack of knowledge, increase understanding and confidence about when and how to reach out, and what the outcome might be. This would usefully be done on a regular basis, to keep knowledge amongst the staff team up to date.

### Referring to in-house specialist domestic abuse roles

General practices that are IRIS trained and have an Advocate Educator or hospitals with Idva provision will have a direct point of contact to refer a patient to a specialist service. This is the most effective form of referral pathway as professionals are likely to get to know the colleague in these specialist roles and feel confident to give them a call to ask their advice or make a referral. Knowing there is someone on hand to do a risk assessment with the patient, undertake ongoing safety planning and make any other necessary referrals relieves a lot of pressure for health professionals and increases their likelihood to enquire.

### Referring to specialist local services

It is vital that every health service has established links with the specialist services in their local area to build an integrated response to domestic abuse. If your Trust has a Domestic Abuse Coordinator or Clinical Lead for Domestic Abuse they should be responsible for ensuring strong links with local services.



**Established links with the specialist services in their local area to build an integrated response to domestic abuse.**

### Steps to ensuring a robust relationship include:

- 1 Invite** representatives from local specialist services to attend VAWG/ domestic abuse and health steering groups. Consider inviting representatives from specialist services to come and speak about the service and how to refer at team meetings or as part of a lunch staff briefing. This process will improve the confidence of health professionals to refer as they will be able to reassure and clearly explain to the patient what the service can offer and the type of response they can expect.
- 2 Create** a shared vision for health's response to domestic abuse. Your relationship with the service you hope to refer patients on to is vital to the success of your response to domestic abuse. Their expertise in this field will be important in creating a domestic abuse referral pathway.
- 3 Acknowledge** that your desired increase in referrals from health will increase the caseload of an already underfunded, overstretched non-profit organisation. Consider whether your organisation has the resources to help the specialist service to meet this excess demand, and how you can support the case they may need to make to their existing commissioners (for example Police and Crime Commissioner, Local Authority) as well as exploring the option for pooling domestic abuse budgets across different commissioners. This can often achieve more than individual agencies acting unilaterally.

93 All names have been changed to protect the anonymity of the survivors.

94 <https://safelives.org.uk/practice-support/resources-marac-meetings>

95 <https://safelives.org.uk/node/507>

**4 Agree, record and analyse** the best way for the specialist service to receive referrals from health professionals. This should include explicit agreements about when to make a referral, share information and what type of information to share, as well as how you will jointly and regularly review data to improve practice. You should also consider agreeing how referrals from health will be counted and recorded. Ideally, both partners should be recording when referrals are made. This will ensure that the progress made via this integrated response is measured and can be used to provide evidence of an improved health response for inspections and future funding decisions. To find out more about data collection see [Chapter 12: Data Collection, Monitoring, Analysis and Practice Improvement](#).

**5 Respect** each other's expertise, the different pressures facing each organisation and how this may affect partnership working.

An example referral pathway template can be found in [Appendix 8: Domestic Abuse Policy Template](#). This referral route should be made clear in all domestic abuse training for staff (including mandatory Level 1 training). It should be displayed clearly for health professionals to see and be easily accessible on the intranet.

## Referring in to multi-agency risk assessment conferences (Maracs)

Maracs are a vital component of a coordinated community response to domestic abuse and should meet agreed standards of operation<sup>96</sup>. Almost 300 operate around the UK. Professionals from domestic abuse services, health, police, adult services, child services, probation, education, housing, drug and alcohol services attend the Marac to discuss high-risk cases of domestic abuse and create a coordinated action plan to increase the safety of the survivor and hold the perpetrator to account. An Idva will be present to advocate for the needs of the survivor(s) in each case but the information you hold within the health service could be absolutely critical to someone being safe. Your expertise will be highly valued, even for cases which are not 'open' to your service. The meetings are usually held every two to four weeks although this can vary significantly from area to area.

Referrals to Marac can be made by any professional when they assess a survivor to be at high risk of serious harm or homicide as a result of the domestic abuse they are being subjected to. A Marac referral may be made if one of the following criteria are met:

1. A [SafeLives' DASH Risk Identification Checklist](#) has been undertaken and a score of 14 or more has been identified.
2. A professional deems the survivor at high risk based on their professional judgement when 'the particular context of a case gives rise to serious concerns even if the survivor has been unable to disclose the information that might highlight their risk more clearly.'<sup>97</sup>

3. The perpetrator's abuse appears to be escalating in frequency and/or severity. Each Marac will have different criteria for an apparent escalation e.g. there have been four incidents by the same perpetrator on the same survivor in the last 12 months and they are increasing in severity or frequency
4. Another instance of abuse has occurred between the same survivor and perpetrator(s) within 12 months of the last time it was heard at Marac.

It is vital that health services are represented at these meetings. To ensure this happens you should:

- Check who the Marac representative for your organisation is and ensure they are attending the meeting regularly.
- If there is currently no assigned Marac rep, decide who is best placed to undertake this role. The rep should be an employee of the organisation, not the Domestic Abuse Coordinator or Health Based Idva as they must be able to make decisions and take actions on behalf of the organisation. Thus you do not want this to be the most junior member of the team as they will need to be able to decide and make decisions on behalf of their agency. For further information on how to be a successful Marac rep please see the [SafeLives Toolkit for Marac reps](#).

- Agree a process for who can make Marac referrals. This should not stop Marac referrals taking place providing that relevant policies as to who to refer on to are in place. This process needs to be well advertised and communicated to all staff so they are aware of what they are expected to do. Pathfinder recommends that professionals do not use the DASH Ric checklist unless they have received specialist training in how to use the tool. If you believe a patient is at risk from domestic abuse, you will need to seek out a trained colleague or member of a specialist service who can perform the risk assessment. Regardless, you should still make a Marac referral if your professional judgement tells you the case is clearly high risk.
- Ensure this process for Marac referrals is reflected in the organisation's domestic abuse policy and that training is provided to professionals.
- Bear in mind, through this process, that Domestic Homicide Reviews commonly find that the only service in touch with both victim(s) and perpetrator(s) was one or more of the local health services. The information you hold may be vital in saving a life, as is your professional expertise in creating effective safety plans.



## Over 51,000

DHRs commonly find that the only service in touch with both victim(s) and perpetrator(s) was one or more of the local health services.

<sup>96</sup> <https://safelives.org.uk/sites/default/files/resources/The%20principles%20of%20an%20effective%20MARAC%20FINAL.pdf>

<sup>97</sup> Safelives (2014) SafeLives Dash Risk Checklist Quick Start Guidance, [www.safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf](http://www.safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf)

## Other local support services

It is important to be aware of all services and support groups for survivors of domestic abuse and VAWG, outside of the local domestic abuse dedicated services. Ensure that the intranet and any referral pathways specify services available to survivors of other forms of gender-based violence including so-called 'honour'-based abuse, sexual violence, female genital mutilation, modern day slavery and child sexual exploitation. Remember that survivors of domestic abuse may have experienced sexual violence and rape or other forms of gender-based violence, so it is important to discuss what exactly the patient feels they need support with so you can refer them on to the best agency for them.

In some areas there will be services that are set up to specifically support survivors from certain communities e.g. BME, LGBT+ and disabled people. These services are particularly important as a survivor may feel more comfortable to seek help and engage if they know that there are services who can understand their particular needs and situation. These services will also have best practice advice and guidance on the safety of survivors facing specific forms of violence and abuse. Knowing about these services and being able to refer is important to provide a robust response to all survivors. Challenging any assumptions you have as you do this will be important – for example women in same sex relationships often feel 'unseen' because services to which they're trying to flag a problem assume that the woman with them is a caring friend or even a sister, missing the opportunity to speak to them alone.

Remember to not assume that your patient will want to access any particular service, make their options clear to them and support them to access whichever service they feel is best for them. If there are no local services available, a survivor can be signposted to national helplines, such as the [Freephone National Domestic Abuse Helpline](#) and [Live Fear Free helpline for Survivors in Wales](#).

Furthermore, if a patient turns down a referral to a specialist domestic abuse service or Idva they may still like the option to seek other non-specialist support. For this reason, don't forget to map any local women's or young people's support groups or counselling services in the area. If the patient has declined a referral in the past, referrals should always be offered again. Sometimes a survivor will access a service long after a referral was suggested. You might not be aware, therefore, of the difference you can make to someone by offering this support.

For more information, see our specialist guidance for health professionals on how to respond appropriately to:

- [LGBT+ survivors](#) – See Appendix 3
- [Older survivors](#) – See Appendix 4
- [Disabled survivors](#) – See Appendix 5
- [BME survivors](#) – See Appendix 6

## Chapter 11: Domestic Abuse Training

**"People haven't been informed. They haven't been trained about it. There is no knowledge. So, domestic violence is the black eye, you haven't got a black eye, must just be an argument in the family and what's wrong with that. Part of life isn't it. You call the police, you think they will listen, they look at you and say, oh why are you making such a big fuss."**

–Miriam<sup>98</sup>, survivor consulted as part of the Pathfinder survivor consultation process

### Pathfinder recommendation:

- Every health service should have a sustainable training strategy in place to ensure all staff receive the relevant level of domestic abuse training in line with NICE guidelines
- All domestic abuse training should be rooted within an equalities framework and cover the experiences of people who experience unique forms of discrimination due to the intersection of their gender with other identity characteristics including race, class, poverty, disability, age and sexual orientation

In Pathfinder's experience of working with health professionals to improve their response to domestic abuse, one of the most effective ways to encourage staff to enquire about domestic abuse and respond effectively has been to equip them with the knowledge, skills and confidence to do so.



98 All names have been changed to protect the anonymity of the survivors.





Hayley Ferns, Domestic & Sexual Abuse Advisor at Glow, discussing the impact of domestic abuse training on practice.

Feedback from professionals trained on our sites during the life of the project have reflected this, with one senior staff nurse from Northern Devon Healthcare Trust commenting:

'I feel much more comfortable about domestic abuse issues particularly regarding questioning patients and how to take things forward following disclosure. Plan to discuss with my manager formal questioning on our own assessment tools.'

Your training strategy should be recorded within a wider domestic abuse strategy or policy and created with the support of your Learning and Development team to ensure sustainability.

When assessing your service's domestic abuse training offer to employees, you should consider:



All staff should be trained to respond to domestic abuse in line with NICE guidelines<sup>99</sup>.



Eleanor Hepworth, Domestic Abuse Coordinator at Standing Together, offers advice on how to deliver a sustainable domestic abuse training Trust-wide.

**1 What domestic abuse training is currently delivered and who to?**

All staff should be trained to respond to domestic abuse in line with NICE guidelines<sup>99</sup>. NICE recommends that all health staff receive **Level 1** domestic abuse training. This should include how to respond to a disclosure of domestic abuse sensitively and how to direct people to relevant services. This level of domestic abuse training can be conducted via e-learning or face-to-face sessions and is often included as part of mandatory safeguarding training.

**Level 2** domestic abuse training should cover prevalence and dynamics of domestic abuse and health professionals' role in responding including how to assess immediate safety and make referrals to specialist services. NICE recommends that this training be undertaken by nurses, accident and emergency doctors, adult social care staff, ambulance staff, children's centre staff, children and family social care staff, GPs,

mental health professionals, midwives, health visitors, paediatricians, health and social care professionals in education (including school nurses), prison staff and alcohol and drug misuse workers.

Finally, professionals who are most likely to respond to domestic abuse in their jobs day to day such as safeguarding nurses, midwives and health visitors should receive **Level 3** training. This training should be a full day of face-to-face specialist learning including how to assess risk, safety plan and continue liaison with specialist support services.

All health staff must refresh their training every two years – HR teams need to remind managers to include this in staff work plans and staff must be able and allowed to train in the next level up if they are interested in doing so as part of their learning and development plan.

If your service does not currently offer these three levels of domestic training to the relevant health staff, then next steps need to be identified to introduce these learning opportunities. Considering the following questions will help clarify these next steps based on your Trust's needs.

## 2 Is your training content relevant and up to date?

It is vital that any training content delivered to health professionals is well informed and up to date with current legislation, regulation, policies and research. Content must acknowledge the gendered power dynamics of domestic abuse in the wider context of gender-based violence. It must provide information about other abuses of power and control, for example, in same sex relationships and in child to parent abuse and give examples of how these forms of abuse may affect how patients present to professionals. This information must be practical and directly relevant to their role in responding to survivors.

When thinking through the content of your domestic abuse training you should consider:

- Was training content produced by or in collaboration with domestic abuse specialists?
- Is training content specific to the health setting it is provided in and as relevant as possible to the health professionals it will be provided to?
- Does the training highlight the experiences of and nuanced responses to older, BME, LGBT+ and disabled people? Is the training reflective of all local populations?
- Who is responsible for updating the training? Is this captured in their job description?
- How often is training content reviewed and updated? Is this recorded within a wider VAWG/domestic abuse strategy?

If you wish to assess the content of the domestic abuse training you offer you can use our [Domestic Abuse Training Assessment Tool](#) in [Appendix 12](#) to do so. After assessing your content, think through how best to approach filling the gaps and consider approaching a specialist organisation to help with this. This will ensure the content is as accurate and useful as possible.

## 3 Who delivers this training?

In Pathfinder's experience, the most effective training strategies exist when a named individual is responsible for delivering training in line with the Trust's wider VAWG/domestic abuse strategy. We recommend employing a Domestic Abuse Coordinator to undertake this work. Employing a Coordinator to be responsible for this work ensures that the approach can be centralised and joined-up. It allows the Coordinator to be plugged into the queries and needs of frontline staff and ensures that any changes to the service's domestic abuse response (referral pathways, changing staff policies etc) are reflected accurately in the training delivered to staff. If a Coordinator is not possible, the Safeguarding Lead should undertake this work.

If training will be delivered **internally** by professionals within the Trust you should consider:

- Do they have enough resources and capacity to meet the demand of the whole service?
- Are they domestic abuse experts with an understanding of the VAWG context? Are they able to deliver training consistently to a high standard and in line with current research, legislation and practice?
- Are trainers given the opportunity to attend adequate refresher training and supervision sessions to maintain their own knowledge and well-being?

- Is training delivery the responsibility of a stand-alone post or an add-on to another role? Is training delivery acknowledged in their job description and accounted for in terms of their capacity?
- Is your lead confident with describing and offering good practice advice that will speak to the different communities within your area in terms of race and ethnicity, sexuality, religion, disability? If not, can they be assisted by specialists who can make sure the training is comprehensive and inclusive?

If training will be delivered **externally** by your local specialist service you should consider:

- How regularly do they deliver training to staff? Does this meet the demand of all employees?
- Do you provide the local service with enough resources to provide a consistent service and follow up with any subsequent issues and queries attendees have?
- Are you adequately compensating that service for preparation time, and the involvement of those with lived experience?
- Do you have a formal service agreement in place outlining the service you require from them to meet the full needs of employees? Formally acknowledging your reliance on their service and committing to providing them with regular funding to meet your needs allows under-funded services to commit their resources and plan to deliver training for you long-term. This agreement should also set out how the service will provide you with training data to monitor and jointly analyse, and who would be responsible for managing bookings and advertising sessions.

## 4 Is training delivered regularly and sustainably?

For health staff to retain information and skills and feel confident to use them in their everyday practice, it is important that they receive training regularly. Domestic abuse training should be refreshed every 2 years. To ensure this, ask:

- Will training be mandatory for certain people?
- Who is responsible for monitoring how often people have received training and refreshers?

## 5 How does this training strategy feed into your wider VAWG/domestic abuse strategy?

Your strategy should specify a local training plan e.g. a five year plan for your service with identified professionals or specialist services who will provide the training and oversee the delivery plan; the strategy should include a plan for ongoing staff training needs analysis.

Your domestic abuse policy should state, and the HR team must implement, that all health staff must undertake mandatory Level 1 training at induction and any additional training, according to the level appropriate to their role. Consider how you will achieve this, whether domestic abuse training will form part of an induction for all new staff and whether it will be embedded into existing Level 3 Safeguarding Children and Adults training taking place.

## 6 How will training be monitored and analysed for impact?

It is important for every service to keep a record of what level of domestic abuse training each staff member has had and when they are due to attend a refresher course. Your Domestic Abuse Coordinator should set out a process with Learning and Development to share information about the staff that they have trained so that this can be logged on internal systems. Furthermore, at the end of any training the Coordinator should disseminate evaluation feedback forms and check back in with staff six months after their training to ensure that course content met their learning needs and that learning is being implemented into practice.

Feedback forms and follow up check-ins should monitor and analyse the following:

- Immediate reactions – how learners felt about the training, did they find it informative? Would they recommend it to colleagues? Was it relevant to them and their role?
- Immediate outcomes – did it change the learners' knowledge, skills and attitudes assessed at the end of the learning process?
- Intermediate outcomes – is there evidence of staff's behaviour change in the workplace? E.g. increased enquiry, disclosure and referrals
- Ultimate outcome – improved outcomes for the departments/services responding to domestic abuse e.g. general increased rates of enquiry, disclosure and referrals.

If training hasn't had the desired impact, the content and format should be revised accordingly. Experiential learning, which fully includes the voice of those with lived experience, should always be considered. Involving some element of independent review of the impact of training provided will be valuable. For example, consider how you are involving those with lived experience in the process of assessing whether your staff have actually increased their knowledge and expertise. Your local specialist domestic abuse service will be able to help with this.



**Keep a record of what level of domestic abuse training each staff member has had and when they are due to attend a refresher course.**

## Promising practice example

In **Southern Health NHS Foundation Trust** a small-scale study was completed by a CT1 psychiatry trainee, Safeguarding Lead and Domestic Violence Lead in a local community mental health team on 'Increasing staff confidence about domestic abuse identification, disclosure and safeguarding in a community mental health team\*'.

The study began with a baseline survey of staff confidence across the following domains:

1. Knowing the definition of domestic abuse
2. The process you would use to escalate a domestic abuse concern
3. How you would make a referral
4. How to complete risk assessment forms
5. How and when to refer to specialist services
6. Domestic abuse acronyms e.g. Idva
7. What Marac means
8. How to ask service users about domestic abuse
9. Who to signpost service users to if they make a disclosure, and when to involve the police

A four-hour training package was delivered by the specialist service with a focus on targeting the above surveyed questions. Staff were then re-surveyed to see if staff confidence had increased and the results showed an increase in confidence from 25% to 85% across all originally surveyed questions.

\*This study was carried out by Beth Mccausland CT1 Psychiatry Trainee, Siobhan O'Halloran Safeguarding Lead and Nicola Minnicozzi at Southern Health NHS Foundation Trust



# Chapter 12:

## Data Collection, Monitoring, Analysis and Practice Improvement

### Pathfinder recommendations:

- Every health service should collect data on domestic abuse training attended by staff
- Every health service should collect data on enquiry into domestic abuse to understand gaps in training
- Every health service should record disclosures of domestic abuse in the words of the survivor
- Every health service should collect disaggregated data on protected characteristics
- Every health service should collect data on referral pathways
- Every health service should ensure that their patient medical records are able to capture the data we suggest clinicians collect around domestic abuse
- Every health service should have a clear strategy for how data on domestic abuse is put together with other relevant data, such as safeguarding and equalities monitoring with a clear framework for how data collection will be rooted in the need for practice improvement.

**"Now [you] must document on a hospital record. Now it's a computerised record, box you tick. If you suspect domestic violence but it's not disclosed, [you must] document that you asked. Continue monitoring and surveillance. A lot of what we do is fact-finding and info-sharing"**

–Lead nurse for safeguarding

**"In an attack situation they are really good at sharing information. I got inundated with leaflets, phone calls from different services .... just checking up whether I had support in place. In that area... between doctors, hospitals and stuff it's all a bit shoddy. You are constantly telling the same story over and over. And often you aren't in the place where you want to be telling the story over and over."**

–Vickie<sup>100</sup>, survivor consulted as part of the Pathfinder survivor consultation process



Teresa Kippax from the CQC talks about the importance of recording domestic abuse incidents accurately.

### Why is data collection important?

Data collection, monitoring, analysis and a clear route to practice improvement is essential to understanding the health sector's response to domestic abuse. Data should be monitored at a strategic level on a regular basis to assess effectiveness of the service's response to domestic abuse. The data you collect and how you collect it is key to ensuring that this evidence can be used to effectively support survivors of domestic abuse. It is also a great way to highlight and promote the good practice you have been undertaking and measure the impact of change in policy, practice, training or other parts of your response, so that resources can be targeted effectively in the future.

Effective analysis and discussion about practice improvement can involve external specialists, as well as staff from within the service, so there is a chance to test each other's assumptions and perspective and come up with the most creative and comprehensive plans for further change. That specialist service can also advise on the inclusion of patients/survivors in this process of analysis and practice improvement.



**Data is key to evidencing the need for specialist DA interventions**

## C What data should you be collecting?

Pathfinder recommends collecting evidence on the following:

### 1 Staff Training

A record of which staff members and teams have been trained enables health practices to focus on future training and to support those teams that may be missing training or need updates. The impact of this training, as discussed above, is also vitally important to capture. Simply attending a training course is not a signifier of improved practice.

### 2 Enquiry in Domestic Abuse

Collecting data on enquiry into domestic abuse illustrates where there are gaps in the training or in the confidence of staff asking the question. If a staff member has a concern about a patient and enquires about abuse, a note should be recorded that an enquiry was made, as well as the response to the enquiry (even where there is no disclosure). Data collection on enquiry also helps understand who is being asked – is it only women with children who are asked about abuse for children’s safeguarding? Is it only women in a certain age bracket being asked (there are stereotypes which may lead to women over 55, and teenage girls in relationships with abusers, being missed for example)? By understanding enquiry by staff, training can focus on specific gaps in their knowledge. It will also highlight where training already delivered hasn’t been sufficient to shift the culture in your organisation, to increase professional curiosity.

### 3 Disclosure of Abuse

Disclosures of abuse should always be safely recorded. We know that it can be harmful for survivors to have to repeat their story to multiple professionals as this can be traumatising and impair their mental health and wellbeing. Although we understand that not all professionals have access to electronic medical records, recording disclosures electronically could limit the number of times survivors have to explain the abuse to another professional. Any disclosure should be clearly and factually documented and include the patient’s own words. However, this must be recorded safely and confidentially. Staff need to be aware of safety implications of this for themselves and the survivor and ensure this is done sensitively. The perpetrator should not be able to gain access or be able to see that this has been recorded. If a perpetrator becomes aware of a disclosure this can increase the risk to survivors and any children in the household.



**Collecting data on enquiry into domestic abuse illustrates where there are gaps in the training or in the confidence of staff asking the question.**

### 4 Demographic Information

A data collection tool specific to the disclosure of domestic abuse or data extracted directly from computer systems can help you understand the communities that you are supporting and whether specific provision is needed for older people, BME communities, individuals with physical disabilities, those with mental health issues or people from LGBT+ communities. This data can also provide solid evidence to commissioners and the executive board that these specific domestic abuse support provisions are necessary and important.

#### Demographic information we suggest collecting includes:

- 1) Age of patient
- 2) Biological sex
- 3) Gender identity
- 4) Sexual orientation
- 5) Ethnicity
- 6) Whether the patient is pregnant or has children in the household (for Child Safeguarding Concerns)
- 7) Disability
- 8) Substance use
- 9) Mental health

It is important to remember that it is not only patients who are survivors and perpetrators of domestic abuse. Domestic abuse can and will affect staff members and it is just as important that this confidential information about staff members is recorded as well. Again, this must be confidential and no staff member outside of the immediate support given should be able to identify the survivor or perpetrator.

### 5 Information about the Perpetrator(s) and Abuse Type

The survivor’s relationship to the perpetrator(s) is important to record to ensure that the right support plan can be put in place for the patient. This also includes whether the individuals concerned live together some or all of the time.

Knowing the type of abuse that is being perpetrated ensures that survivors receive the specialist support that they need and that this support is recognised as important within the community. Wider issues related to VAWG such as FGM, Forced Marriage and so-called ‘Honour’ based abuse should all be recorded alongside domestic abuse.

Survivors should be encouraged to identify if there are multiple perpetrators who pose a risk to their safety and wellbeing. This is relevant to all survivors, and assumptions about this only being relevant to specific religions or ethnicity should be avoided. The survivor with whom you are speaking might also know of others who are at risk, again they should be encouraged that they can share this information so that you and other agencies can act on the fullest picture possible. You must be transparent with the survivor with what guidance you will need to follow regarding confidentiality and safeguarding, so that they are properly informed.

## C 6 Referrals

If a disclosure is made to a member of staff then a referral to specialist support should be offered, internally within the health setting or through an established external pathway. A note of what action you took, where the survivor has been referred to and confirmation that this referral has been received by a multi-agency setting, health based specialist or a specialist domestic abuse service is vital for the survivor's safety. Data collection on who you are referring to also highlights links between specialist services and health settings.

Further tools and information about data collection can be found in the Appendix to the Board of Science 2014 report on domestic abuse [here](#) and Kings College Linking Abuse and Recovery through Advocacy (for survivors and Perpetrators) resource which can be downloaded [here](#).

### What data should a Health Based Idva be collecting?

If a Health Based Idva, IRIS Advocate Educator or any other health based domestic abuse specialist holds cases, they should be collecting data above and beyond what is collected by the NHS.

Specialist data collection tools, such as [SafeLives Insights](#), IRISi monitoring or a similar outcomes measurement tool are often in place where a domestic abuse specialist is connected to a health setting. These tools allow commissioners to really understand what resources are essential for survivors in the health setting and in the community.

### Promising practice example

Practice in terms of data collection around domestic abuse has differed in all of the Pathfinder sites. No two sites or teams have been the same! We thought we'd use one example here of a Safeguarding team at one of the sites.

The Safeguarding team currently uses a simple Excel spreadsheet to track the demographics of patients who are being subjected to abuse, which departments the patients are being referred from, notes on the disclosure by the patient and finally, the actions of the hospital. This simple Excel spreadsheet not only shows the support the client needs and the actions of the staff, but it also allows the Safeguarding team to see where referrals are coming from and, more importantly, which departments are not referring domestic abuse cases on, and so may need some more training.

We all know and understand how busy health professionals are. However, recording a few simple details on an Excel spreadsheet each time a disclosure relating to domestic abuse takes place and ensuring that this document is kept in line with GDPR regulations to protect the disclosure from being shared any further, can really make the difference to patients in health settings and may lead to lives being saved.

# Chapter 13: Awareness Raising

## Pathfinder recommendation:

- Every health service should have a clear awareness raising strategy for ensuring that patients and staff are aware of health professionals' role in responding to domestic abuse

A good response to domestic abuse should include a strategy detailing how your organisation will make survivors aware of the support options available to them. This includes raising the awareness among staff, as well as the public. Publicising information about local domestic abuse specialist services that patients can self-refer to, as well as the national domestic abuse helplines, helps alert survivors to the support that they can access themselves. Even if they are not able to disclose to a health practitioner on the day, knowing the services exist may make them more likely to ask for help in the future.



**Create notices, posters or leaflets publicly stating your commitment to responding safely to patients experiencing abuse and encouraging them to speak to a member of staff if they feel unsafe.**

## Awareness raising among patients

There are several ways you can ensure that patients attending your hospital or surgery are made aware of your response to domestic abuse. It is helpful to create notices, posters or leaflets publicly stating your commitment to responding safely to patients experiencing abuse and encouraging them to speak to a member of staff if they feel unsafe or are concerned about their wellbeing. This is a good way of letting patients know that your service is a safe space to disclose abuse and that they can expect a compassionate and appropriate response.

Furthermore, your service should make information about domestic abuse and local specialist services widely available to patients for them to take away with them.

Examples of this include:

- Displaying posters or stickers in women's toilets with the local specialist service number positioned so they can tear it off to take away with them. This gives survivors who were accompanied to the service by the perpetrator an opportunity to take the information without endangering themselves.
- Providing information about local services within packets given to people providing urine samples
- Giving out pens with helpline numbers disguised within a barcode on it
- Including information about domestic abuse and local specialist services on your organisation's website and in any newsletters or e-newsletters circulated to patients



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When planning how your service will raise awareness effectively among patients you should consider the following factors:

- 1** Safety! Ensure that any awareness raising tactics used do not increase the risk to the survivor and make sure that all information can be accessed in private so as not to alert the perpetrator.
- 2** Is the language used on the poster/leaflets easy to understand? For example, many survivors of domestic abuse say that they wouldn't have named it that way, so it is better to ask questions such as 'Do you feel safe at home?' rather than using very specific legal language.
- 3** Is the material accessible to patients with learning difficulties? Ensure that the material includes clear, simple language and does not include any jargon.
- 4** Do your materials include translations for patients who do not speak English? Information should be available in all the most commonly spoken languages in your area.
- 5** Are any images used appropriate? Avoid classic depictions of a woman being physically assaulted as this can traumatise or further victimise and alienate survivors, including those survivors who don't 'see themselves' in stock imagery, and those survivors for whom physical abuse has not been part of their experience. It is important to remember that domestic abuse happens to everyone regardless of race, sexuality, age, ability and socioeconomic background so images should represent as many different experiences/survivors as possible. You should seek advice from your local specialist service on appropriate language and imagery to use.

- 6** Have you considered the trauma-impact of the posters? Do they avoid using images and language that could trigger a survivor or make them feel unsafe?
- 7** Have you asked survivors to review the posters and input in the language and visuals so that the posters are created with and not just for survivors?
- 8** Who will provide these resources? If you are relying on local specialist services to provide materials, you must acknowledge the cost implications for them to advise on, print and deliver them. Collaborate with your local service to come up with the best ways of raising awareness locally and be prepared to pay for the resources you require. Pathfinder recommends that the VAWG/domestic abuse strategic group look into commissioning resources jointly across local health services as this is likely to be cheaper and ensures consistency of messaging if a woman sees the leaflet/post in several different services.

## Awareness raising among staff

Robust training, leadership and communications strategies should ensure a good level of awareness of domestic abuse among staff, however, high staff turnover in the NHS means awareness raising efforts should be continuous.

Examples of how to achieve this include:

- 1** Having a page on the organisation's intranet with information about domestic abuse, how to respond and local services to refer to including information about how staff can access support if they are being subjected to abuse. This page should be easily accessible, searchable and linked to from the homepage.
- 2** Making referral pathway diagrams and information about local services visible in each department/ward. These should not be visible to patients.
- 3** Circulating regular newsletters to staff informing them about referral pathways, contact details for Health Based Idvas/ Domestic Abuse Coordinators/Clinical Leads, updates to the domestic abuse policy, in-house and multi-agency training available to them. Alternatively, inclusion in existing newsletters or e-newsletters.

- 4** Run refresher workshops; invite an Idva, survivor and/or local specialist BME, disability or LGBT+ VAWG services in to speak to staff. There may be staff members who want to speak about their own experiences and this can be a powerful way of shifting culture within an organisation. If staff do want to do this they should be provided with proper support from their HR team and/or specialist service.

- 5** Remember some of your staff will be experiencing domestic abuse. Disseminate posters and leaflets in staff areas encouraging staff members to speak to the Idva, their manager or HR if they are experiencing domestic abuse themselves. Information on the intranet and newsletters should also remind staff that they are entitled and encouraged to use the domestic abuse services. Staff may also have non-recent experiences from childhood; they should be offered appropriate support for this too if it's needed.



**High staff turnover in the NHS means domestic abuse awareness raising efforts should be continuous.**

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## D

## Section D: Funding, Commissioning and Sustainability

This section gives recommendations on how to commission integrated domestic abuse interventions within health settings.

### The section is aimed at:

- Commissioners
- CCGs
- Local authorities

### The following chapters are included in this section:

- [Chapter 14: Funding, Commissioning and Sustainability](#)

### Throughout the chapter the following recommendations are made:

- Every CCG should establish a commissioning strategy that integrates health with specialist local VAWG/domestic abuse, substance use, mental health, and other relevant services such as services run by and for BME, disabled and LGBT+ survivors.
- Any specialist services commissioned by a health service should be working to the VAWG sector's shared core standards and be subject to ongoing assurance processes. Services which include perpetrator response should hold or be working to the Respect accreditation standard.

101 <https://safelives.org.uk/commissioning-support/vawg-sector-shared-core-standards>

102 <http://respect.uk.net/information-support/local-respect-accredited-services/>

## Chapter 14: Funding, Commissioning and Sustainability

**"I went to that many organisations telling them I wanted to kill myself because I'd had enough and all they could do is put me on the waiting list...Everyone knows that's a twelve week waiting list, and I needed help then. I know obviously they haven't got the funding or whatever, but there needs to be more help out there for people going through mental health issues because there wasn't any"**

–Amina<sup>103</sup>, survivor consulted as part of the Pathfinder survivor consultation process

### Pathfinder recommendations:

- Every CCG should establish a commissioning strategy that integrates health with specialist local VAWG/domestic abuse, substance use, mental health, and other relevant services such as services run by and for BME, disabled and LGBT+ survivors.
- Any specialist services commissioned by a health service should be working to the VAWG sector's shared core standards<sup>104</sup> and be subject to ongoing assurance processes. Services which include perpetrator response should hold or be working to the Respect accreditation standard<sup>105</sup>.

It is crucial that health commissioners are focusing on funding sustainable services supporting survivors of domestic abuse within the health sector. In 2010, the Department of Health's strategy recommended that "Primary Care Trusts (PCTs) and NHS Trusts should work together with other agencies to ensure that appropriate services are available to all victims of violence and abuse"<sup>106</sup>. Furthermore, the first Government taskforce looking at the relationship between health and domestic abuse was launched in 2010, chaired by Professor Sir George Alberti. It concluded that "the NHS has a vital role to play in dealing with violence and abuse and its consequences, both short and long-term."<sup>107</sup> More recently the Government stated in its response to the Joint Committee on the draft Domestic Abuse Bill that from April 2020 NHS England are planning for Idvas to be integral to every Trust Domestic Violence and Abuse Action Plan<sup>108</sup>.

The Department of Health strategy recommended that NHS commissioners should assess local needs and local services for survivors of sexual abuse and ensure that appropriate commissioning arrangements are in place.

103 All names have been changed to protect the anonymity of the survivors.

104 <https://safelives.org.uk/commissioning-support/vawg-sector-shared-core-standards>

105 <http://respect.uk.net/information-support/local-respect-accredited-services/>

106 Department of Health (2010), Responding to violence against women and children – The role of the NHS

107 Responding to violence against women and children – the role of the NHS: The report of the Taskforce on the Health Aspects of Violence Against Women and Children, March 2010

108 The Government Response to the Report from the Joint Committee on the draft Domestic Abuse Bill (2019)

We recommend a robust needs assessment is conducted by each Trust. This would include:

- the total patient population served by the hospital and attendances
- demographic analysis of the patient population (noting the gendered nature of domestic abuse, and the evidence of higher rates of domestic abuse against other groups with marginalised protected characteristics)
- the incidence of domestic abuse experienced and disclosed by patients and staff
- analysis of the actual incidents disclosed by patients and staff where such information is safely recorded (or using the ONS's finding that 5.9% of the overall population experienced domestic abuse)

- level of local provision – taking into consideration safe caseloads for Health Based Idvas (for example using a metric that a FTE Idva could receive 100 referrals annually).

There is consensus that health services are an appropriate agency to identify survivors earlier and provide them with the support needed to make them safer and improve their quality of life. There are also strong cost arguments for the role of the health sector in tackling domestic abuse. Domestic abuse has been estimated to cost the health service in the UK £2.3 billion every year<sup>109</sup>.

The scale of the problem is large, however interventions shown to be effective, such as Health Based Idvas, already exist. Idvas in health settings and the community are highly effective. At the end of their case, the majority of survivors reported to Idvas significant reductions in abuse and positive changes in their safety and quality of life. Over two fifths of survivors (60%) reported a cessation of abuse and over 70% of all Idva clients felt more confident, optimistic about the future and reported they had an improved quality of life and feeling of wellbeing. Over 80% of survivors felt safer<sup>110</sup>.

NICE recommends that local strategic partnerships should establish an integrated commissioning strategy with input from local domestic abuse services and survivors with lived experience<sup>111</sup>. It is encouraged that the strategy is based on the following principles:

- aligned or, where possible, integrated budgets and other resources
- one partner takes the strategic lead and oversees delivery on behalf of the local strategic partnership services address all levels of risk and all degrees of severity of domestic abuse
- services are based on evidence-based commissioning principles and the local needs assessment and mapping exercise (see above)
- agencies work together to deliver services
- monitor implementation of the strategy and evaluate its effectiveness for different groups.

## Commissioning of Health Based Idvas

It is vital that an integrated commissioning strategy leads to an integrated care pathway for identifying, referring (either externally or internally) and providing interventions to support adults and children who experience domestic abuse. This can be provided by an Idva co-located in an NHS Trust.

Health Based Idvas will support the survivor, whether a patient or staff member, to be safe and well, and consequently reduce the need for healthcare interventions as a result of the harm perpetrated. This in turn decreases the cost of domestic abuse to the health sector. SafeLives estimates the annual potential cost savings of a Health Based Idva provision at **£2,050 per survivor**<sup>112</sup> on the basis that commissioners prioritise funding for a minimum of two co-located Health Based Idvas per acute hospital.

Commissioning a local specialist domestic abuse service to provide this service and co-locating the Idvas into the health setting is the preferred option, as the Idvas will continue to have links to the wider provision of support and referral routes available through the service. This could include recovery programmes, group work, counselling or peer support. It also means the Idvas will continue to be line managed by a domestic abuse practitioner who can advise and provide regular case management support. In addition, they will continue to receive clinical supervision as part of the specialist service, which is essential for their wellbeing and sustaining them in their role. Concurrently, being embedded in the hospital will mean that they are able to network as needed to make the service successful.



Caroline Holt, Head of Safeguarding at Royal Devon and Exeter NHS Foundation Trust discusses the need to change the messaging around domestic abuse.

<sup>109</sup> Home Office, The economic and social cost of domestic abuse (2019) [www.gov.uk/government/publications/the-economic-and-social-costs-of-domestic-abuse](http://www.gov.uk/government/publications/the-economic-and-social-costs-of-domestic-abuse)

<sup>110</sup> SafeLives, Insights Idva England and Wales dataset 2018-19 Adult Independent domestic violence advisor (Idva) services, <https://safelives.org.uk/sites/default/files/resources/Idva%20NDS%20201819.pdf>

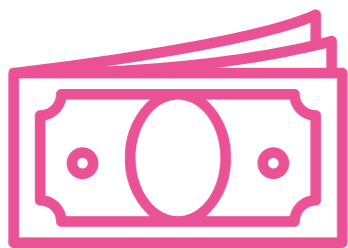
<sup>111</sup> NICE Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (2014)

<sup>112</sup> SafeLives, Cry for Health (2016)



Please see [Appendix 10: Business Case for Health Based Idva Service Provision](#) for more information on how to make the case for an Idva service in your Trust. Also see [Appendix 9: Domestic Abuse Coordinator Job Description](#) and [Appendix 11: Health Based Idva Service Level Agreement Template](#) for further information about the role of a Domestic Abuse Coordinator and a Health Based Idva.

It is crucial that commissioning of a Health Based Idva service is sustainable; with sustainable funding necessary in order to attract confident, high-calibre Idvas, who can network and train all levels of staff. Health Based Idva services should form part of a wider commissioning strategy, rather than being standalone posts, and should not detract from wider provision of Idva services within community settings or the appropriate responsibilities of health professionals themselves. SafeLives' Cry for Health report<sup>113</sup> estimated that the cost of securing a team of specialist Idvas for every NHS acute provider in England would be £15.7 million. The report also provides a checklist for commissioners of health based domestic abuse services and this should be used as guidance.



## £15.7m

the cost of securing a team of specialist Idvas for every NHS acute provider in England

Safe caseload and staffing level guidance can be found on the SafeLives website. We recommend engaging with one of the Pathfinder partners for additional advice about safe and effective commissioning of specialist domestic abuse services, including with respect to pooled budgets with other commissioners, equalities issues, and outcome measurement frameworks.

### Commissioning of the IRIS Programme

IRIS Commissioning Guidance (2018) highlights that there are three main elements in the cost of domestic abuse for GP services: the consultation itself; prescriptions consequent to the consultation; travel and opportunity costs to the patient. It also highlights that on average, survivors of domestic violence and abuse experience more visits by and to doctors. The long-term effects of abuse on women's health mean that substantial amounts of costs for general practices will go on supporting the physical and mental health effects of domestic violence and abuse.

The IRIS programme provides a cost-effective domestic abuse intervention in general practice. Research on the cost effectiveness of the IRIS programmes commissionable model was undertaken in 2018. This analysis looked at six sites in which IRIS had been running for at least two years and it found that the IRIS programme saved £14 per woman aged 16 or older registered in general practice from a societal perspective over ten years, and increased quality-adjusted life years for all women eligible for the intervention. From an NHS perspective, IRIS was found to be cost saving or cost effective in four out of six sites and borderline cost effective in another. For society, IRIS is cost-effective and saves money. The net annual monetary benefit was positive both from an NHS and a societal perspective (£22 and £42 respectively).

### The use of data in commissioning

Commissioners need information regarding the patients in the healthcare system and the treatments they receive in order to review, plan and commission current and future services. This is done using anonymised data of who uses what services, collected by NHS Trusts, NHS Foundation Trusts, independent sector providers and charities.

The data collection can be an exhaustive task in itself; it requires consistency across practitioners and departments. It should be targeted at both the adult survivor as well as their children. This can be difficult to achieve with the capacity that health practitioners currently have. However, data collection continues to be a crucial part of the commissioning process.

This task should be conducted by the Safeguarding team, the Domestic Abuse Coordinator and the Health Based Idva if one is available. Together, they can collect and input the data, analyse it and regularly report on the findings, trends and any significant changes. This provides information not only on what is being effectively used and should continue to be funded, but more importantly what is missing and where the gaps are. Data collection tools are widely available, such as SafeLives' Insights outcome measurement tool.

# Conclusion

The interventions and approaches pioneered and tested across Pathfinder sites between 2017–2020 highlight the benefits of a whole-health approach. The Pathfinder project has provided a unique opportunity to bring together expertise from specialist organisations in the sector as well as share the good practice developed, on the ground, at the pilot sites. The Toolkit brings together all elements of this good practice into a comprehensive and sustainable model response to domestic abuse in health.

What Pathfinder has highlighted in the course of this work is that stand alone interventions will not be fully effective without a change in culture within a health service. It is critical that a supportive environment is established first of all; where health staff feel motivated and confident to identify and respond to abuse, a process that goes beyond training and specialist provision and speaks to the leadership and strategic approach within a health service, as well as the national direction provided by the Department of Health and Social Care, NHS England and other key professional bodies. A coordinated and systemic approach lies at the heart of this work and is critical in ensuring sustainability and a safer and more effective response to domestic abuse.

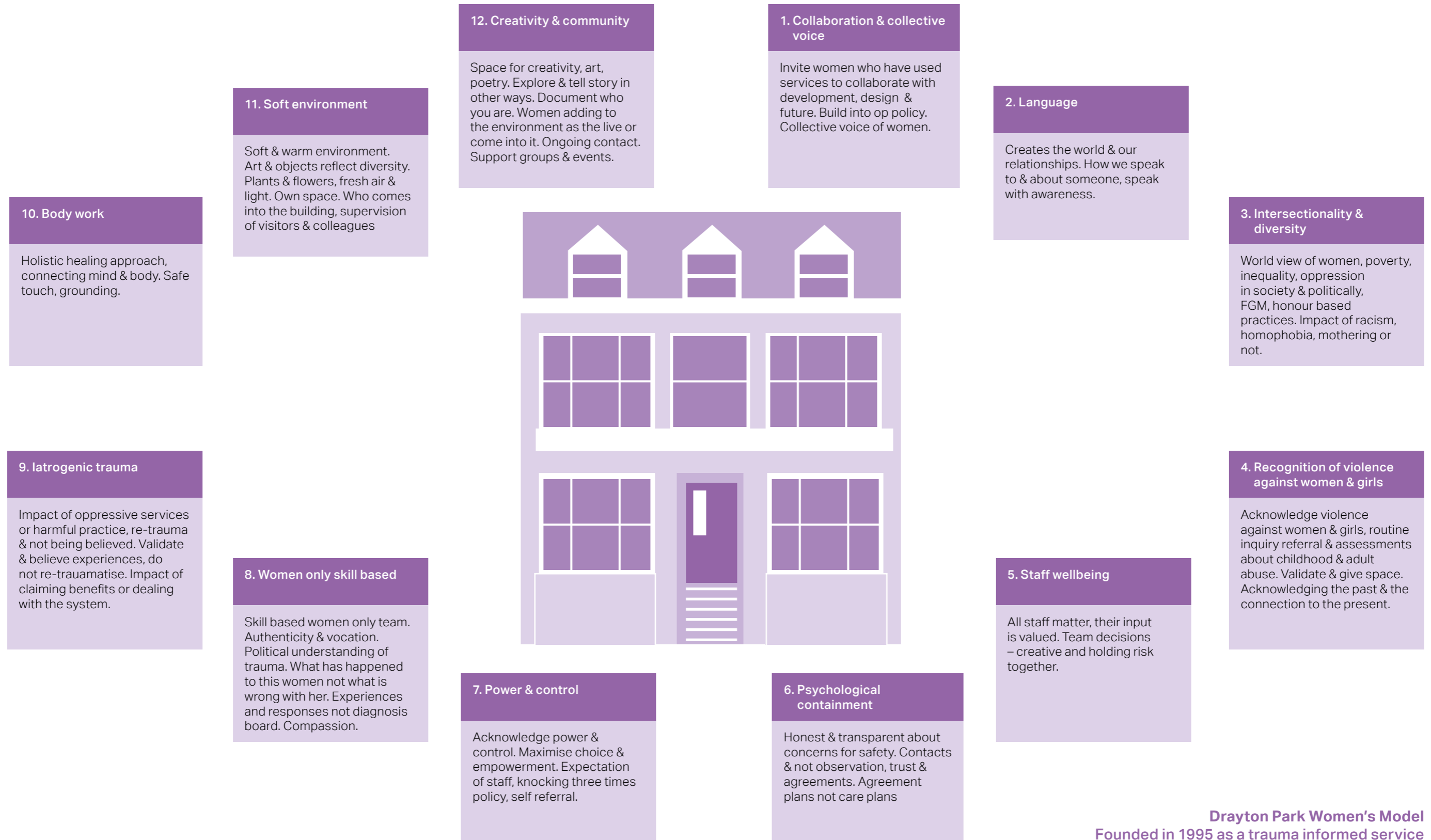
Ultimately, it is essential that this work is survivor-led and reflects the intersecting needs and experiences of all survivors. An integral part of Pathfinder's work has focused on embedding survivors' voices throughout the planning, implementation and evaluation of the project. In particular, it has emphasised the additional barriers and discrimination faced by survivors from particular groups. It is paramount that health services are mindful of these barriers and differences in order to ensure an inclusive, nuanced and high-quality response that speaks to the needs of all patient survivors (please see our Survivor Consultation Report for more details on key recommendations).

The work of Pathfinder has been evaluated by the University of Cardiff. An evaluation report detailing the impact of this project will be available in the coming months.

# Glossary

<b>Acronym</b>	<b>Full Name</b>	<b>Acronym</b>	<b>Full Name</b>
AE	Advocate Educator	IDVA	Independent Domestic Violence Adviser (or Advocate)
A&E	Accident and Emergency		
AVA	Against Violence and Abuse	IDSVA	Independent Domestic and Sexual Violence Adviser (or Advo-cate)
Barnardos	Domestic Violence Risk		
RIM	Identification Matrix	IRIS	Identification and Referral to Improve Safety
BME /	Black, and Minority Ethnic or		
BAMER	Black, Asian, Minority, Ethnic and Refugee	LADO	Local Authority Designated Officer (a safeguarding lead)
BSL	British Sign Language	LGBT+	Lesbian, Gay, Bisexual, Transgender
CCG	Clinical Commissioning Group	LSP	Local Strategic Partnership
CCR	Coordinated Community Response	MASH	Multi Agency Safeguarding Hubs
CMHT	Community Mental Health Teams	MARAC	Multi Agency Risk Assessment Conference
DA	Domestic Abuse	ONS	Office for National Statistics
DAL	Domestic Abuse Link or Lead	PTSD	Post-Traumatic Stress Disorder
DAC	Domestic Abuse Coordinators	RIC	Risk Identification Checklist
DASH RIC	Domestic Abuse Stalking and Harassment Risk Identification Checklist	SARC	Sexual Assault Referral Centre
DHR	Domestic Homicide Review	SLA	Service Level Agreement
DRIDVA	Dentistry Responding in Domestic Violence and Abuse	SPECSSS	Separation, Pregnancy, Escalation, Cultural, Stalking, Sexual Assault and Strangulation
DVA	Domestic Violence and Abuse	SV	Sexual Violence
DV	Domestic Violence	UN	United Nations
ED	Emergency Department	VAWG	Violence Against Women and Girls
EDI	Equality, Diversity and Inclusion	V/S	Victim/Survivor
FM	Forced Marriage		
FGM	Female Genital Mutilation		
HIDVA	Health Independent Domestic Violence Adviser (or Advocate)		

# Appendix 1: The Drayton Park Model



**Drayton Park Women's Model**  
Founded in 1995 as a trauma informed service  
in Camden & Islington NHS Foundation Trust  
Shirley McNicholas



# Appendix 2:

## Domestic Abuse Strategic Action Plan Template

This template action plan has been created as a tool for NHS Trust domestic abuse steering groups looking to identify gaps in their response to domestic abuse and assign actions to fill them. The suggested actions mirror the recommendations and content of the Toolkit and the template should be adapted to fit your local context and needs. Any suggested actions that are already in place can be deleted and responsibilities and deadlines should be assigned for all remaining actions. The resulting action plan should be reviewed regularly by the steering group. We have indicated which of these actions should be the responsibility of the Domestic Abuse Coordinator if you have one.

Actions	Responsibility	Deadline
<b>Governance and Strategy</b>		
There should be an assigned Clinical Lead for Domestic Abuse to both be part of the Trust VAWG/Domestic Abuse and Health Steering group and to represent the Trust at the local area Health VAWG/Domestic Abuse Strategic Group. This responsibility should be recognised in their job de-scription.		
There should be a standalone policy for patients experiencing and perpetrating domestic abuse. This should be aligned with the organisation's equality and diversity and safeguarding policies.	Domestic Abuse Coordinator	
There should be a standalone policy for staff experiencing and perpetrating domestic abuse. This should be aligned with the organisation's equality and diversity and safe-guarding policies.	Domestic Abuse Coordinator	
There should be a member of staff responsible for keeping the domestic abuse policies up to date. This responsibility should be recognised in their job description.	Domestic Abuse Coordinator	

Actions	Responsibility	Deadline
The Trust should undertake a range of diversity accreditations and schemes to promote high EDI standards in the workplace and to better respond to the needs of all patients and staff.		
The Trust should set up effective staff networks for staff members to promote diversity. As a minimum, networks should exist for staff who are black and minority ethnic, disabled, LGBT+ and allies.		
All employees and patients should have access to an independent service for BSL and other translation services.		
The Trust should have designated Marac <sup>114</sup> representatives for each geographical area that they cover and ensure that staff are aware of who this is, including any appropriate internal referral procedures <sup>115</sup> .		
There should be a staff member responsible for ensuring that employees who are survivors/perpetrators of abuse have appropriate support available (including workplace specific adjustments and allowances that can be made to increase safety). This responsibility should be recognised in their job description.	HR Department	
Service level agreements should be in place with local services needed for survivor safety. This might include: social services, the police, schools, domestic abuse services (including perpetrator services), drug and alcohol services and other healthcare services.	Domestic Abuse Coordinator	
The Trust should be consistently represented at local domestic abuse related forums including: <ul style="list-style-type: none"> <li>→ Marac</li> <li>→ VAWG Strategic partnership groups</li> <li>→ MAPPAs</li> <li>→ Safeguarding boards</li> </ul>		
This responsibility should be recognised in the relevant staff member's job description.		
Survivors should be regularly consulted on the quality of services and involved in the development of new services designed to meet their needs.	Domestic Abuse Coordinator	

114 <https://safelives.org.uk/practice-support/resources-marac-meetings>

115 <https://safelives.org.uk/node/507>

Actions	Responsibility	Deadline
<b>Domestic Abuse Specialist Roles and Interventions</b>		
The Trust should employ a full-time Domestic Abuse Coordinator to be responsible for the roll-out of the Trust's domestic abuse strategy, data collection and the coordination and delivery of domestic abuse training.		
The Trust should employ at least two co-located Health Based Idvas, depending on the size of the trust, and embed them effectively within an NHS staff team. All Idvas should be qualified to undertake the work having attended the full SafeLives' accredited Idva training course.	Domestic Abuse Coordinator	
Any specialist services commissioned by or jointly with the Trust should be working to the VAWG sector's shared core standards <sup>116</sup> and be subject to ongoing assurance processes. Services which include a perpetrator response should hold or be working to the Respect accreditation standard <sup>117</sup> .	Domestic Abuse Coordinator	
If the Trust has a Health Based Idva service, a service level agreement should be written up between the NHS Trust and local specialist service hosting the role, to ensure the operational details of the role are agreed.	Domestic Abuse Coordinator	
The Trust should embed a Domestic Abuse Champions Network to support the retention of expertise across departments.	Domestic Abuse Coordinator	
The Trust should ensure that domestic abuse interventions are funded sustainably and that data monitoring is used to highlight gaps in service provision in order to target funding appropriately.		
The Trust should work with local services to jointly-commission adequate service provision which includes the needs of survivors experiencing multiple disadvantage. Funding should cover the accessibility needs of the local population including translation of domestic abuse related literature and easy access to interpreters during consultations.		

116 <https://safelives.org.uk/commissioning-support/vawg-sector-shared-core-standards>

117 <http://respect.uk.net/information-support/local-respect-accredited-services>

Actions	Responsibility	Deadline
<b>Best Practice Implementation</b>		
All health staff should have access to the facilities they need to ensure that any domestic abuse enquiry is done in private and family members and friends are not used as interpreters.		
All health staff should be equipped with the knowledge and skills they need to enquire about domestic abuse sensitively and supportively through an explorative conversation. Do staff have reliable access to quiet and confidential spaces for safe enquiry?	Domestic Abuse Coordinator	
All health staff should understand the impact of trauma and consider how to ask and respond in a way that takes into account and acknowledges trauma responses.	Domestic Abuse Coordinator	
All health staff should know how to record any disclosure of domestic abuse in the survivor's own words and offer specialist support.	Domestic Abuse Coordinator	
Mental health Trusts should ensure staff understand how experiences of domestic abuse contribute to current presentations of mental distress.	Domestic Abuse Coordinator	
Mental health Trusts should ensure domestic abuse questions are embedded into assessment documentation and in clinical audit <sup>118</sup> .	Domestic Abuse Coordinator	
The Trust should embed clear and effective referral pathways into local specialist services. Contact information, referral forms and risk assessments should be readily available for staff to use.	Domestic Abuse Coordinator	

118 Sally Macmanus (2015), 'Guidance for Trust managers Responding effectively to violence and abuse (REVA project) Briefing 2. Implementing and sustaining routine enquiry about violence and abuse in mental health services, available online, [www.dmss.co.uk/pdfs/REVA-Brief-2-Guidance-for-Trust-managers-FINAL-071015.pdf](http://www.dmss.co.uk/pdfs/REVA-Brief-2-Guidance-for-Trust-managers-FINAL-071015.pdf) (accessed March 25 2020), p. 7.

Actions	Responsibility	Deadline
<b>Domestic Abuse Training</b>		
The service should have a sustainable training strategy in place to ensure all staff receive the relevant level of domestic abuse training in line with NICE guidelines, rooted within an equalities framework and suitably adapted to the differing roles of healthcare staff.	Domestic Abuse Coordinator	
There should be a staff member responsible for developing and implementing the domestic abuse training strategy in the trust. This responsibility should be recognised in their job description.	Domestic Abuse Coordinator	
Staff should be given sufficient time to attend training in order to respond to survivors safely.		
Staff should be given wider training on equality and diversity which forms an important basis for their everyday work and links to working with survivors and perpetrators of abuse.		
Mental health Trusts should ensure there are a suitable amount of practitioners trained to provide evidence-based treatment for survivors who have mental health issues.		
Practitioners working with children and young people (CYP) should be trained to identify those experiencing abuse and to ask questions in an age-appropriate way.	Domestic Abuse Coordinator	
Mental health Trusts should ensure CAMHs practitioners are specially trained to provide mental health interventions for children and young people who have experienced domestic abuse.	Domestic Abuse Coordinator	
If the Trust has a network of Domestic Abuse Champions, they should have regular access to training which allows them to fulfil their role properly.	Domestic Abuse Coordinator	
Managers and HR personnel should receive training and resources on managing employees experiencing and perpetrating domestic abuse.	Domestic Abuse Coordinator	

Actions	Responsibility	Deadline
<b>Data Collection &amp; Information Sharing</b>		
The Trust should collect data on domestic abuse training attended by staff and how confident staff are to respond to domestic abuse.	Domestic Abuse Coordinator	
The Trust should collect data on enquiry into domestic abuse to understand gaps in the Trust response.		
The Trust should record disclosures of domestic abuse in the words of the survivor.		
The Trust should collect disaggregated data on protected characteristics of those experiencing and perpetrating domestic abuse.		
The Trust should collect data on referral pathways used including those to BME, disability and LGBT+ specialist services, Maracs and perpetrator services.		
The Trust should have a clear strategy for how data on domestic abuse is put together with other relevant data, such as safeguarding and equalities monitoring with a clear framework for how data collection will be rooted in the need for practice improvement.	Domestic Abuse Coordinator	
There should be a member of staff responsible for monitoring domestic abuse related data and taking action as a result of data gathered through monitoring. This responsibility should be recognised in their job description.	Domestic Abuse Coordinator	
The Trust should monitor how many child and adult safeguarding referrals are domestic abuse related.		
The Trust should monitor the number of Domestic Abuse Champions trained and how often they are asked for advice.	Domestic Abuse Coordinator	
The Trust should monitor information shared inside and outside of the Trust and whether it is done safely (e.g. appropriate use of secure email addresses and password protected documents).		
The Trust patient record system should facilitate the recording and collation of all above information.		



Actions	Responsibility	Deadline
<b>Domestic Abuse Awareness Raising</b>		
The Trust should have a clear awareness raising strategy for ensuring that patients and staff are aware of health professionals' role in responding to domestic abuse.	Domestic Abuse Coordinator	
There should be a staff member that is responsible for ensuring there is a clear domestic abuse communications strategy for staff members and service users. This responsibility should be recognised in their job description.	Domestic Abuse Coordinator	
The Trust should raise awareness of the links between domestic abuse and health among patients by displaying leaflets and posters. These should be in a range of accessible formats including 'easy read' literature and in a variety of languages commonly spoken locally.	Domestic Abuse Coordinator	
Every department within the health service should be consistently stocked with appropriate literature.	Domestic Abuse Coordinator	
Staff confidence in responding to domestic abuse should be discussed formally in staff supervision.		

# Appendix 3: Specialist Guidance for Health Professionals – Responding to Lesbian, Gay, Bisexual and Trans+ People Experiencing Domestic Abuse

This document provides specialist guidance to support health professionals to respond appropriately to Lesbian, Gay, Bisexual, or Transgender+ (LGBT+) survivors of abuse. It is paramount that professionals have a good understanding of the experience of LGBT+ people, as well as the unique ways LGBT+ survivors can be affected by domestic abuse and the barriers they may face when seeking help. Additional specialist training should complement this guidance. Advice should be sought from specialist organisations when unsure of suitable action.

This document was edited and endorsed by [Galop](#), the UK's only specialist LGBT+ anti-violence charity.



## Contents

- Definitions
- How LGBT+ people experiencing domestic abuse may present to health professionals
- Asking the question
- How to respond appropriately and safely
- Making a referral
- What to bear in mind
- Fact sheet
- Barriers to support
- Possible indicators of abuse

## Definitions

This guidance refers to LGBT+ survivors. It is important to recognise that LGBT+ survivors are not a homogenous community. People who are LGBT+ will have a range of different sexual orientations and gender identities, as well as different experiences. However, in the context of domestic abuse, there are some key issues that affect LGBT+ survivors. Combined, these have often meant that LGBT+ survivors experiences are either not recognised or not well understood:

- The 'public story' of domestic abuse is often about violence and abuse in heterosexual relationships, usually by a man against a woman. While this reflects a stark reality (women in heterosexual relationships account for the vast majority of survivors of domestic abuse), this public story can exclude LGBT+ survivors. It can also be manifested in the response of professionals and services which may not always recognise or consider the needs of LGBT+ people
- There are various myths and stereotypes about LGBT+ people that can be a barrier to recognising domestic abuse. These can affect professional perception, but they can also make it hard for survivors to either recognise abuse or make a disclosure. These include the belief that abuse doesn't happen in LGBT+ relationships, that there is a stereotypical abuser (usually the bigger or stronger partner) or somehow the abuse is not as serious as abuse in heterosexual relationships<sup>119</sup>.
- Taken together, this can lead to a 'gap of trust' whereby LGBT+ survivors fear they will not get a sympathetic response and face discrimination<sup>120</sup>.
- This can reflect real or perceived fear that they might experience homo/bi/transphobia when accessing services, perhaps because of a previous negative experience of accessing services. It may also reflect some LGBT+ people's experience of homo/bi/transphobia in their everyday lives. A recent national survey of LGBT+ people found that 40% of respondents had experienced a homo/bi/transphobic incident in the previous 12 months committed by someone they did not live with<sup>121</sup>.
- As a result, LGBT+ survivors can face a double barrier – needing to disclose both their experience of domestic abuse and their sexual orientation and gender identity.
- Even if someone is able to recognise the abuse they are experiencing, and tries to seek help, they may struggle to access it. There are also only a handful of specialist LGBT+ domestic abuse services nationally, which means to access help and support LGBT+ survivors often have to use generic services which may not always have the skills or training to respond effectively<sup>122</sup>. If LGBT+ people need to access refuge, they may be worried about experiencing homo/bi/transphobic abuse, with LGBT+ men also facing the challenge that there are only a relatively small number of refuge spaces they can access<sup>123</sup>.

119 Galop (Undated) Myths and stereotypes about violence and abuse in same-sex relationships. Available at: [www.galop.org.uk/wp-content/uploads/For-Service-Providers-Myths.pdf](http://www.galop.org.uk/wp-content/uploads/For-Service-Providers-Myths.pdf).

120 Donovan, C. and Hester, M. (2014) Domestic violence and sexuality: what's love got to do with it? Bristol: Policy Press

121 Government Equalities Office (2018) National LGBT Survey: Research Report. Available at: [www.gov.uk/government/publications/national-lgbt-survey-summary-report](http://www.gov.uk/government/publications/national-lgbt-survey-summary-report).

122 Magić, J. & Kelley, P. (2019) Recognise & Respond: Strengthening advocacy for LGBT+ survivors of domestic abuse. Available at: [www.galop.org.uk/wp-content/uploads/Galop\\_RR-v4a.pdf](http://www.galop.org.uk/wp-content/uploads/Galop_RR-v4a.pdf).

123 Stonewall Housing (2014) ROAR: Because silence is deadly. Available at: [https://stonewallhousing.org/wp-content/uploads/2018/09/ROAR\\_full\\_v2.pdf](https://stonewallhousing.org/wp-content/uploads/2018/09/ROAR_full_v2.pdf).

As a result, domestic abuse amongst LGBT+ people is underreported<sup>124</sup>:

- 2.5% of people accessing support from domestic abuse services identified as LGBT+
- In the 12 months to the end of March 2018, LGBT+ survivors accounted for only 1.2% of cases discussed at Multi-Agency Risk Assessment Conferences (Marac)

Yet, LGBT+ people experience domestic abuse at a similar prevalence to that reported by heterosexual women<sup>125</sup>. For trans people, research is even more limited, although some studies indicate prevalence may be higher<sup>126</sup>. Furthermore there is evidence that LGBT+ survivors may experience higher levels of multiple disadvantage<sup>127</sup>, perhaps because LGBT+ survivors may access support later.

## How LGBT+ people experiencing domestic abuse may present to health professionals

LGBT+ people's experience of domestic abuse will be similar to that of other survivors including physical, emotional or psychological, financial and sexual abuse. Symptoms or conditions which are indicators of possible domestic abuse include PTSD, anxiety, frequent and unexplained injuries, protective other parties attending appointments (see the Possible Generic Indicators of Abuse section for more examples).

There is comparatively little research in LGBT+ survivors' experience of domestic abuse, however it is important to remember that gender may intersect with someone's experience of abuse. For example, for women, the perpetrator may be more likely to be a former heterosexual (male) partner while LGBT+ survivors may also face violence from family members, and may also be more likely to have multiple perpetrators<sup>128</sup>. Men may face barriers to reporting because they feel services are for women, in other cases professionals may make assumptions about gender which means they do not ask about domestic abuse<sup>129</sup>.

124 SafeLives (2018) Free To be Safe: LGBT+ people experiencing domestic abuse. Available at: [www.safelives.org.uk/knowledge-hub/spotlights/spotlight-6-lgbt-people-and-domestic-abuse](http://www.safelives.org.uk/knowledge-hub/spotlights/spotlight-6-lgbt-people-and-domestic-abuse).

125 Messinger, A.M. (2017) LGBTQ intimate partner violence: lessons for policy, practice, and research. Oakland, California: University of California Press.

126 The Scottish Trans Alliance (2010) Out of sight, out of Mind? Transgender people's experiences of domestic abuse. Available at: [www.scottishtrans.org/wp-content/uploads/2013/03/trans\\_domestic\\_abuse.pdf](http://www.scottishtrans.org/wp-content/uploads/2013/03/trans_domestic_abuse.pdf).

127 SafeLives (2018) Free To be Safe: LGBT+ people experiencing domestic abuse. Available at: [www.safelives.org.uk/knowledge-hub/spotlights/spotlight-6-lgbt-people-and-domestic-abuse](http://www.safelives.org.uk/knowledge-hub/spotlights/spotlight-6-lgbt-people-and-domestic-abuse)

128 SafeLives (2018) Free To be Safe: LGBT+ people experiencing domestic abuse. Available at: [www.safelives.org.uk/knowledge-hub/spotlights/spotlight-6-lgbt-people-and-domestic-abuse](http://www.safelives.org.uk/knowledge-hub/spotlights/spotlight-6-lgbt-people-and-domestic-abuse).

129 Croom, L. (2004) Domestic Homicide Review relating to the death of Mr C. Available at [www.safeinthecity.info/published-domestic-homicide-reviews](http://www.safeinthecity.info/published-domestic-homicide-reviews).

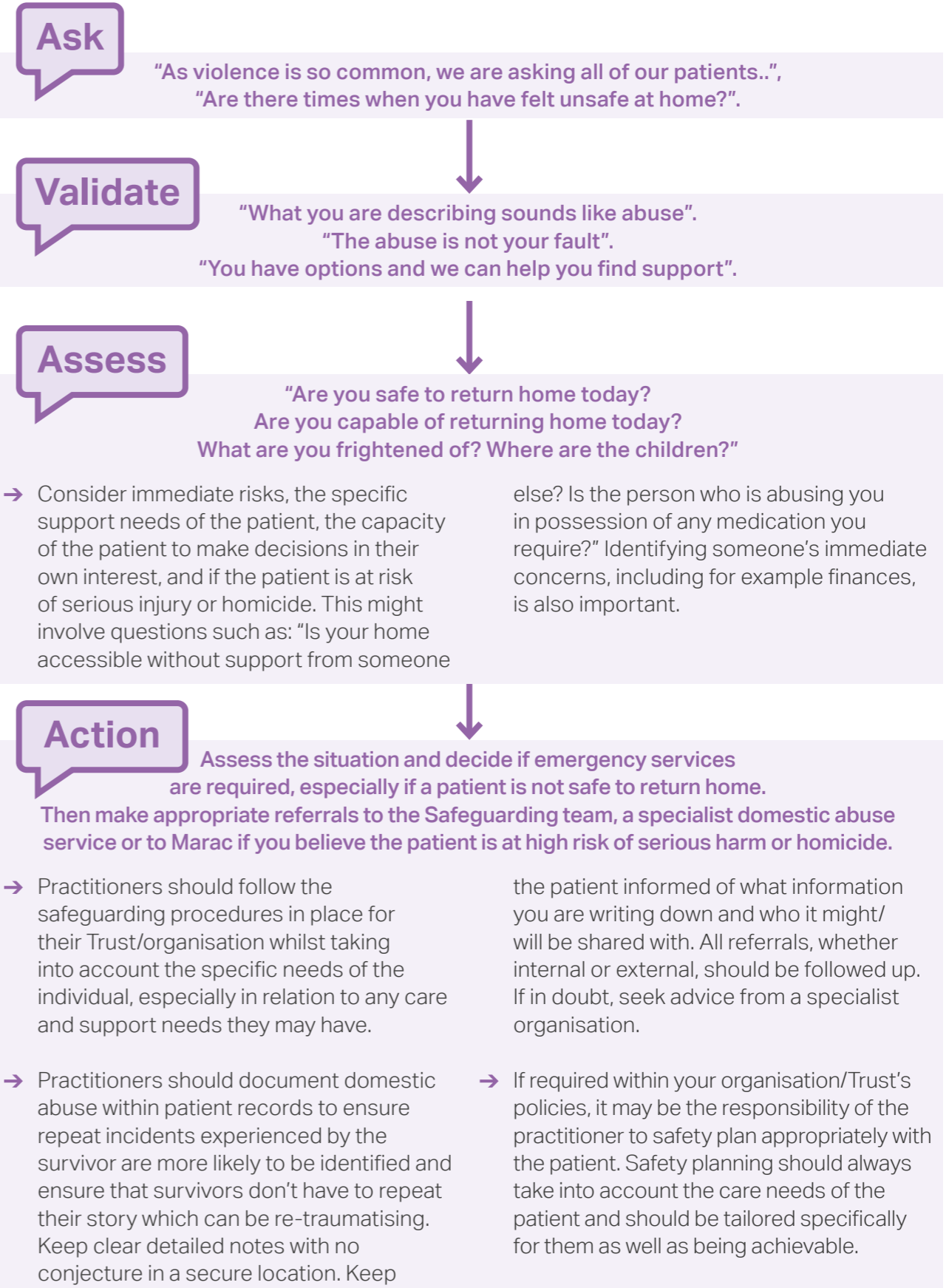
LGBT+ survivors may also experience unique forms of abuse, whereby abusers exploit gender and sexual norms<sup>130</sup>. This is often referred to as 'identity abuse'. These unique forms of abuse often use a survivor's sexual orientation or gender identity and can include:

- Accusing someone of not being a 'true' LGBT+ person
- Making someone feel ashamed of their sexual orientation / gender identity
- Preventing access to LGBT+ spaces or resources<sup>131</sup>
- Forcing someone to remain 'in the closet'. Conversely, making threats to out or actually outing someone
- Using gender norms to justify violence and abuse<sup>132</sup>
- Use of HIV status<sup>133</sup>
- There are also specific issues for trans survivors, with abuse targeted at or relating to gender identity. For example, in recent research, 51% of trans survivors in the last year reported partner had ridiculed their gender identity<sup>134</sup>.

## How to respond appropriately and safely

It is important to recognise and respond to the experiences of LGBT+ survivors, including identifying specific needs during the process of reporting and help-seeking. Of primary importance is listening to the patient and believing them. It is also crucial to allow the patient the chance to set their own terms on how they want to be supported.

Key steps to follow to ensure you respond appropriately include:



130 Selton, S.Z. (2018) 'A Queer Theorist's Critique of Online Domestic Violence Advocacy: Critically Responding to the National Coalition Against Domestic Violence Web Site', *Journal of Homosexuality*, 65(10), pp. 1275-1298.

131 Magić, J. & Kelley, P. (2019) Recognise & Respond: Strengthening advocacy for LGBT+ survivors of domestic abuse. Available at: [www.galop.org.uk/wp-content/uploads/Galop\\_RR-v4a.pdf](http://www.galop.org.uk/wp-content/uploads/Galop_RR-v4a.pdf).

132 Messinger, A.M. (2017) *LGBTQ intimate partner violence: lessons for policy, practice, and research*. Oakland, California: University of California Press.

133 Heintz, A., and Melendez, R. (2016) 'Intimate partner violence and HIV/STD risk among lesbian, gay, bisexual and transgender individuals', *Journal of Interpersonal Violence*, 21(2), pp. 193-208.

134 Stonewall (2018) *LGBT in Britain: Home and Communities*. Available at: [www.stonewall.org.uk/sites/default/files/lgbt\\_in\\_britain\\_home\\_and\\_communities.pdf](http://www.stonewall.org.uk/sites/default/files/lgbt_in_britain_home_and_communities.pdf)



## Making a referral

- If you believe the patient's safety or their children to be at immediate risk, you should call the emergency services. You can also remind deaf or non-verbal survivors that if they feel unsafe, they can contact 999 by SMS text. To register, text 'Register' to 999.
- Your service may have a specialist co-located service, such as an Idva or Advocate Educator, who you can refer patients to.
- Your service should have a list of local services (including domestic abuse services) that patients can be referred to.
- National helplines may also be helpful:
  - [LGBT+ Domestic Abuse Helpline](#) – 0800 999 5428
  - [National Domestic Violence Helpline](#) – 0808 2000 247
  - [Men's Advice Line](#) – 0808 801 0327
- If the patient is high risk, you may need to refer the patient to the local Marac (Multi-Agency Risk Assessment Conference). Child safeguarding procedures will also have to be initiated where appropriate in accordance with the policies in place. If required within your organisation/Trust's policies, it may be the responsibility of the practitioner to make an initial risk assessment, using a recognised system (e.g. DASH, SPECSSS). Make sure you know the local Marac and Safeguarding Board co-ordinators. Again, your service may have an Idva to support patients who can assist you with this, or any other relevant queries.
- Aim to establish the patient's wishes and feelings around issues and explain to them what you are doing and who else will be involved.
- Maintain a written record of what your concerns are, what the person has told you (using their exact words) and the actions you are taking. All referrals, whether internal or external, should be followed up.

## What to bear in mind:

- Signal acceptance of LGBT+ people e.g. appropriate imagery on posters or leaflets.
- Tailor services to meet needs of LGBT+ survivors e.g. undertake routine monitoring, ask sexual orientation / gender identity rather than making assumptions, and ensure you have access to specific risk tools like the LGBT+ Power & Control Wheel (an example can be accessed [here](#)).
- While existing risk identification tools (like the DASH RIC) can be used with LGBT+ survivors, Stonewall Housing's 'ROAR' project pilots a set of additional questions that can be used alongside the DASH RIC. The aim is to help professionals use their professional judgement when assessing the risk associated with domestic abuse or so-called 'honour' based abuse experienced by LGBT+ people. This can be accessed at: [www.safelives.org.uk/node/781](http://www.safelives.org.uk/node/781).
- Ensure you can communicate in a way that meets their needs – for example, using minicom, videophone or interpreting services for hard of hearing or deaf service users. Where possible (and safe to do so) give the options in writing.
- Be familiar with pathways e.g. local and national LGBT+ services.

## Do not:

- Never use a family member or close friend as an interpreter. You should have access to an independent service for BSL and other translation services or have trained members of staff in your services and ensure that video replay and hearing loop services are available. Take a flexible approach to communication if interpreters are not an option.
- Allow other individuals to stay in the room (including the individual's carer) unless completely necessary. Involve parents, caregivers, spouses, partners, service providers and other family members only if a survivor gives full consent while keeping in mind that the individual might be fearful of an abuser and of disclosing.
- Rush the process. Make sure that you cannot be interrupted, and that you have sufficient time for an emotional and difficult topic of conversation. If someone is making a disclosure for the first time, it is important you can give them the time and space to talk about their experiences.

## Barriers to support

When seeking help, LGBT+ survivors appear more likely to access help and support from informal sources of help and support, in particular counsellors/therapists<sup>135</sup> and friends<sup>136</sup>. There is also evidence to suggest LGBT+ survivors may be at relatively high levels of risk when they do present to services<sup>137</sup>.

A recent report by Galop<sup>138</sup> identified the following structural and cultural barriers:

- Low visibility and representation of LGBT+ issues within services, across internal publications and/or publicly available materials and websites or within physical organisational space.
- Lack of established partnerships with LGBT+ communities and organisations.
- Lack of quality referral pathways.
- Low understanding and awareness of professionals around unique forms of coercive control targeted at sexual orientation or gender identity.
- Services appearing heterosexist and relying on assumptions that all their clients are heterosexual and cisgender.
- Services relying on misconceptions around the dynamics of domestic abuse as it impacts on LGBT+ communities.

More information on barriers to help and support is available in a factsheet produced by Galop called 'Barriers Faced by LGBT People in Accessing Non-LGBT Domestic Violence Support Services', which can be accessed at [www.galop.org.uk/factsheets](http://www.galop.org.uk/factsheets).

It is also important to think about how these barriers might overlap with other hurdles survivors face to disclosure in relation to immigration status, disability, language, faith, etc.

## Possible generic indicators of abuse

This list is by no means exhaustive but offers more common indicators of abuse:

- Symptoms of depression, low self-esteem, PTSD, anxiety, fearfulness.
- Suicidal ideation, suicidal tendencies or self-harm.
- Somatic disorders, problems sleeping, physical exhaustion.
- Sudden weight loss, eating disorders.
- Substance misuse.
- Unexplained injuries, or injuries for which the survivor describes stories that appear improbable.
- Repeated injuries, frequent visits to A&E, or delays between injury and presentation.
- Sexually transmitted infections or gynaecological injuries.
- Problems with the central nervous system (headaches, cognitive problems, hearing loss), gastrointestinal problems.
- Cancels appointments last minute, is often late or needing to be back home by a certain time.
- Isolated from friends and/or family members.
- Little or no access to financial resources independent of a partner.
- Describes a partner or family member as prone to anger or controlling.
- Protective other party frequently attending appointments.

<sup>135</sup> Donovan, C. and Hester, M. (2014) Domestic violence and sexuality: what's love got to do with it? Bristol: Policy Press

<sup>136</sup> Messinger, A.M. (2017) LGBTQ intimate partner violence: lessons for policy, practice, and research. Oakland, California: University of California Press.

<sup>137</sup> SafeLives (2018) Free To be Safe: LGBT+ people experiencing domestic abuse. Available at: [www.safelives.org.uk/knowledge-hub/spotlights/spotlight-6-lgbt-people-and-domestic-abuse](http://www.safelives.org.uk/knowledge-hub/spotlights/spotlight-6-lgbt-people-and-domestic-abuse).

<sup>138</sup> Magić, J. & Kelley, P. (2019) Recognise & Respond: Strengthening advocacy for LGBT+ survivors of domestic abuse. Available at: [www.galop.org.uk/wp-content/uploads/Galop\\_RR-v4a.pdf](http://www.galop.org.uk/wp-content/uploads/Galop_RR-v4a.pdf).

# Appendix 4:

## Specialist Guidance for Health Professionals – Responding to Older Survivors Experiencing Domestic Abuse

This document provides specialist guidance to support Health Professionals responses to older survivors of abuse. Practitioners should seek out training where possible, and ask advice from designated staff or specialist organisations if unsure of suitable action.

This document was edited and endorsed by [Solace Women's Aid](#).



### Contents

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### Definitions

There is not a common definition of the age at which someone becomes an 'older person'. In policy and practice, this can vary, but is often from 50<sup>139</sup> or over 55<sup>140</sup>. However, older survivors have often been a hidden group and as a result not regularly recognised in either policy or practice. This is a result of a number of issues:

- Until relatively recently, the Crime Survey for England and Wales (CSEW) only asked adults aged 16-59 about domestic abuse, excluding those over 60 years and above. In 2017 the age limit was increased to 74<sup>141</sup>.
- There is a lack of awareness among professionals, as well as the public, about the abuse of older survivors<sup>142</sup>.
- Older survivors may be influenced by traditional beliefs and attitudes about gender roles and/or marriage. They may not be aware of their legal or financial rights or sources of support<sup>143</sup>.
- Different terminology can be used to describe the same situation – from elder abuse to adult safeguarding to domestic abuse<sup>144</sup>. That can lead to confusion and may mean the needs of older survivors are overlooked.

- It is important to recognise that this confusion is not just about terminology, it can reflect real challenges. There can be differences in both policy and practice responses to older people affected by violence and abuse, depending on whether this is understood as adult safeguarding or domestic abuse<sup>145</sup>. This can mean professionals are unsure whether to use the 'domestic abuse' or the 'safeguarding' pathway<sup>146</sup>.
- Another challenge is who the perpetrator may be. Older people can experience abuse from a former or current partner (intimate partner violence) or an adult family member (which is often referred to as adult family violence or familial violence).
- Another issue which can hide domestic abuse is if someone has a caring responsibility. In some cases, an older survivor may be cared for by an intimate partner or family member. Sometimes incidents of violence or abuse can be wrongly attributed to carer's stress. In other cases, an older survivor may be caring for someone, including an adult child. In either case, older survivors (and professionals) may not understand these experiences as 'domestic abuse'.

139 Blood, I. (2004) Older women and domestic violence: A report for Help the Aged/hact. Available at [www.ageuk.org.uk/documents/en-gb/for-professionals/research/older%20women%20and%20domestic%20violence%20\(2004\)\\_pro.pdf?dtrk=true](http://www.ageuk.org.uk/documents/en-gb/for-professionals/research/older%20women%20and%20domestic%20violence%20(2004)_pro.pdf?dtrk=true).

140 A specialist intervention delivered by Solace Women's ('The Silver Project') works with women aged over 55. For more information, to: [www.solacewomensaid.org/advice-support](http://www.solacewomensaid.org/advice-support).

141 For more information, go to [www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2018](http://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2018).

142 Carthy, NL and Taylor, R (2018) Practitioner perspectives of domestic abuse and women over 45. *European Journal of Criminology*, 15(4): 503–519.

143 Scott, M., McKie, L., Morton, S., Seddon, E. and Wassof, F. (2004) Older women and domestic violence in Scotland '...and for 39 years I got on with it'. Available at: [www.womenssupportproject.co.uk/userfiles/file/uploads/DMOlderReport.pdf](http://www.womenssupportproject.co.uk/userfiles/file/uploads/DMOlderReport.pdf).

144 Benbow, S. M., Bhattacharyya, S. and Kingston, P. (2018) Older adults and violence: an analysis of Domestic Homicide Reviews in England involving adults over 60 years of age. *Ageing & Society*, 39 (6): 1097-1121.

145 Wydall, S., Clarke, A., Williams, J. and Zerk, R. (2018) Domestic Abuse and Elder Abuse in Wales: A tale of Two Initiatives. *British Journal of Social Work*, 48(4): 962–981.

146 McLaughlin, H., Robbins, R., Bellamy, C., Banks, C., and Thackray, D. (2018). Adult social work and high-risk domestic violence cases. *Journal of Social Work*, 18(3), pp. 288–306.



- Older women are vulnerable to poor mental health as a result of long-term abuse and are at increased risk of severe injury or death if assaulted by their abuser. Additionally, survivors often experience heightened anxiety about the outcome of reporting abuse (specifically on housing and any dependent relationship).
- It is also important to note that domestic abuse may occur in institutions such as care homes, supported accommodation and wards, rather than only in the home.

As a result, domestic abuse amongst older people is underreported.

- Only 3% of survivors aged 60 or over are accessing Independent Domestic Violence Advisor (Idva) services<sup>147</sup>
- Older women are under-represented in community-based support, with only 3.4% of services user being over 61 and with this falling to 1.4% in refuge<sup>148</sup>.

It has been estimated that 120,000 individuals aged 65+ experienced at least one form of abuse (psychological, physical, sexual or financial) in one year<sup>149</sup>. Additionally, older victims account for one in four victims of domestic homicide in England and Wales<sup>150</sup>. Older women are also often invisible when considering other forms of Violence against Women and Girls too, including sexual violence<sup>151</sup>.

Older survivors are almost as likely to experience abuse from a family member as a partner. In some cases, they may experience abuse from a friend or care worker. Women are more likely to experience abuse than men (3.8% of women and 1.1% of men in the past year), and men are more often the perpetrators<sup>152</sup>. However, the gender difference may be less pronounced for older survivors, meaning men may be at an increased risk<sup>153</sup>. This is likely to reflect the increased prevalence of domestic abuse perpetrated by adult (usually male) children.

### How older people experiencing domestic abuse may present to health professionals

Older people's experience of domestic abuse will be similar to that of any age group including physical, emotional or psychological, economical and sexual abuse. Symptoms or conditions which are indicators of possible domestic abuse include PTSD, anxiety, frequent and unexplained injuries (see the Possible Generic Indicators of Abuse section for more examples). Many older people may have lived with the abuse for prolonged periods before getting help. This can worsen the impact of domestic abuse and may also affect someone's feelings about their circumstances and options. For example, if someone is experiencing abuse from an intimate partner, they may feel a sense of shame or embarrassment about the time spent in the relationship<sup>154</sup>.

Alternatively, if the abuser is an adult child, they may feel a sense of guilt or responsibility, or want to protect them as a family member.

There could be a range of health impacts of domestic abuse for older people as with any survivor. However, it is important to recognise that if an older survivor has lived with domestic abuse for a prolonged period of time, the impact may be severe. This could include the long-term impact of trauma, with effects similar to post-traumatic stress disorder (PTSD)<sup>155</sup>. When working with older survivors, it is important to consider the extent to which any health impacts are the consequence of domestic abuse rather than assuming they are a consequence of ageing / lack of mental capacity.

Specific ways that older survivors may be affected include<sup>156</sup>:

- Increased likelihood of depression, anxiety and risk of suicide
- An impact on cognitive functioning (including memory lapses and difficulties with concentration)
- Chronic pain (such as bone and joint problems, digestive problems and high blood pressure)
- Substance misuse (including alcohol use, smoking and the use of prescription and non-prescription drugs)
- A decline in physical or cognitive health, along with a corresponding increase in frailty and dependence on others for support, can put older people at risk of abuse.

→ Older survivors who are unwell may also be less able to defend themselves, be neglected if they have limited or no mobility or need support around continence which can be exploited by a perpetrator.

→ At the same time, illness may impact on someone's view of themselves, as well as their needs and response to any abuse. For example, if someone is experiencing a decline in physical or cognitive health they may fear being institutionalised, meaning they could be reluctant to disclose domestic abuse. A fear of losing their home, including possessions and memories, can also be a barrier in this context.

### Is it safe to enquire about domestic abuse?

Remain open-minded and create a comfortable environment for disclosures. Take normal precautions – however, older patients who are experiencing domestic abuse may face specific barriers to services and therefore need a different response<sup>157</sup>.

Some older survivors may never have been asked or spoken about domestic abuse before. Others may have sought help in the past but perhaps did not get a good response. They may also be reluctant to access services, perhaps because they think that the help and support available is for younger people, or because they cannot imagine leaving a relationship or finding safety as a realistic option.

147 SafeLives (2016) Safe Later Lives: Older people and domestic abuse. Available at: [www.safelives.org.uk/spotlight-1-older-people-and-domestic-abuse](http://www.safelives.org.uk/spotlight-1-older-people-and-domestic-abuse)

148 Women's Aid (2020) The Domestic Abuse Report 2020: The Annual Audit. Available at: [www.womensaid.org.uk/research-and-publications/the-domestic-abuse-report/](http://www.womensaid.org.uk/research-and-publications/the-domestic-abuse-report/)

149 SafeLives (2016) Safe Later Lives: Older people and domestic abuse. Available at: [www.safelives.org.uk/spotlight-1-older-people-and-domestic-abuse](http://www.safelives.org.uk/spotlight-1-older-people-and-domestic-abuse)

150 Bows, H. (2018) Domestic Homicide of Older People. (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK. *The British Journal of Social Work*, 49 (5): 1234-1253.

151 Solace Women's Aid (2016) The Silver Project: Domestic Abuse Service for Women Over 55. Available at: [www.solacewomensaid.org/get-informed/professional-resources/silver-project-evaluating-our-domestic-abuse-service-women-over](http://www.solacewomensaid.org/get-informed/professional-resources/silver-project-evaluating-our-domestic-abuse-service-women-over).

152 National Institute for Clinical Excellence (2016) Domestic violence and abuse: multi-agency working. Available at: [www.nice.org.uk/guidance/ph50](http://www.nice.org.uk/guidance/ph50).

153 Clarke, A. H., Wydall, S., Williams, J. R., & Boaler, R. R. (2012). An Evaluation of the 'Access to Justice' Pilot Project. Available at: <https://gov.wales/evaluation-access-justice-pilot-project>.

154 Scott, M., McKie, L., Morton, S., Seddon, E. and Wassof, F. (2004) Older women and domestic violence in Scotland '...and for 39 years I got on with it'. Available at: [www.womenssupportproject.co.uk/userfiles/file/uploads/DMOlderReport.pdf](http://www.womenssupportproject.co.uk/userfiles/file/uploads/DMOlderReport.pdf).

155 Scott, M., McKie, L., Morton, S., Seddon, E. and Wassof, F. (2004) Older women and domestic violence in Scotland '...and for 39 years I got on with it'. Available at: [www.womenssupportproject.co.uk/userfiles/file/uploads/DMOlderReport.pdf](http://www.womenssupportproject.co.uk/userfiles/file/uploads/DMOlderReport.pdf).

156 Allcock, A (2018) ESSS Outline: Older women and domestic abuse. Available at: [www.iriss.org.uk/resources/esss-outlines/older-women-abuse](http://www.iriss.org.uk/resources/esss-outlines/older-women-abuse).

157 Bows, H (2017) Practitioner views on the impacts, challenges, and barriers in supporting older victims of sexual violence. *Violence Against Women*, 24(9), pp.1070-1090.

Solace Women's Aid 'Silver Project' identified five key barriers to accessing services. These are summarised here and described in more detail in the Barriers to Support section at the back of the guidance:

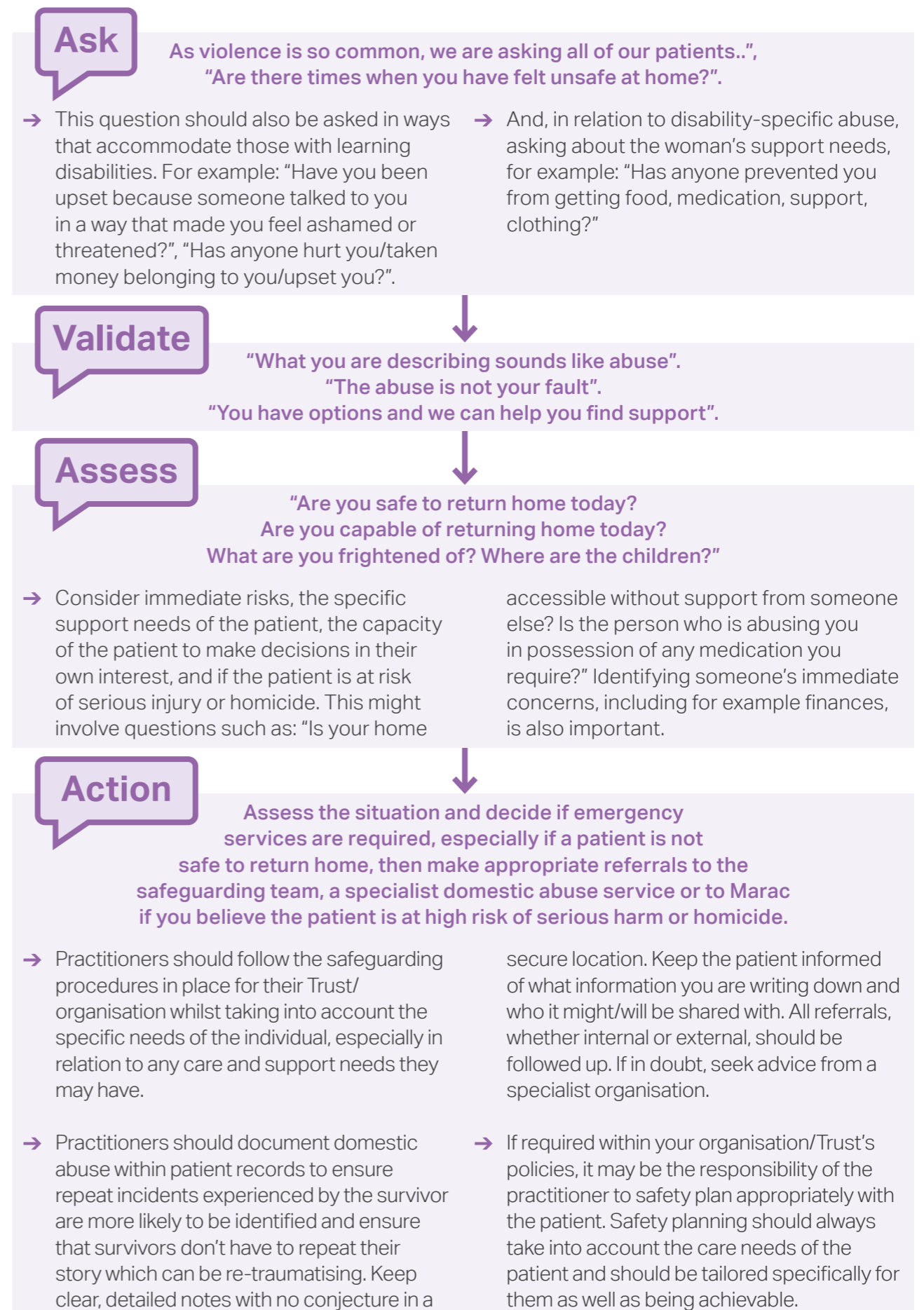
1. Health and mobility issues are affecting the survivor's ability to access services.
2. The survivor has limited eligibility for housing, legal or financial support.
3. The survivor will experience additional barriers to leaving the abusive relationship due to multiple needs (dementia, alcohol use, ...).
4. The perpetrator is elderly or has health issues of their own.
5. The abuser is the survivor's adult child or grandchild.

As with any survivor, it is important to also consider whether an older survivor has the capacity to respond safely. Start from the assumption that the patient is able to make their own decisions and ensure you make every effort to enable the patient to speak for themselves. For those judged to lack the capacity to make certain decisions, they will need additional help and support under the Mental Capacity Act (2005). The Care Act (2014) says that an independent advocate must be engaged if a person's needs mean they may have difficulty taking part in such decisions as disclosing abuse and/or leaving a perpetrator. In this case, do not pursue an enquiry if the person lacks capacity to consent unless you have already arranged an advocate. The council has a duty to supply said person with an advocate when they have no family or friends to support. Advocates can support with safeguarding and reviews, assessments, and making decisions.

## How to respond appropriately and safely

Making enquiries safely and appropriately requires additional considerations when the patient is living with disability. Of primary importance is listening to the patient and believing them. It is also crucial to allow the patient the chance to set their own terms on how they want to be supported.

### Key steps to follow to ensure you respond appropriately include:



## Making a referral

- If you believe the patient's safety or their children to be at immediate risk, you should call the emergency services. You can also remind deaf or non-verbal survivors that if they feel unsafe, they can contact 999 by SMS text. To register, text 'Register' to 999.
- Your service may have a specialist co-located service, such as an Idva or Advocate Educator, who you can refer patients to.
- Your service should have a list of local services (including domestic abuse services) that patients can be referred to.
- National helplines may also be helpful:
  - [National Domestic Violence Helpline](#) – 0808 2000 247
  - [Age UK Advice Line](#) – 0800 678 1602
  - [The Silver Line](#) – 0800 4 70 80 90
- If the patient is high risk, you may also need to refer the patient to the local Marac (Multi-Agency Risk Assessment Conference). Child safeguarding procedures will also have to be initiated where appropriate in accordance with the policies in place. If required within your organisation/Trust's policies, it may be the responsibility of the practitioner to make an initial risk assessment, using a recognised system (e.g. DASH, SPECSS). Make sure you know the local Marac and Safeguarding Board co-ordinators. Again, your service may have an Idva to support patients who can assist you with this, or any other relevant queries.
- Aim to establish the patient's wishes and feelings around issues and explain to them what you are doing and who else will be involved.
- Maintain a written record of what your concerns are, what the person has told you (using their exact words) and the actions you are taking. All referrals, whether internal or external, should be followed up.

## What to bear in mind:

- Address the individual, not the interpreter, family members, partner or carer of the patient. Sit across from the patient and maintain eye contact.
- Ensure you can communicate in a way that meets their needs – for example, using minicom, videophone or interpreting services for hard of hearing or deaf service users. Where possible (and safe to do so) give the options in writing.
- See the whole situation, not just the domestic abuse. Consider for example the care needs of the patient and how they would get the tailored support when disclosing. If you are supporting a patient with a condition you know little about, be open to being led by them.
- Where an older patient has particular health needs, including mobility requirements, ensure they are not physically excluded by adapting the environment, so it is completely accessible. This may mean making arrangements for someone to be transported to or from appointments.

## Do not:

- Use a family member or close friend as an interpreter. Where possible book interpreters or have trained members of staff in your services and ensure that video replay and hearing loop services are available. Take a flexible approach to communication if interpreters are not an option.
- Allow other individuals to stay in the room (including the individual's carer) unless completely necessary. Involve parents, caregivers, spouses, partners, service providers and other family members only if a survivor gives full consent while keeping in mind that the individual might be fearful of an abuser and of disclosing.

- Rush the process. Make sure that you cannot be interrupted, and that you have sufficient time for an emotional and difficult topic of conversation. If someone is making a disclosure for the first time, it is important you can give them the time and space to talk about their experiences.

## Barriers to support

Solace Women's Aid 'Silver Project' identified the following five key barriers to accessing services:

### 1. Health & mobility issues are affecting the survivor's ability to access services.

It can take longer for older survivors to get the right support because they can't get out as easily, don't have anywhere safe to go or do not have access to a mobile phone. This may be exacerbated by the fact the perpetrator is also their carer.

### 2. The survivor has limited eligibility for housing, legal or financial support.

Older survivors might require specially adapted homes to help them live independently. This can limit the options available to them due to a lack of housing and a long waiting list for adapted properties.

If they have savings or a home of their own it could mean they are not eli-gible for legal aid. Others may face financial hardship as leaving the perpe-trator can require costly care options.

### 3. The survivor will experience additional barriers to leaving the abusive relationship due to multiple needs.

Older survivors typically live with abuse for many years before getting help. This could mean that it will take them longer to deal with the trauma or leave the abusive situation at all.

They may have multiple needs such as dementia or use alcohol as a coping mechanism. This can mean that you will need to work with clients on a longer-term basis and steps to safety, such as re-housing, legal advice and access to care, may take longer.

### 4. The perpetrator is elderly or has health issues of their own.

In some cases, the perpetrator has dementia or memory loss, or condi-tions which are known to make them violent. The perpetrator may be viewed as vulnerable and not capable of serious harm. A criminal justice response may be seen as inappropriate, and could result in an inadequate or unsuitable response by professionals.

### 5. The abuser is the survivor's adult child or grandchild.

Survivors in these cases may be less likely to report the abuse to the au-thorities. This is often because they still love their child and want them to get help. They may worry about being alone or even blame themselves for the abuse because of how the child was raised.

The perpetrator may also have specific needs around mental ill-health or problematic alcohol or substance use. However, unless they are a risk to the community, you may find that services are reluctant to intervene.

\*\*It is also important to think about how these barriers might overlap with other hurdles women face to disclosure in relation to immigration status, sexuality, language, faith, etc.



## Possible generic indicators of abuse

This list is by no means exhaustive but offers more common indicators of abuse:

- Symptoms of depression, low self-esteem, PTSD, anxiety, fearfulness.
- Suicidal ideation, suicidal tendencies or self-harm.
- Somatic disorders, problems sleeping, physical exhaustion.
- Sudden weight loss, eating disorders.
- Substance misuse.
- Unexplained injuries, or injuries for which the survivor describes stories that appear improbable.
- Repeated injuries, frequent visits to A&E, or delays between injury and presentation.
- Sexually transmitted infections or gynaecological injuries.
- Problems with the central nervous system (headaches, cognitive problems, hearing loss), gastrointestinal problems.
- Cancels appointments last minute, is often late or needing to be back home by a certain time.
- Isolated from friends and/or family members.
- Little or no access to financial resources independent of a partner.
- Describes a partner or family member as prone to anger or controlling.
- Protective other party frequently attending appointments.

## Appendix 5: Specialist Guidance for Health Professionals – Responding to Disabled Women Experiencing Domestic Abuse

This document provides specialist guidance to support Health Professionals responses to disabled survivors of abuse. Considering the substantially different forms of abuse women living with disability face, practitioners should seek out training where possible, and ask advice from designated staff or specialist organisations if unsure of suitable action.

The document was edited and endorsed by Dr Susie Balderston, Co-founder and Policy Director of [Vision Sense](#), a UK disability charity aiming to remove barriers to communication so no one living with complex disabilities is left out of life.



### Contents

- Definitions
- Violence against disabled women and girls
- How disabled people experiencing domestic abuse may present to health professionals
- Is it safe to enquire about domestic abuse?
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## Definitions

It is generally agreed that an individual has a disability if they are living with a physical or mental impairment which has a substantial and long-term adverse impact on the individual's ability to live day-to-day. Disability can be seen to encompass the following:

- **cognitive disabilities** which may affect learning, reasoning and processing of information
- **sensory disabilities** which may affect touch, taste, smell, hearing and sight
- **mental illnesses** which may affect patterns of thought and behaviours
- **physical impairments** which may affect the ability for the individual to move their body freely or without pain, or the functioning of other bodily systems (e.g. cardiovascular, respiratory, nervous).

The term 'disabled' encompasses a variety of life circumstances<sup>158</sup>. Defining disability is complex for a number of reasons: some disabilities are 'invisible', some individuals self-define as 'disabled' while others prefer to refer to their health outside of the notion of being 'disabled' by it<sup>159</sup>, and many individuals may be living with more than one disability.

Most individuals living with disability promote the 'social model' of disability. This model indicates that disability is not a result of an individual's impairment, but instead the attitudes and structures in society which exclude and marginalise those with impairments. Adopting the social model of disability as a health care practitioner is a crucial first step towards overcoming barriers in services that survivors living with disability might face.

## Violence against disabled women and girls

The fact of having a disability impacts the forms and extent to which violence against women takes place.

- Disabled women are two to five times more likely than men and non-disabled women to experience sexual violence<sup>160</sup>; that is 1.6 times for people with intellectual impairments and 3.8 times more likely for mental health service users<sup>161</sup>.
- One in five (20%) disabled survivors experienced ongoing physical abuse, whilst 7% face sexual abuse<sup>162</sup>. Financial abuse is also significantly more frequent for disabled survivors.
- Disabled women are also much more likely than non-disabled women to suffer abuse from the individuals they are most dependent on for care, such as intimate partners, family members or carers; 31% of the violence against disabled survivors is from a current partner, and 14% from a family member<sup>163</sup>.

- Disabled women are more likely to face repeated and sustained abuse and suffer higher rates of injury than male survivors<sup>164</sup>.
- Violence against disabled people is overwhelmingly perpetrated by men<sup>165</sup>.

Some reasons for the higher prevalence of abuse include; the increased risk of isolation, increased physical, emotional, and economic dependency as a result of lack of services, difficulties recognising and identifying disability related abuse, and, crucially, societal barriers that get in the way of accessing support<sup>166</sup>. This list is by no means exhaustive. There are also numerous barriers to women living with disability both disclosing abuse and accessing support. These include: fear over lost support, inaccessibility of support, and perpetrators limiting support<sup>167</sup>.

There are forms of abuse that are also specific to disabled women often where their disability may be used as a tool of abuse<sup>168</sup>. This can include:

- **The abuser may control the survivor through their support needs:** denying access to mobility or communication aids to limit the survivor's independence, tampering with food or medication, controlling communication by acting as a deaf or non-verbal woman's communicator, refusing external assistance on the woman's behalf, forms of rough 'assistance'.

- **The abuser may use the societal stigma around disability to manipulate and abuse the woman:** persuading her that no one else will want her or care for her, threatening institutionalisation, mocking or degrading the woman's disability, threatening to 'out' her as disabled (for example if she has a mental illness she has not disclosed to others), threatening that no one will believe her due to her disability.

- **The abuser may use the inaccessibility of other support to control the survivor:** inaccessible environments may make escape impossible from her own home, inaccessible reporting processes or staying with the woman as her 'carer' during appointments so that she cannot disclose, using her lack of knowledge of support services because information is not accessible to her, knowledge of the fact there is less support for disabled people to live independently, using the fear that her children will be removed to make her stay.

It is also important that violence, neglect and abuse which occurs in institutions such as care homes, supported accommodation and wards is also included in the remit of domestic violence – a disabled person's 'home' is much more likely to be residential care or an institution than for non-disabled individuals<sup>169</sup>.

158 The remit of 'disability' is outlined in full in the Equality Act (2010), available here: [www.legislation.gov.uk/ukpga/2010/15/contents](http://www.legislation.gov.uk/ukpga/2010/15/contents)

159 The remit of 'disability' is outlined in full in the Equality Act (2010), available here: [www.legislation.gov.uk/ukpga/2010/15/contents](http://www.legislation.gov.uk/ukpga/2010/15/contents)

160 Balderston, S. (2013) survivorVictimised again? Intersectionality and Injustice in disabled women's lives after hate crime and rape. In Texler Segal, M., Demos, V. (Eds.) *Advances in Gender Research Volume 18a – Gendered Violence*. Cambridge MA: Emerald Publishing.

161 Hughes, K., Bellis, M.A., Jones, L., Wood, S., Bates, G., Eckley, L., McCoy, E., Mikton, C., Shakespeare, T., Officer, A. (2012) Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies. *Lancet*, 379 (9826): 1621–1629.

162 SafeLives (2017). *Disabled Survivors Too: Disabled people and domestic abuse. Spotlight*. [online] London: SafeLives.

163 SafeLives (2017). *Disabled Survivors Too: Disabled people and domestic abuse. Spotlight*. [online] London: SafeLives.

164 Walby, S., Towers, J., Balderston, S., Corradi, C., Francis, B., Heiskanen, M., HelwegLarsen, K., Mergaert, L., Olive, P., Palmer, E., Stöckl, H., Strid, S. (2017) *The Concept and Measurement of Violence against Women and Men*. Bristol: Policy Press.

165 Vision Sense, AVA and CeDR (2019). *Tackling Violence Against Disabled Women & Girls A Toolkit for Social Care, Housing, Mental Health and Safeguarding Services 2019*. London: DRILL.

166 Radford, J., Harne, L., & Trotter, J. (2006). Disabled women and domestic violence as violent crime. *Practice*, 18(4), 233-246.

167 Vision Sense, AVA and CeDR (2019). *Tackling Violence Against Disabled Women & Girls A Toolkit for Social Care, Housing, Mental Health and Safeguarding Services 2019*. London: DRILL.

168 Bashall, R. (2016). *Recognising and supporting disabled victims of domestic abuse*. [online] SafeLives. Available at: [http://safelives.org.uk/practice\\_blog/recognising-and-supporting-disabled-victims-domestic-abuse](http://safelives.org.uk/practice_blog/recognising-and-supporting-disabled-victims-domestic-abuse).

169 *ibid*

## How disabled people experiencing domestic abuse may present to health professionals

People with disabilities experience many similar forms of overt and covert sexual assault abuse and control as people without disabilities. Symptoms or conditions which are indicators of possible domestic violence include PTSD, anxiety, frequent and unexplained injuries, protective other parties attending appointments (see the Possible Generic Indicators of Abuse section for more examples).

The health impacts of abuse are also much higher for women living with disability. Domestic abuse can negatively impact a woman's ability to manage her primary physical disabilities and lead to the onset of debilitating secondary conditions. Disabled survivors who are experiencing domestic abuse are also twice as likely to have previously planned or attempted suicide (22% vs 11%) than non-disabled survivors<sup>170</sup>.

There are also certain disability-specific forms of abuse which may lead a survivor to present differently, but remember that both disability and abuse are often 'hidden'. For disabled patients and their perpetrators, possible indicators of abuse might also include:

- A carer who refuses to leave the room when appropriate or when asked.
- A patient who has not been taking their medication appropriately or their health-related equipment has been damaged or other signs of neglect related to their health-care needs.
- There is no care plan in place for this patient, or this patient should have seen services long ago. They might have untreated injuries or health problems or there may be a delay between disabilities related injuries and presentation to a service.

## Is it safe to enquire about domestic abuse?

Remain open-minded and create a comfortable environment for disclosures. Best practice is always routine enquiry considering the prevalence of abuse. Take normal precautions – however, there are further considerations for assisting disabled women:

- **Is their carer present?** Create a comfortable situation in which the patient can be without their carer. Ensure she has a chance to disclose personally, without other members of her care team/ family being in the room or responsible for interpretation or communication. If it is difficult to see a patient alone initially, organise a follow up appointment as soon as possible, making clear that part of the appointment will be between the clinician and the patient only. Alternatively, if in a GP surgery, chaperones should be available with prior organisation to offer support to patients during appointments.
- **Do they have an appropriate interpreter?** If and where possible use an interpreter. Take a flexible approach to communication if interpreters are not an option. Use Google Translate, gestures or role play alongside linking service users into ESOL and/or BSL courses where possible. Do not use children or family members as interpreters.
- **Do they have the capacity to respond safely?** Start from the assumption that the patient is able to make their own decisions and ensure you make every effort to enable the patient to speak for themselves. For those judged to lack the capacity to make certain decisions, they will need additional help and support under the Mental Capacity Act (2005). The Care Act (2014) says that an independent

advocate must be engaged if a person's needs mean they may have difficulty taking part in such decisions as disclosing abuse and/or leaving a perpetrator. In this case, do not pursue an enquiry if the person lacks capacity to consent unless you have already arranged an advocate. The council has a duty to supply said person with an advocate when they have no family or friends to support. Advocates can support with safeguarding and reviews, assessments, and making decisions.

## How to respond appropriately and safely

Making inquiries safely and appropriately requires additional considerations when the potential survivor is living with disability. Of primary importance is listening to the patient and believing them. It is also crucial to allow the patient the chance to set their own terms on how they want to be supported.



**Key steps to follow to ensure you respond appropriately include:**

**Ask**

**"As violence is so common, we are asking all of our patients..",  
"Are there times when you have felt unsafe at home?"**

- This question should also be asked in ways that accommodate those with learning disabilities. For example: "Have you been upset because someone talked to you in a way that made you feel ashamed or threatened?", "Has anyone hurt you/taken money belonging to you/upset you?".
- And, in relation to disability-specific abuse, asking about the woman's support needs, for example: "Has anyone prevented you from getting food, medication, support, clothing?"

**Validate**

**"What you are describing sounds like abuse".  
"The abuse is not your fault".  
"You have options and we can help you find support".**

**Assess**

**"Are you safe to return home today?  
Are you capable of returning home today?  
What are you frightened of? Where are the children?"**

- Consider immediate risks, the specific support needs of the patient, the capacity of the patient to make decisions in their own interest, and if the patient is at risk of serious injury or homicide. This might involve questions such as: "Is your home accessible without support from someone else? Is the person who is abusing you in possession of any medication you require?" Identifying someone's immediate concerns, including for example finances, is also important.

**Action**

**Assess the situation and decide if emergency services are required, especially if a patient is not safe to return home, then make appropriate referrals to the Safeguarding team, a specialist domestic abuse service or to Marac if you believe the patient is at high risk of serious harm or homicide.**

- Practitioners should follow the safeguarding procedures in place for their Trust/organisation whilst taking into account the specific needs of the individual, especially in relation to any care and support needs they may have.
- Practitioners should document domestic abuse within patient records to ensure repeat incidents experienced by the survivor are more likely to be identified and ensure that survivors don't have to repeat their story which can be re-traumatising. Keep clear detailed notes with no conjecture in a secure location. Keep the patient informed of what information you are writing down and who it might/will be shared with. All referrals, whether internal or external, should be followed up. If in doubt, seek advice from a specialist organisation.
- Practitioners should document domestic abuse within patient records to ensure repeat incidents experienced by the survivor are more likely to be identified and ensure that survivors don't have to repeat their story which can be re-traumatising. Keep clear detailed notes with no
- If required within your organisation/Trust's policies, it may be the responsibility of the practitioner to safety plan appropriately with the patient. Safety planning should always take into account the care needs of the patient and should be tailored specifically for them as well as being achievable.

**Making a referral**

- If you believe the patient's safety or their children to be at immediate risk, you should call the emergency services. You can also remind deaf or non-verbal survivors that if they feel unsafe, they can contact 999 by SMS text. To register, text 'Register' to 999.
- Your service may have a specialist co-located service, such as an Idva or Advocate Educator, who you can refer patients to.
- Your service should have a list of local services (including domestic abuse services) that patients can be referred to.
- National helplines may also be helpful:
  - [National Domestic Violence Helpline](#) – 0808 2000 247
  - [Action on Hearing Loss](#) – UK charity supporting deaf people and those with hearing loss and tinnitus – 0808 808 0123 or text 0780 0000 360
  - [Sign Health](#) – sign-language based service for survivors of domestic abuse – 020 3947 2601 or text 07970 350366
  - [Dial UK](#): Advice line run by and for disabled people – 0808 800 3333
  - [Royal National Institute of Blind People \(RNIB\)](#) – Information and support for anyone with visual impairment – 0303 123 9999
- If the patient is high risk, you may also need to refer the patient to the local Marac (Multi-Agency Risk Assessment Conference). Child safeguarding procedures will also have to be initiated where appropriate in accordance with the policies in place. If required within your organisation/Trust's policies, it may be the responsibility of the practitioner to make an initial risk assessment, using a recognised system (e.g. DASH, SPECSSS). Make sure you know the local Marac and Safeguarding Board co-ordinators. Again, your service may have an Idva to support patients who can assist you with this, or any other relevant queries.
- Aim to establish the patient's wishes and feelings around issues and explain to them what you are doing and who else will be involved.
- Maintain a written record of what your concerns are, what the person has told you (using their exact words) and the actions you are taking. All referrals, whether internal or external, should be followed up.

## What to bear in mind:

- Address the individual, not the interpreter, family members, partner or carer of the patient. Sit across from the patient and maintain eye contact.
- See the whole situation, not just the domestic abuse. Consider for example the care needs of the patient and how she would get the tailored support she needs were she to disclose. If you are supporting a patient with a condition you know little about, be open to being led by them.
- Ensure disabled patients are not physically excluded by adapting the environment so it is completely accessible.

## Do not:

- Use a family member or close friend as an interpreter. Where possible book interpreters or have trained members of staff in your services and ensure that video replay and hearing loop services are available. Take a flexible approach to communication if interpreters are not an option.
- Allow other individuals to stay in the room (including the individual's carer) unless completely necessary. Involve parents, caregivers, spouses, partners, service providers and other family members only if a survivor gives full consent while keeping in mind that the individual might be fearful of an abuser and of disclosing.
- Rush the process. People with cognitive disabilities and/or mental illnesses may take longer to process feelings and information. Make sure that you can't be interrupted, and that you have sufficient time for an emotional and difficult topic of conversation.

## Barriers to support

There are numerous barriers to women both disclosing abuse and accessing support. Below is a very general list of barriers disabled survivors face to accessing services<sup>171</sup>:

- **Perpetrators limiting support:** Abusers exploit the challenges presented by disability, knowing that this will limit a woman's ability to access support. If the abuser is a survivor's primary carer, they may prevent the survivor from accessing support or disclosing if the carer accompanies her to meetings etc.
- **Fear over lost support:** survivors may be particularly reluctant to make a charge for fear they would be left with no one to provide the personal care, fear that their children will be removed, and/or fear of having to live in a care home.
- **Capacity and understanding:** Those with cognitive and learning disabilities might not identify themselves as abuse survivors, might not understand questioning around abuse and/or might not be aware of the services they can approach<sup>172</sup>.
- **Inaccessible support (deaf women):** For deaf women, there is a lack of accessible information about abuse and legal rights and a lack of accessible domestic abuse services (e.g. many help lines aren't accessible). There may also be fear that interpreters may not keep confidentiality. Professionals might also try to use a woman's child as an interpreter, limiting what she wants to say and/or potentially being traumatic for the child if she does disclose. Non-verbal women often face similar barriers.

- **Inaccessible support (general):** Refuges and other sources of support are frequently inaccessible or do not cater to women with physical and/or mental disabilities. This is something that many disabled women are aware of, whilst for others they might disclose and find there is no suitable support for them available. Financial abuse might limit the ability for survivors to travel to support services.
- **Shame and stigma:** For older adults who have lived with a lifetime of abuse, they may experience shame for having put up with it for so long.
- **Disabled perpetrators of abuse:** Women who have experienced violence from disabled men report difficulties in being taken seriously by the police and social services.
- **Disbelief and/or minimisation:** Disabled survivors report that they are often not believed by services. Other disabled women report professionals minimising the abuse and/or telling them they are lucky to have a partner who is caring for them.

It is also important to think about how these barriers might overlap with other hurdles women face to disclosure in relation to immigration status, sexuality, language, faith, etc.

## Possible generic indicators of abuse

This list is by no means exhaustive but offers more common indicators of abuse:

- Symptoms of depression, low self-esteem, PTSD, anxiety, fearfulness.
- Suicidal ideation, suicidal tendencies or self-harm.

- Somatic disorders, problems sleeping, physical exhaustion.
- Sudden weight loss, eating disorders.
- Substance misuse.
- Unexplained injuries, or injuries for which the survivor describes stories that appear improbable.
- Repeated injuries, frequent visits to A&E, or delays between injury and presentation.
- Sexually transmitted infections or gynaecological injuries.
- Problems with the central nervous system (headaches, cognitive problems, hearing loss), gastrointestinal problems.
- Cancels appointments last minute, is often late or needing to be back home by a certain time.
- Isolated from friends and/or family members.
- Little or no access to financial resources independent of a partner.
- Describes a partner or family member as prone to anger or controlling.
- Protective other party frequently attending appointments.

The NICE guidelines (2014) provide an outline for both identifying and asking questions about abuse<sup>173</sup>. AVA, a national charity working to end gender-based violence and abuse, also offers comprehensive e-learning courses related to identifying domestic violence and abuse – available at: [www.elearning.avaproject.org.uk](http://www.elearning.avaproject.org.uk)

171 Vision Sense, AVA and CeDR (2019). Tackling Violence Against Disabled Women & Girls A Toolkit for Social Care, Housing, Mental Health and Safeguarding Services 2019. London: DRILL.

172 McCarthy, M., Hunt, S., & Milne-Skillman, K. (2017). 'I Know it was Every Week, but I Can't be Sure if it was Every Day: Domestic Violence and Women with Learning Disabilities. *Journal of Applied Research in Intellectual Disabilities*, 30(2), p.269-282.

173 National Institute for Clinical Excellence (2016) Domestic violence and abuse: multi-agency working. Available at: [www.nice.org.uk/guidance/ph50](http://www.nice.org.uk/guidance/ph50).

# Appendix 6:

## Specialist Guidance for Health Professionals – Responding to Black and Minority Ethnic Women Experiencing Domestic Abuse

This document, produced by Imkaan, provides specialist guidance to support Health Professionals responses to Black and Minority Ethnic (BME) survivors of abuse. Where possible, specialist training should be accessed to complement this guidance. If unsure how to respond to particular cases, professionals should contact their local specialist BME organisations for support.

This document was written by [Imkaan](#), the only UK-based, second-tier women's organisation dedicated to addressing violence against Black and minoritised women and girls.



### Contents

Definitions

How might BME survivors of domestic abuse present?

Is it safe to enquire about domestic abuse?

How to respond appropriately and safely

Making a referral

What to bear in mind

Barriers to support

### Definitions

The terms BME & BAME are used interchangeably in the UK context, with BME standing for 'Black and Minority Ethnic' and BAME standing for 'Black, Asian and Minority Ethnic'. Both are rooted within policy and are extensively used by government departments, public bodies and many other organisations across England, Scotland and Wales. However, for the purpose of this document we will be using the term BME.

BME survivors may not report abuse to the police for a range of reasons; including concerns about the impact or stigma on their wider family or community, language difficulties and feeling distrustful of the police because of past negative experiences.<sup>174</sup> For this reason, health professionals have a unique opportunity to notice the signs of abuse and support them to access the services and support they need. BME women may be reluctant to disclose abuse due to fear of not being believed, understood or supported appropriately and that their children will be removed. Racism and discrimination is likely to form part of BME women's experiences which can lead them to fear that medical professionals might report them to the Home Office or the police.

BME communities continue to experience inequalities within health. BME people are disproportionately diagnosed with mental health issues in comparison to their white counterparts every year. BME communities often face barriers when accessing culturally appropriate services. They may not have access to the services on offer to them or the services they do access may have a lack of cultural understanding.<sup>175</sup>

It's important that NHS services take an approach that is reflective of the different needs and particular experiences of BME women. An intersectional approach is a way of understanding and responding to the ways different factors, such as gender, age, disability and race, intersect to shape individual identities and their experiences of statutory services. [Learn more here.](#)

<sup>175</sup> Thiara, R.K. and Roy, S. (2012) Vital Statistics 2 Key Findings Report on Black, Asian, Minority Ethnic and Refugee women and children facing violence and abuse. London: Imkaan



## How might BME survivors present?

Violence against BME women may be perpetrated by intimate partners or by multiple individuals including family members. Providers need to be able to respond appropriately to BME survivors; clear of prejudice, judgement and stereotypes around particular communities.

There may not be many differences to how BME women survivors present in relation to non-BME survivors when affected by domestic abuse (see the Possible Generic Indicators of Abuse section for more examples), however, BME women are disproportionately affected by some types of domestic abuse i.e. Forced Marriage, so called 'Honour-based' Violence and Female Genital Mutilation.

## Is it safe to enquire about domestic abuse?

It is important to ensure that patients are asked about domestic abuse in a safe and private space and not with family or friends present.

If you need to access interpreters for your patient, it is critical you do not use family or friends. If the patient comes from a small community, the interpreter might be known to the patient. An independent/anonymous service should be sought where possible.

## How to respond appropriately and safely

It is important to recognise and respond to the experiences of BME survivors, including identifying specific needs during the process of reporting and help-seeking. Of primary importance is listening to the patient and believing them. Do not judge or assume, it's important that BME women and girls are not stereotyped when accessing services or assumptions formed regarding different groups of BME communities. It is also crucial to allow the patient the chance to set their own terms on how they want to be supported.

Key steps to follow to ensure you respond appropriately include:

### Ask

"As violence is so common, we are asking all of our patients..",  
"Are there times when you have felt unsafe at home?"

### Validate

"What you are describing sounds like abuse".  
"The abuse is not your fault".  
"You have options and we can help you find support".

### Assess

"Are you safe to return home today?  
Are you capable of returning home today?  
What are you frightened of? Where are the children?"

- Consider immediate risks, the specific support needs of the patient, the capacity of the patient to make decisions in their own interest, and if the patient is at risk of serious injury or homicide. This might involve questions such as: "Is your home accessible without support from someone else? Is the person who is abusing you in possession of any medication you require?" Identifying someone's immediate concerns, including for example finances, is also important.

### Action

**Assess the situation and decide if emergency services are required, especially if a patient is not safe to return home, then make appropriate referrals to the safeguarding team, a specialist domestic abuse service or to Marac if you believe the patient is at high risk of serious harm or homicide.**

- Practitioners should follow the safeguarding procedures in place for their trust/organisation whilst taking into account the specific needs of the individual, especially in relation to any care and support needs they may have.
- Practitioners should document domestic abuse within patient records to ensure repeat incidents experienced by the survivor are more likely to be identified and ensure that survivors don't have to repeat their story which can be re-traumatising. Keep clear detailed notes with no conjecture in a secure location. Keep the patient informed of what information you are writing down and who it might/will be shared with. All referrals, whether internal or external, should be followed up. If in doubt, seek advice from a specialist organisation.
- If required within your organisation/Trust's policies, it may be the responsibility of the practitioner to safety plan appropriately with the patient. Safety planning should always take into account the care needs of the patient and should be tailored specifically for them as well as being achievable.

## Making a referral

- If you believe the patient's safety or their children to be at immediate risk, you should call the emergency services. You can also remind deaf or non-verbal survivors that if they feel unsafe, they can contact 999 by SMS text. To register, text 'Register' to 999.
  - Your service may have a specialist co-located service, such as an Idva or Advocate Educator, who you can refer patients to.
  - Your service should have a list of local services (including domestic abuse services) that patients can be referred to.
  - If the patient is high risk, you may also need to refer the patient to the local Marac (Multi-Agency Risk Assessment Conference). Child safeguarding procedures will also have to be initiated where appropriate in accordance with the policies in place. If required within your organisation/Trust's policies, it may be the responsibility of the practitioner to make an initial risk assessment, using a recognised system (e.g. DASH, SPECS). Make sure you know the local Marac and Safeguarding Board co-ordinators. Again, your service may have an Idva to support patients who can assist you with this, or any other relevant queries.
  - Aim to establish the patient's wishes and feelings around issues and explain to them what you are doing and who else will be involved.
  - Maintain a written record of what your concerns are, what the person has told you (using their exact words) and the actions you are taking. All referrals, whether internal or external, should be followed up.
- National helplines may also be helpful:
    - [Forced Marriage Unit](#) – provides information on how to protect, advise and support victims of forced marriage – 020 7008 0151
    - [Karma Nirvana](#) – supporting victims of honour-based abuse and forced marriage – 0800 5999 247
    - [Galop](#) – National LGBT+ Domestic Abuse Helpline – 0800 999 5428.
    - [Southall Black Sisters](#) – domestic violence resource centre for Asian, African, Caribbean women (provides temporary financial support to those with no recourse to public funds and advice on accessing support for abused women with insecure immigration status) – 0208 571 0800 (Mon, Weds, Fri, 9.30am– 4.30pm).
    - [Muslim Women's Network](#) – a national specialist faith and culturally sensitive helpline – 0800 999 5786
    - [Jewish Women's Aid](#) – the only specialist organisation in the UK supporting Jewish women and children affected by domestic abuse & sexual violence.
    - [Latin American Women's Aid](#) – provides refuge support for Latin American women and children fleeing gender-based violence.
    - [FORWARD](#) – the leading African women-led organisation working to end VAWG with a focus on FGM – 020 8960 4000
    - [Chinese Mental Health Association](#) – provide a range of services for Chinese people who need support around mental health.

## What to bear in mind:

- Some groups of women encounter specific forms of judgement from mainstream services. It is important to adapt responses to address these structural barriers and to challenge the system<sup>176</sup>.
  - Try not to judge or assume. It's important that BME women and girls are not stereotyped when accessing services or assumptions formed regarding different groups of BME communities.
  - It's not one size fits all and it's important to be aware of what services are available locally.
  - Be aware of your local referral pathways and who is the lead on Domestic Abuse/ Violence against Women and Girls within your department and whether you have an Independent Domestic Violence Advisor (Idva) or Domestic Abuse Lead.
  - Find out what specialist 'by and for' BME Violence against Women and Girls (VAWG) / Domestic Abuse women's organisations are in your local area, let BME women know what is available for them. It's important that BME women are provided with all their options, and that they can choose where and how they would like to access the support.
  - It's important that Trusts have up to date information on key contacts within specialist services so that referrals can be made easily, and the work is done collaboratively to benefit BME women by agreeing referral protocols with these organisations in advance, ensuring staff are trained on referral protocols.
  - Address the individual, not the interpreter, family members, partner or carer of the patient. Sit across from the patient and maintain eye contact.
- Ensure you can communicate in a way that meets their needs – for example, using minicom, videophone or interpreting services for hard of hearing or deaf service users. Where possible (and safe to do so) give the options in writing.
  - See the whole situation, not just the domestic abuse. Consider for example the care needs of the patient and how they would get the tailored support she needs were she to disclose. If you are supporting a patient with a condition you know little about, be open to being led by them.
  - Be familiar with pathways e.g. local and national BME & VAWG services

## Do not:

- Use a family member or close friend as an interpreter. You should have access to an independent service for BSL and other translation services or have trained members of staff in your services and ensure that video replay and hearing loop services are available. Take a flexible approach to communication if interpreters are not an option.
- Allow other individuals to stay in the room (including the individual's carer) unless completely necessary. Involve parents, caregivers, spouses, partners, service providers and other family members only if a survivor gives full consent while keeping in mind that the individual might be fearful of an abuser and of disclosing.
- Rush the process. Make sure that you cannot be interrupted, and that you have sufficient time for an emotional and difficult topic of conversation. If someone is making a disclosure for the first time, it is important you can give them the time and space to talk about their experiences.

<sup>176</sup> Thiara, R.K. and Roy, S. (2020) Reclaiming Voice: Minoritised Women and Sexual Violence Key Findings: University of Warwick and Imkaan

## Barriers to support

There are numerous barriers which can stop BME survivors coming forward, including:

- structural racism
- hostile environment
- fear of not being believed
- information is not accessible or available
- pressure to remain in the family
- lack of interpreter at the first point of contact
- stigma and shame attached if they leave
- financial dependence on abusive partner and no recourse to public funds
- lack of knowledge of where to seek help
- stay with perpetrator because of children
- language
- isolation
- services are hard to access
- being judged

## Possible Generic indicators of abuse

This list is by no means exhaustive but offers more common indicators of abuse:

- Symptoms of depression, low self-esteem, PTSD, anxiety, fearfulness.
- Suicidal ideation, suicidal tendencies or self-harm.
- Somatic disorders, problems sleeping, physical exhaustion.
- Sudden weight loss, eating disorders.
- Substance misuse.
- Unexplained injuries, or injuries for which the survivor describes stories that appear improbable.
- Repeated injuries, frequent visits to A&E, or delays between injury and presentation.
- Sexually transmitted infections or gynaecological injuries.
- Problems with the central nervous system (headaches, cognitive problems, hearing loss), gastrointestinal problems.
- Cancels appointments last minute, is often late or needing to be back home by a certain time.
- Isolated from friends and/or family members.
- Little or no access to financial resources independent of a partner.
- Describes a partner or family member as prone to anger or controlling.
- Protective other party frequently attending appointments.

# Appendix 7: Domestic Abuse Policy Assessment Tool

This checklist has been created as a tool for assessing the content of a health organisation’s Domestic Abuse Policy. The tool refers to both patients and staff as survivors of domestic abuse and has been designed to assess both combined and standalone patient/staff policies. Pathfinder recommends that every NHS Trust and CCG should have both a staff and patient policy.

## 1. Prevalence and Impact

Requirements for policy	RAG Rating
Includes a definition of domestic abuse. (Pathfinder recommends including the Home Office or UN definitions)	
Details the prevalence of domestic abuse and its impact upon survivors and their families. This should include statistics highlighting the link between health and domestic abuse.	
Acknowledges the key role health professionals play in identifying and responding to domestic abuse and states that domestic abuse is a healthcare issue.	
Acknowledges that domestic abuse is unacceptable and a human rights violation.	
Acknowledges the link between domestic abuse and other forms of violence against women and girls. Highlights that anyone can experience or perpetrate domestic abuse but that women disproportionately experience it and that men overwhelmingly perpetrate it.	
Acknowledges that domestic abuse is about power and control and includes or references the Duluth Power and Control Wheel.	
Acknowledges the impact of domestic abuse on children and that exposure to domestic abuse constitutes child abuse. States that children are often used by perpetrators to maintain power and control that this has social/physical/psychological effects on the child, in some instances many years after two adults have separated.	
Acknowledges difficulties faced by patients and staff when disclosing domestic abuse and accessing support including examples of the barriers they face.	
Acknowledges the impact of patient and staff ethnicity, gender, religion, sex, marital status, pregnancy status, sexuality, disability, age and class upon disclosure and support needs.	
Acknowledges the potential for the multiple disadvantage someone might be facing, in the context of domestic abuse.	
Includes a statement detailing your service’s commitment to responding to and supporting patients and staff experiencing domestic abuse.	



## 2. Partnership Working and Multi-Agency Working

Requirements for policy	RAG Rating
Describes where to find a register of staff domestic abuse champions who can give advice when a disclosure is made.	
Details how to refer to the co-located Idva service where this provision exists.	
Documents clear pathways to support and key external agency contact details. This should include specialist services who support disabled, older (55+), BME, LGBT+ and teenage/younger patients and staff where possible. It is important to state that practitioners should not assume that survivors would prefer a specialist organisation rather than a mainstream one, so a choice of support services must be offered.	
Defines the purpose of a Marac (multi-agency risk assessment conference) and states the Trust's commitment to participating in the process in a robust and effective way.	
Details how and when to refer to Marac.	
States which staff members are expected to make a Marac referral and their responsibilities following the referral (e.g. to attend the meeting, provide relevant expertise on all cases not just the specific one(s) referred, and follow up with actions etc).	

## 3. Identification, Enquiry and Training

Requirements for policy	RAG Rating
Outlines signs of domestic abuse including signs that a colleague may be experiencing domestic abuse.	
Outlines how your service will identify domestic abuse using appropriate questions and whether all patients will be asked or if patients will be asked selectively.	
Outlines what a suitable environment looks like for enquiry into domestic abuse (e.g. private, confidential, independent interpreter if needed/wanted).	
States the importance of having independent translators. It should be stressed that it is not appropriate or safe to use family members, friends or members of the community as translators in situations where the practitioner and patient don't speak the same language.	
States that professionals should enquire about domestic abuse if they are concerned about a patient or staff member regardless of whether they have been asked about domestic abuse before.	

States the importance of validation once a disclosure is received. Response to disclosure should be; non-judgemental, non-victim blaming and not focused exclusively on symptoms without acknowledging cause so that survivor's self-help behaviours, autonomy and independence are promoted, and respect and dignity are honoured.

Acknowledges that patients and staff who face domestic abuse may experience multiple concurrent disadvantages; domestic abuse may not be the only adverse experience they have experienced or are experiencing. Refer to the [AVA's Complicated Matters Toolkit](#) for further information if needed.<sup>177</sup>

Outlines your organisation's training strategy for staff including what level of training is mandatory for which staff, how often staff should attend training, and the intended impact of that training.

Outlines how staff domestic abuse training will be recorded and monitored, including impact of that training and whether it met the stated intention.

Outlines your organisation's commitment to ensuring all staff have access to a higher level of domestic abuse training should they want it, in line with NICE guidelines.

## 4. Risk Assessment and Safeguarding

Requirements for policy	RAG Rating
Includes guidance on which risk assessments should be used with patients and staff who disclose domestic abuse (e.g. DASH RIC, SPECS, Barnardos RIM) and which staff members should use them.	
Provides examples of safety plans that health staff can use with survivors and states that staff should work with other relevant agencies to create and maintain safety plans.	
Acknowledges that risk can change over time and thus needs to be monitored.	
Provides guidance on circumstances warranting additional assessments including carrying out a carer's assessment and links with other safeguarding policies.	
Requires an appropriate assessment of the impact of multiple disadvantage on the risks and safety of the survivor. Refer to the <a href="#">AVA's Complicated Matters Toolkit</a> for further information if needed. <sup>178</sup>	
States the responsibility to make patients and staff aware of the health practitioners' role in responding to domestic abuse, including limits to confidentiality, information sharing and referral processes.	
Acknowledges patient and staff autonomy and their right to make their own decisions. Where the mental capacity of the patient is affected, independent advocates should be used to aid decision-making.	

<sup>177</sup> Against Violence and Abuse (2018) *Complicated Matters: a Toolkit addressing domestic and sexual violence, substance use and mental ill-health*, accessed: <https://avaproject.org.uk/resources/complicated-matters/ava-toolkit-2018reprint/>

<sup>178</sup> Against Violence and Abuse (2018) *Complicated Matters: a Toolkit addressing domestic and sexual violence, substance use and mental ill-health*, accessed: <https://avaproject.org.uk/resources/complicated-matters/ava-toolkit-2018reprint/>

## 5. Record Keeping and Information Sharing

Requirements for policy	RAG Rating
<p>Outlines information sharing protocols, requirements and restrictions relating to patients/staff experiencing domestic abuse and perpetrators. This should include protocols relating to the sharing of information with:</p> <ul style="list-style-type: none"> <li>→ In-house Idva service, safeguarding team or Domestic Abuse Lead</li> <li>→ Marac</li> <li>→ Specialist services and Idvas who aren't employed by the Trust</li> <li>→ Social services</li> <li>→ Police</li> <li>→ Other external agencies that form part of the local coordinated community response.</li> </ul>	
<p>States that practitioners should always ask for consent to share information but should do so without consent if they believe a patient/staff member, adult, or a child is at risk of serious harm.</p>	
<p>Details what information practitioners should be recording in electronic medical records stating that any concerns regarding domestic abuse should be recorded regardless of whether the patient or staff member disclosed abuse.</p>	
<p>Details where information about domestic abuse should be documented including; where risk assessments should be stored, safe marking of health records with domestic abuse alert, consideration of who can access service user domestic abuse information (including cases involving staff members experiencing domestic abuse), safe places to document domestic abuse information confidentially.</p>	
<p>Outlines how information about domestic abuse should be documented including guidance on how to record safely and comprehensively (including dates, times, locations and any witnesses) and without judgment.</p>	
<p>States that practitioners should share data in line with current data protection regulations.</p>	

## 6. Engaging Perpetrators

Requirements for policy	RAG Rating
<p>States the importance of holding the perpetrator accountable for their actions.</p>	
<p>States that when engaging with perpetrators, practitioners should always act in the best interest of adult and child survivors. This includes:</p> <ul style="list-style-type: none"> <li>→ never sharing information with a suspected perpetrator or breaching confidentiality</li> <li>→ never suggesting couples counselling</li> <li>→ never relying on them for translation services</li> <li>→ never colluding with their controlling behaviour or compromising the safety of the survivor(s) in any way.</li> </ul>	
<p>Outlines the procedure for escalating concerns that a patient or staff member may be perpetrating domestic abuse with links to safeguarding procedures.</p>	
<p>Explicit reference to Respect guidance around safely engaging perpetrators.<sup>179</sup></p>	

## 7. Staff as Survivors or Perpetrators

Requirements for policy	RAG Rating
<p>Recognises the importance of economic independence for survivors and domestic abuse as a workplace issue.</p>	
<p>Emphasises prioritisation of safety and health over work efficiency.</p>	
<p>Recognises how domestic abuse can affect a survivor's ability to work and awareness of potential indicators that an employee is experiencing domestic abuse.</p>	
<p>Recognises the impact of domestic abuse upon the survivor and perpetrator's work colleagues and employers.</p>	
<p>Acknowledges the statutory responsibilities of employers in tackling domestic abuse.</p>	
<p>Includes a clear statement on the organisational commitment to tackling domestic abuse.</p>	
<p>Provides guidance on the role and responsibilities of each department in supporting staff who are experiencing or perpetrating domestic abuse.</p>	
<p>Includes clear information on the measures that can be taken to support employees experiencing domestic abuse in the workplace including a template work safety plan.</p>	

<sup>179</sup> Respect (20008) Domestic Violence Working with perpetrators – A guide for Healthcare Professionals. Accessible: <https://respectphoneline.org.uk/wp-content/uploads/2017/01/Working-with-perpetrators-A-guide-for-Healthcare-Professionals.pdf>

Includes guidance on conducting risk assessments with employees including who should be expected to undertake the risk assessment in a consistent and safe way.

Includes details of various staff members who are Domestic Abuse Champions and can provide support for colleagues experiencing domestic abuse outside of line managers or HR.

Includes guidance on the process for responding to survivors and perpetrators who both work for the Trust.

Includes documented pathways to support (including key external agency contact details) which consider intersectional needs.

## Staff Roles and Responsibilities

### Chief Executive / Foundation Trust Board

- Show leadership and commitment, including reference to domestic abuse in keynote speeches, staff communications (written, webinars, other), conferences
- Allocation of resources to ensure policy compliance
- Ensure managers are aware of their responsibilities and compliance with policy
- Enable survivor employees to feel supported, and perpetrators addressed

### Chief Nurse

- Operational implementation of domestic abuse policies
- Updating the Trust Board if domestic abuse policy is not adhered to

### Executive Directors, Directors, Non-Executive Directors and Associate Directors

- Ensure that all relevant service specifications drawn up include service stand-ards for domestic abuse

### Operational Managers (Including Service Directors and their Deputies, Team Leaders and Senior Nurses)

- Demonstrate leadership, be informed about and take responsibility for the actions of their staff around identifying and managing domestic abuse
- Ensure that responsibilities around domestic abuse are identified in appraisal and Personal Development Plans
- Ensure that services are provided in a way that ensures a safe environment for children and young people and minimises any risks, informing the named professionals of investigations into clinical incidents where domestic abuse is a theme
- Ensure that staff are familiar with policies and guidelines surrounding domestic abuse
- Ensure that staff make accurate and comprehensive healthcare records where domestic abuse is identified in line with clinical record keeping policies
- Ensure that staff access domestic abuse training appropriate to their role

### Lead/Named Professionals for Safeguarding

- Embed separate domestic abuse training within their safeguarding curriculum
- Fostering multi-agency working within local health and social care

### Health Based Idva

- Offer direct support to survivors (including staff) and their families within the hospital
- Support staff to risk assess and respond appropriately to domestic abuse
- Attend local Maracs where appropriate/possible for high risk information sharing
- Embed referral pathways and raise awareness of domestic abuse and the Idva role within the hospital

### Domestic Abuse Coordinator

- Have strategic oversight of the domestic abuse work through engaging with internal and external stakeholders, monitoring domestic abuse data, and ensuring policies and procedures are in place and adhered to
- Support the delivery of domestic abuse training for staff
- Provide domestic abuse expertise and support to the Trust
- To coordinate the implementation, supervision, training and professional development of the Domestic Abuse Champions Network
- To work with Domestic Abuse Champions to ensure domestic abuse resources are available throughout the Trust

### Multi Agency Risk Assessment Conference (Marac) Representatives

- Undertake appropriate training as identified by the Trust
- Responsible for attending Maracs local to the Trust, soliciting and disseminating information, offering advice to staff regarding high risk cases and liaising with the Trust Idva on high risk cases. See SafeLive's [Toolkit for Marac Reps](#).

### Human Resources

- Managers to ensure appropriate domestic abuse training is provided to HR staff – to safeguard against poor management of performance related issues where domestic abuse could be the underlying cause
- Offer informed, confidential advice to staff experiencing domestic abuse
- Support staff wellbeing and safety both at work and home
- Appropriate response if a staff member is perpetrating abuse against another staff member or other individual within the hospital setting (may need a [LADO](#) referral)

### Ward/Line Managers and Matrons

- Ensure their teams receive domestic abuse training appropriate to their individual role
- Offer swift HR and Occupational Health referral to staff members experiencing domestic abuse
- Provide support to staff receiving domestic abuse disclosures
- Nominate a proportionate number of Domestic Abuse Champions in their clinical areas



### Domestic Abuse Champion Role

- Act as a lead within the department; providing advice to staff on specific domestic abuse cases, engaging with the Domestic Abuse Champion Network Trust-wide
- Ensure pathways and resources are accessible to staff and correct documentation of domestic abuse cases
- Liaise with line managers/Matrons to ensure, where possible, at least one Champion is available in each shift in high risk areas (Maternity, Sexual Health, Emergency Medicine, Mental Health)

### All Staff

- All staff have a responsibility to be aware of domestic abuse and the pathways and specialist resources to respond to it effectively

# Appendix 8: Domestic Abuse Policy Template

## X NHS Trust Domestic Abuse Policy and Guidance

### Purpose

This policy sets out the X Trust position concerning the issue of domestic abuse. Domestic abuse infringes fundamental human rights as recognised in the United Nations Convention and is a major health issue, affecting people from all walks of life, across all ages, ethnic groups and socio-economic classes. The effects of domestic abuse are far reaching with numerous significant health, psychological and social impacts for both adults and children who have experienced relationships with an abuser<sup>1</sup>.

This policy provides guidance for all Trust staff, students and volunteers on initiating questions about domestic abuse within the context of their holistic assessment and undertaking [routine/selective enquiry](#) [\[delete as appropriate\]](#). The policy outlines a standardised approach within the assessment and management of domestic abuse. It sets out three minimum standards:

1. Patients should be asked about their experiences of domestic abuse.
2. Information regarding domestic abuse must be recorded in patient health records.
3. Appropriate action must be taken in all cases where domestic abuse is identified.

A helpful mnemonic for remembering the key steps to take when responding to domestic abuse is:

#### A – Ask

#### V – Validate

#### A – Assess

#### A – Action

#### These steps are outlined within the policy.

Health staff can make a significant difference to the health and quality of life for individuals experiencing domestic abuse by recognising that responding to domestic abuse is a process rather than an act. Everyone has a role to play in this process. **Responding to domestic abuse requires a coordinated approach, working with other agencies in supporting and providing options for survivors of domestic abuse and accountability for perpetrators to ensure the best interventions are planned and implemented.** The health service on its own cannot meet all of the needs of individuals experiencing domestic abuse or respond to perpetrators of abuse, but it is uniquely placed to play a pivotal role in the identification, assessment and response process to domestic abuse.

X Trust recognises the need to identify domestic abuse and ensure that all interventions are timely and proactive. This document is not a substitute for face-to-face training or broader systems change work. It is meant as a guide to optimise the identification of and response to domestic abuse. All staff are expected to complete relevant training as required by their role within the Trust.

<sup>1</sup> Department of Health, Responding to Violence against women and girls – the role of the NHS. London, Department of Health, 2010

## Training

X Trust acknowledges the importance of training which equips staff to carry out this policy in an effective manner, that is training which increases knowledge, skill, confidence and motivation. The Trust domestic abuse training offering is as follows:

[Detail here; the content of and levels of training available, who provides the training, when/where/how often it can be accessed, which members of staff are expected to attend training and levels required according to their role, how training will be recorded and monitored, what the intended impact is].

For staff members with specialist roles such as Safeguarding Leads, Domestic Abuse Coordinators, Idvas, Marac representatives and Domestic Abuse Champions, ongoing professional development opportunities will be provided through the following routes:

[Detail here the commitment the Trust makes in terms of time, resources and funding for staff with specialist roles].

### Key points of the policy

- All members of staff have a responsibility to identify and respond to domestic abuse
- People presenting to frontline staff with indicators of possible domestic abuse are asked about their experiences in a private discussion
- People experiencing domestic abuse receive a response from level 1 or 2 trained staff
- Responses to domestic abuse should put safety first and include safety planning
- People experiencing domestic abuse are offered a referral to specialist support services
- People who disclose that they are perpetrating domestic abuse are offered a referral to specialist services. If accredited

frontline services for perpetrators are not available locally, a referral should be made to the Respect national helpline.

- Domestic abuse should be discussed regularly in staff meetings and supervision so that all staff members feel confident in responding to the issue.

Insert here details of policy lead, ratifying committee or group, status of policy, date due for review and reference number.

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Addendum II: Example Flow Chart of the Trust Response to Domestic Abuse

## 1. Scope

This policy applies to all clinical and non-clinical staff whether registered, unregistered, bank, temporary, locum staff and those on honorary contracts. It applies to all staff employed directly or indirectly by X Trust, including students, volunteers and those on temporary contracts, secondments or other flexible working arrangements.

## 2. Responsibilities

See the 'Staff Roles and Responsibilities' Section in Appendix 7: Domestic Abuse Policy Assessment Tool of the Pathfinder Toolkit for a suggested list of roles and responsibilities.

## 3. Definitions

The agreed United Kingdom HM Government definition of Domestic Abuse is:

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

- psychological
- physical
- sexual
- financial
- emotional

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

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

This definition, which is not a legal definition, includes so called 'honour' based abuse, female genital mutilation (FGM) and forced marriage, and victims are not confined to one gender or ethnic group."

This is not a legal definition since there is currently no specific offence of 'domestic abuse' under '**criminal law**', but many forms of domestic abuse **are** crimes.

The main characteristic of domestic abuse is that the behaviour is intentional and is calculated to induce fear, misuse power and to control how the survivor thinks, feels and behaves. The past legal and cultural understanding of domestic abuse has been too narrowly focused on single physically violent incidents rather than complex and controlling patterns of behaviour. These patterns can endure after a relationship has notionally 'ended', for example through economic abuse, child contact disputes and stalking and harassment.

It is recognised that the desire to exert power and control in family, domestic and intimate relationships underpins the majority of domestic abuse which takes place and that abuse is usually inflicted to achieve this end.

### Definition of Domestic Abuse With Regards to Adult Safeguarding

The Statutory Guidance issued under the Care Act published in October 2014 (amended in 2016), states that adult safeguarding 'means protecting an adult's right to live in safety, free from abuse and neglect (Section 14.7). Safeguarding duties apply to an adult who:

- Has need for care and support (whether or not the authority is meeting any of those needs).
- Is experiencing, or is at risk of, abuse or neglect.
- As a result of those care and support needs is unable to protect themselves from either the risk of, or experience of abuse or neglect (Section 14.2).

Domestic abuse is therefore categorised as one of the types of abuse perpetrated against adults 'at risk' (please see the Adult Safeguarding policy for further information).

## 4. Terminology

The terms 'domestic violence' and 'domestic abuse' are often used interchangeably but 'domestic abuse' is felt to be a more inclusive way to describe a range of behaviours which include violence as well as other forms of abuse.

When referring to people experiencing domestic abuse the terms 'victim' or 'survivor' are often used interchangeably. In Marac meetings both terms are used and the person is recorded as the V/S (victim/survivor). It is always best to be guided by the preferred terminology of those affected.

The term 'Intersectionality' was created by Professor Kimberlé Williams Crenshaw and refers to a theoretical framework for understanding how aspects of one's social and political identities (gender, race, class, sexuality, ability, etc.) might combine to create unique modes of discrimination. An intersectional approach also recognises that historic and ongoing experiences of discrimination will impact on a woman's sense of trust. It is therefore the responsibility of the organisation to ensure that a sensitivity to the gendered dynamics of domestic abuse and other forms of VAWG does not ignore other areas of inequality that a woman may encounter. An effective, intersectional approach is not limited to interactions with individual women, but should be at the core of each aspect of an organisation's work, from governance through to evolution. An intersectional approach should be at the heart

of an organisation's broader commitment to anti-discriminatory practice<sup>2</sup>. X Trust therefore commits to taking an intersectional approach in its response to the issue of domestic abuse.

The term 'multiple disadvantage' refers to those people who face multiple and intersecting inequalities including gender based violence and abuse, substance use, mental ill health, homelessness, being involved in the criminal justice system and the removal of children<sup>3</sup>. Mainstream support services have proven ineffective in responding to people facing multiple disadvantage, who find themselves struggling to navigate a 'maze' of services that are overly complex, inflexible and insufficiently coordinated to meet their needs<sup>4</sup>. A high proportion of survivors experience multiple disadvantage and as such X Trust commits to taking into account the needs of those experiencing multiple disadvantage into the response to the issue of domestic abuse. The Trust also recognises that no postcode, level of income or educational attainment provides immunity from domestic abuse, and will ensure it makes no assumptions about who can be a victim, or a perpetrator.

## 5. Links to Legislation and Other Policies

This policy is supported by (amongst others) the following pieces of UK legislation, listed chronologically;

- Health and Safety at Work. Act 1974
- Family Law Act 1996
- Protection from Harassment Act 1997
- Crime and Disorder Act 1998
- Data Protection Act 2018
- The Human Rights Act 1998
- Female Genital Mutilation Act 2003
- Sexual Offences Act 2003
- Domestic Abuse Crime and Victims Act 2004
- Children Act 1989 (amended 2004)
- Safeguarding Vulnerable Groups Act 2006
- Equality Act 2010
- Care Act 2014 and Statutory Guidance
- Serious Crime Act 2015

This policy is also in line with the following Trust policies:

[Insert other relevant Trust policies here]

## 6. The NICE Quality Standards for Domestic Violence and Abuse (2016)

In Feb 2016, NICE issued a 'Quality Standards' paper on domestic violence and abuse stating that:

**'Multi-agency partnership working at both an operational and strategic level is the most effective approach for addressing domestic violence and abuse. Training and ongoing support from within an organisation are also needed for individual practitioners. Without training in identifying domestic violence and abuse and responding appropriately after disclosure, healthcare professionals may fail to recognise its contribution to a person's condition and to provide effective and safe support'.**

The four quality statements within the NICE guidance are:

- People presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion
- People experiencing domestic violence and abuse receive a response from level 1 or 2 trained staff
- People experiencing domestic violence or abuse are offered referral to specialist support services
- People who disclose that they are perpetrating domestic violence or abuse are offered referral to specialist services.

This policy references and adheres to these quality statements.

2 Imkaan, Rape Crisis England and Wales, Respect, SafeLives and Women's Aid (2016) Sector Sustainability Shared Standards  
 3 AVA, n.d. Multiple Disadvantage – AVA – Against Violence and Abuse. [online] AVA – Against Violence and Abuse. Available at: <<https://avaproject.org.uk/ava-services-2/multiple-disadvantage/>> [Accessed 3 April 2020].  
 4 SHP, n.d. About Multiple Disadvantage. [online] Single Homeless Project. Available at: <[www.shp.org.uk/flic-multiple-needs](http://www.shp.org.uk/flic-multiple-needs)> [Accessed 3 April 2020].



## 7. The Policy

Domestic abuse is widespread – statistics show that at least 29% of women and 13% of men aged 16 to 59 in England and Wales have experienced domestic abuse<sup>5</sup>. However it is important to note that data gathered in surveys often does not take into account important information around context such as who the repeat victims are and whether or not the abuse created fear. When these factors are accounted for, the gendered nature of domestic abuse becomes more apparent (please see 'Domestic Abuse is Gendered' below for more information)<sup>6</sup>.

X Trust acknowledges that domestic abuse is part of a wider spectrum of Violence Against Women and Girls (VAWG) which includes (but is not limited to); sexual violence and harassment, forced marriage, so called 'honour-based abuse', sexual exploitation and female genital mutilation. One study shows that 21% of women accessing specialist BAMER (Black, Asian, Minority Ethnic and Refugee Survivors) domestic abuse services had experienced forced marriage<sup>7</sup>, and estimates from FORWARD (Foundation for Women's Health and Development), show that 60,000 girls under 15 are at risk of FGM in the UK<sup>8</sup>.

### a. Domestic Abuse is Gendered

Whilst both men and women can experience domestic abuse, women are at greater risk of homicide vs. men. In 2016, 44% of female homicide victims were murdered by their partner/ex-partner compared with 6% of male victims<sup>9</sup>. Research informs us that in terms of scale, scope and range of abusive behaviours used in addition to the repeat pattern of abuse, this is a crime in which the majority of perpetrators are male and survivors/victims are female<sup>10</sup>.

Two women a week are killed each year in England and Wales and an estimated 19 per year in London by a male partner or ex-partner. However, thirty men each year are also killed by a perpetrator of domestic abuse, two-thirds of whom are other men<sup>11</sup>. This may be a same-sex partner, sibling or young/adult child.

### b. Domestic Abuse Occurs in Same-Sex Relationships

Lesbian and bisexual women experience domestic abuse at a similar rate to heterosexual women (29.9%), although a third of this is associated with male perpetrators<sup>12</sup>. 49% of gay and bisexual men have experienced at least one incident of domestic abuse since the age of 16<sup>13</sup>.

### c. Domestic Abuse is a Safeguarding Children Risk Factor

In the UK around 1 in 5 children have experienced domestic abuse<sup>14</sup>. In households where domestic abuse is occurring – and where children are present – the likelihood is that the children are in the same or the next room<sup>15</sup> (90% of cases). Where domestic abuse is persistent within relationships, children are likely to be affected whether they are present or not (the threat or expectation of abuse and/or control will be ever present and lead to hyper vigilance and heightened threat responses).

Experiencing domestic abuse leads to increased likelihood of behavioural or emotional problems for children<sup>16</sup> and is identified as a source of 'significant harm' for children<sup>17</sup>.

Within this context, it is essential for health professionals to have an understanding of the inter-relationship which frequently exists between domestic abuse of an adult and the abuse and neglect of children. The guidance on safeguarding children states:

**"Where there is evidence of domestic abuse, the implications for any children in the household should be considered, including the possibility that the children may themselves be subject to abuse 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 abuse within the family".**

Please refer to X Trust Safeguarding Children and Young People Policy and Working Together to Safeguard Children (2018) if you have any concerns or suspicions about the welfare of a child/young person that is under the age of 18 years, including any unborn children. Further information on assessment and referral procedures for safeguarding children in the context of domestic abuse can be found later on in the policy. In doing so, consider how you will provide a response that is as holistic as possible, taking into account where responsibility for harmful behaviour lies.

### d. Domestic Abuse and Health Mental Health

Domestic abuse has significant health consequences for adult and child survivors which can include; anxiety, depression, suicidal behaviour, low self-esteem, inability to trust others, flashbacks, sleep disturbances and emotional detachment<sup>18</sup>. Women and men with mental health disorders – including depression, anxiety, post-traumatic stress disorder, eating disorders and psychotic illnesses – are more likely to be victims of domestic and sexual violence than are those in the general population<sup>19</sup>. Research also demonstrates that 77% of women accessing domestic abuse services in England and Wales have suffered from PTSD in addition to high levels of depression and anxiety – all of which were positively correlated to the severity of abuse experienced<sup>20</sup>.

5 Domestic abuse: findings from the Crime Survey for England and Wales – Office for National Statistics [Internet]. Ons.gov.uk. 2018 [cited 29 May 2020]. Available from: [www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2018#prevalence-of-domestic-abuse](http://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2018#prevalence-of-domestic-abuse)

6 Women's Aid, n.d. How Common Is Domestic Abuse? – Womens Aid. [online] Women's Aid. Available at: [shorturl.at/ELMN3](http://shorturl.at/ELMN3) [Accessed 3 April 2020].

7 Thiara, R and Roy, S (2010) Vital Statistics: The experiences of BAMER women and children facing violence and abuse (IMKAAN).

8 <http://forwarduk.org.uk/key-issues/fgm/>

9 ONS, 2015. Violent crimes and Sexual offences. [www.ons.gov.uk](http://www.ons.gov.uk) [accessed 8th February 2017]

10 Hester, M. Who Does What To Whom? Gender and Domestic Violence Perpetrators in English Police Records (European Journal of Criminology, 2013 10: 623-637), pp. 627-628.

11 Povey D (ed), 2005. Crime in England and Wales 2003/2004: supplementary volume 1: Homicide and gun crime. Home Office Statistical Bulletin. No 02/05. London: Home Office

12 Hunt R, Fish J.2008. prescription for change: lesbian and bisexual women's health check. London: Stonewall

13 Stonewall Health Briefing 2012. [www.stonewall.org.uk/sites/default/files/Domestic\\_Abuse\\_Stonewall\\_Health\\_Briefing\\_\\_2012\\_.pdf](http://www.stonewall.org.uk/sites/default/files/Domestic_Abuse_Stonewall_Health_Briefing__2012_.pdf) [Accessed 9th February 2017]

14 Radford, L. et al. (2011) Child abuse and neglect in the UK today. London: NSPCC

15 Abrahams, C. (1994) The Hidden Victims: Children and Domestic Violence. London: NCH Action for Children

16 Humphreys, C. (2006) Relevant evidence for practice (chapter 1 in C. Humphreys and N. Stanley (eds.) Domestic violence and child protection: directions for good practice.)

17 Adoption and Children Act 2002

18 Safelives (2015), Getting it right first time: policy report. Bristol: Safelives

19 Trevillion K, Oram S, Feder G, Howard LM. Experiences of domestic violence and mental disorders: a systematic review and meta-analysis. PloS one 2012; 7(12): e51740.

20 Ferrari G., Agnew-Davies R., Bailey J., Howard L., Howarth E., Peters T.J., Sardinha L., Feder G.S. Domestic violence and mental health: A cross-sectional survey of women seeking help from domestic violence support services. Global Health Action, 8 February 2016 (29890), 1654–9716

**Physical Health**

Physical health implications from domestic abuse are common, wide ranging and can be short-lived or long-lasting. These can include (but are not limited to): broken bones, sprains, cuts, bruises, burns, digestive issues, eating problems, chronic pain of the back/ neck/ abdomen/ stomach/ genital area, headaches, fainting, seizures, unexplained rashes, hypertension and hearing loss. Research has also found that women who experience domestic abuse are at an increased risk of developing cardiometabolic diseases such as cardiovascular disease and type 2 diabetes. The same research has shown that women who have experienced domestic abuse appear to be 40 per cent more likely to die from any cause compared to the general population<sup>21</sup>.

**Sexual Health**

Many survivors experience sexual health and reproductive problems as a result of domestic abuse. These can include: urinary tract or vaginal infections, sexually transmitted infections, sexual dysfunction, delayed pregnancy care, miscarriage, premature labour, stillbirths, multiple unintended pregnancies or terminations, frequent kidney or bladder infections, pelvic pain and vaginal bleeding<sup>22</sup>. It is important that domestic abuse is routinely asked about in sexual health and maternity services.

**e. Domestic Abuse Is Indiscriminate**

Domestic abuse occurs irrespective of ethnicity, religion, class, age, sexuality, disability or lifestyle. However, there are groups of people within the population who current data has identified as more vulnerable.

These include:

- Pregnant women (for 30% of women who experience domestic abuse, the first event occurs during pregnancy<sup>23</sup>)
- New mothers
- Older people (age 55+)
- Teenagers
- Disabled people (twice as many disabled women have experienced domestic abuse compared to non-disabled women<sup>24</sup>)
- Where there are additional barriers to disclosing, reporting or accessing support (e.g. LGBT+ communities, women with no recourse to public funds, language barriers, cultural isolation)

**f. Identifying Domestic Abuse**

All health professionals need to be aware of what domestic abuse is and how it could present in a healthcare setting. The Power and Control wheel (see below) is a tool that can help staff understand and recognise patterns and examples of abusive behaviours used by perpetrators to establish and maintain power and control. Ideally this would be used following training on domestic abuse wherein staff are taught about how the wheel was created and how it can be used within their roles.



DOMESTIC ABUSE INTERVENTION PROGRAMS  
202 East Superior Street  
Duluth, Minnesota 55802  
218-722-2781  
www.theduluthmodel.org

For access to the Power and Control wheel in other languages and other useful wheels (such as the Equality Wheel) please see: [shorturl.at/imrv9](http://shorturl.at/imrv9).

In addition to understanding patterns of abusive behaviour, healthcare staff must also be alert to the possible indicators of domestic abuse in a healthcare setting. Please see Table 1 below for a list of potential indicators of abuse. This is not an exhaustive list and staff should always be aware that survivors of domestic abuse may present in a variety of ways. None of these indicators are absolute

evidence that abuse has occurred but staff should always be alert to the possibility of domestic abuse and take this into consideration when assessing the needs of the patient, employee or visitor.

21 Singh Chandan et al. (2020) 'The Risk of Cardiometabolic Disease and All-Cause Mortality in Female Survivors of Domestic Abuse' is published in the Journal of the American Heart Association, DOI: 10.1161/JAHA.119.014580  
 22 NICE Guidance  
 23 McWilliams, M. and McKiernan, J. (1993) Bringing it out into the open  
 24 Mirrlees-Black, C. (1999) Domestic Violence: Findings from a New British Crime Survey Self-Completion Questionnaire. London, HMSO



**Physical Indicators    Emotional Indicators    Behavioural Indicators    Indicators of Control**

<p>Common types of injury include:</p> <ul style="list-style-type: none"> <li>→ Bruising</li> <li>→ Broken bones</li> <li>→ Burns or stab wounds</li> <li>→ Chronic pain</li> <li>→ Hearing loss</li> <li>→ Injuries inconsistent with explanation of cause</li> <li>→ Multiple injuries at different stages of healing</li> <li>→ Injuries to the breasts or abdomen</li> </ul> <p>Physical symptoms related to stress</p> <ul style="list-style-type: none"> <li>→ Self-harming behaviour</li> <li>→ Tiredness</li> <li>→ Poor nutrition</li> <li>→ Cause or worsen: Asthma, Epilepsy</li> <li>→ Unexplained chronic gastrointestinal symptoms</li> <li>→ Migraine</li> <li>→ Hypertension</li> <li>→ Skin disorders</li> <li>→ Cognitive problems</li> </ul> <p>Symptoms related to sexual health:</p> <ul style="list-style-type: none"> <li>→ Recurrent sexually transmitted infections</li> <li>→ Recurrent urinary tract infections</li> <li>→ Pelvic pain and sexual dysfunction</li> <li>→ Repeated miscarriage or terminations</li> <li>→ Delayed pregnancy care, premature labour and stillbirth</li> <li>→ Vaginal bleeding</li> </ul>	<ul style="list-style-type: none"> <li>→ Repeat presentation with depression, panic, anxiety, self-harm or psychosomatic symptoms</li> <li>→ Attempts or plans to attempt suicide</li> <li>→ Feelings of dependency</li> <li>→ Sleep disturbances</li> <li>→ Anger</li> <li>→ Guilt</li> <li>→ Loss of self-confidence</li> <li>→ Loss of hope</li> <li>→ Eating disorders</li> <li>→ Fear</li> <li>→ Low self-worth</li> <li>→ Feelings of isolation</li> <li>→ Post-traumatic stress disorder</li> <li>→ Increasing likelihood of misusing drugs, alcohol or prescribed antidepressants</li> <li>→ Patient appears frightened, overly anxious or depressed</li> </ul>	<ul style="list-style-type: none"> <li>→ Patient is reluctant/ afraid to speak in front of partner or family member</li> <li>→ Partner or family member is aggressive or dominant, talks for the patient or refuses to leave the room</li> <li>→ Partner or family member always attends unnecessarily</li> <li>→ Frequent attendance</li> <li>→ Frequently missed appointments.</li> <li>→ Non-compliance with treatment</li> <li>→ Early self-discharge from hospital</li> </ul>	<ul style="list-style-type: none"> <li>→ Non-compliance with treatment</li> <li>→ Frequent missed appointments</li> <li>→ Patient has limited access to money, including for things like transport, food etc.</li> <li>→ Patient tries to hide injuries/signs of abuse or minimise their extent</li> </ul>
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**g. Asking Enquiry into Domestic Abuse**

Health services are considered a priority setting in which to enquire about domestic abuse. NICE guidelines (2016) reiterate this and recommend that services have a focused approach to undertaking enquiry about domestic abuse. Enquiry can be undertaken either routinely (all patients/service users are asked) or selectively (patients/service users are only asked when they present with possible indicators – please see table 1 above). It is Department of Health and Social Care policy that routine enquiry is undertaken in maternity, mental health and sexual health services. Selective enquiry should be undertaken where routine enquiry is not. Therefore, in X Trust routine/selective [please select as appropriate] enquiry is undertaken as follows: [detail where routine and selective enquiry are undertaken at your Trust].

Research shows that those not experiencing domestic abuse do not mind being asked about it and for those experiencing domestic abuse enquiring in an effective way can provide an opportunity to disclose.

Results from a study carried out at Guy’s and St Thomas’ GUM clinic<sup>25</sup> demonstrated that:

- Survivors of domestic abuse reported that they expected health professionals to ask about domestic abuse
- Most people are not offended if asked
- A health professional may be the first/only point of contact for someone experiencing domestic abuse
- People experiencing domestic abuse have increased contact with health services

The person perpetrating the abuse is referred to as the perpetrator or alleged perpetrator. When talking to survivors it is best to refer to the perpetrator using the same terms as they themselves use.

**Phrasing the Question and When to Ask**

Where appropriate, enquiry about domestic abuse should first be undertaken during an initial assessment across all services. **Staff should ensure that they ask only when they are alone with the patient.** The presence of a partner or relative may constrain discussions or increase risk, therefore ensure that no family member, partner or friend is present in the room (including children over 2 years old). Where the staff member and patient don’t speak the same language an independent interpreter should be used. **Family members, partners or friends should not be used as interpreters.** Questions should be asked in a sensitive, supportive manner.

It is essential to understand that survivors’ experiences of abuse are traumatic, and to ensure that enquiry is trauma-informed. When thinking about when and how to ask, practitioners should consider how they make a person feel safe and comfortable in a room – ask if they want to sit or stand and where they want a chair to be, explain and show them how you are recording information and show them the forms or your computer screen, also be clear on how information will be shared. When someone does disclose, thank them for trusting you, showing empathy is vital. Trauma-informed practice is about working with someone and offering choice and support where you can so that they feel involved in the processes and clear on what is being asked and why.

If a staff member has noticed potential indicators of domestic abuse but it is not safe to ask, they should document why the question hasn’t been asked, what their concerns are and then organise a follow up appointment to create a safe opportunity to enquire as a matter of urgency.

25 Loke WC, Bacchus L, Torres C, et al (2008) Domestic violence in a genitourinary medicine setting – an anonymous prevalence study in women. Int J STD AIDS;19:747-751



Staff may need to adapt specific questions to suit the patient's circumstances or situation. They may be incorporated into a structured (risk) assessment where there are already, for example, questions about risk of violence to self, others and from others.

The following are examples of framing or introducing the question:

- Because domestic abuse is so common, I always ask patients about it.
- Because domestic abuse has so many effects on physical health and mental health, it is Trust policy to ask patients about it.
- From past experience with other patients, I'm concerned that some of the symptoms related to your physical/mental health may be the result of someone hurting you.

A framing question should be followed up with a more direct question:

- Do you ever feel frightened by your partner or other people at home? Or people within your close network who may not live with you?
- Do you feel safe at home?
- Has a partner/family member ever threatened to harm you or others including any children?
- Have you ever been prevented from leaving the house, seeing friends, getting a job or continuing in education?
- Is there anyone who restricts your access to finances, prevents you from going to work, stops you from contacting others?
- Do you think you are in immediate danger?

Health professionals should not automatically assume that a negative response indicates the absence of abuse. Experiences may often be minimised or not yet be defined as abuse, particularly in the absence of physical violence. In addition, there are many barriers that survivors face in disclosing the abuse they're experiencing. These could include: fear of increased risk if the perpetrator finds out, fear of having children removed, shame/embarrassment, fear of not being believed, previous bad experiences of disclosing or belief in the perpetrator's promises of change. Victim/survivors may also face additional barriers to disclosing and accessing support due to institutional discrimination based on their protected characteristics (e.g. racism) or their experience of multiple disadvantage. If someone is not ready or chooses not to disclose, this should be respected unless the patient is at high risk of harm or there are safeguarding concerns (for themselves or others, including children in which case follow Adult/Children safeguarding procedures). An affirmative response might well be received at a later date. It is important to continue to revisit discussions around domestic abuse – particularly if any of the risk indicators remain.

When asking the question, it is important to remember to explain the limits of confidentiality and reassure the patient/service user that if their situation does need to be discussed with others, that they will be informed who it is and the purpose of the information sharing (see the Confidentiality and Information Sharing section below for more information).

#### Provision of Information

Asking questions should be coupled with provision of information – information should be discreet and in some circumstances may simply involve leaving the contact number of the assessor. Always ask the patient whether they would like information and consider whether it is safe to leave information about domestic abuse amongst other materials with them.

#### h. Validation

##### Disclosure by the Survivor

Practitioners should be supportive and non-judgemental when a disclosure has been made. Those who experience domestic abuse may not have spoken to anyone about their experiences and may be particularly wary of the potential involvement of statutory services. Women who do eventually disclose their experience of abuse typically describe a history of long-standing and escalating violence/abuse.

It is extremely important when a disclosure is made that the survivor feels validated (listened to and believed). **They should be informed that they have the right to live free from violence and abuse and that the abuse is not their fault.** It is also important not to focus exclusively on the presenting symptoms without acknowledging the cause (where the cause is likely to be abuse). Survivor's self-help behaviours, autonomy and independence should be respected and their dignity honoured.

Examples of validating statements include:

**"It's really good that you have been able to say this to me today, it's not okay that someone is treating you like this. This is not your fault and we're here to help and support you. I'm now going to ask you a few more questions, to see how best we can help you."**

#### i. Assessing

##### Managing Disclosures

When a disclosure of domestic abuse is made, a risk assessment needs to be carried out to determine the level of risk and protection plan. This would be the same as with a disclosure of any new information which may present a risk to patients or to others.

##### Assessing Immediate Risk – Urgent Response

In order to assess immediate risk, staff must consider the following questions:

- Is it safe for the patient to return home today?
- Do staff or the patient have any immediate concerns?
- Are there any imminent threats to safety, including to that of any children or other persons?
- Does the patient have a place of safety?

If someone is believed to be at immediate risk, an urgent response must be actioned. In this instance staff must complete the following actions immediately:

- Consider the immediate needs and wishes of the patient ensuring you have attended to their medical needs.
- Inform your line manager/senior staff and seek support from a Safeguarding/Domestic Abuse Lead as appropriate. This may involve contact with Children's services (MASH, EDT), Adult Safeguarding services.

- Refer to your [co-located Independent Domestic Violence Advisor/local Idva service \[delete as appropriate\]](#) (see information below regarding Idva services) who can provide immediate safety planning. If the survivor does not agree to this support, encourage them to contact the Idva service themselves when they are ready to do so.
- Consider if immediate police involvement is required. This is likely to be a rare occurrence but must be considered if there is risk of serious harm or death to a person and immediate safety on leaving the building cannot be assured. It is best to seek the survivor's consent in this situation but is not needed where there is clear evidence of an imminent risk of serious harm to the individual and where there are no alternative and less intrusive methods of preventing harm. The police can also be contacted if the survivor wants to report the domestic abuse whilst attending the service.
- Consider if refuge or temporary accommodation is required. Idva services are often the most effective way of accessing refuge places if the survivor has agreed for contact to be made with them; an Idva will also be able to do detailed work to see if someone can stay safely in their own home. Contact details for national and local support services are listed below.
- Where possible, if immediate safety is at risk consider admitting the patient. Please see Addendum I for information on safety planning within Trust premises.

### Assessing the Ongoing Risk – Standard Response

A standard response should be completed with all survivors disclosing domestic abuse (if there is immediate risk, the standard response should be completed as soon as convenient following the immediate response).

Trust staff should always consider the level of risk to the survivor and any children or adults at risk in the home. Risk around domestic abuse is not static and may change over time. There are several means by which to assess risk:

1. Professional judgement should inform all risk assessments. Staff should consider whether the survivor is at high risk of further harm or death whilst taking into consideration the survivor's own perception of risk.

**SPECSSS** is a useful mnemonic to inform professional judgement. It references seven high risk indicators that have been identified from domestic homicide reviews:

- Separation
- Pregnancy
- Escalation of abuse
- Cultural and community factors (e.g. if the survivor is from a cultural background where so called 'honour-based' abuse, forced marriage or female genital mutilation might be present or there are factors which may serve as a barrier to accessing support including disabilities, immigration status, language barriers etc.)
- Stalking
- Sexual Assault
- Strangulation

Other examples of high-risk indicators are **threats to harm or kill**.

2. Carrying out a structured **X Trust** risk assessment should draw out some of the concerns in more detail with specific questions around the situation at home, threats of violence/controlling behaviour and whether the patient is fearful within any familial/intimate relationships.

3. The SafeLives domestic abuse, stalking and honour-based violence (DASH) risk indicator checklist (RIC) is an evidence-based risk assessment tool. Wherever possible, trained staff should use this tool following a disclosure of abuse. [Domestic Abuse Champions in the Trust are trained to use this tool \[delete if the Trust does not have a leads/champions network\]](#). This assessment tool can be found here and can also be used as a reference list to guide assessment. The tool includes guidance on its use but support in completing it is also available from [Trust Champions \[delete if not appropriate\]](#) and local safeguarding leads.

When carrying out assessments, consider the needs of those facing multiple disadvantage such as drug/alcohol addiction or mental health issues. Please refer to [AVA's Complicated Matters Toolkit](#) addressing domestic and sexual violence, substance use and mental ill-health which contains several suggested assessments which may be useful to carry out in this scenario.

For help with assessing risk, the following members of staff can be contacted [\[delete as appropriate\]](#):

[Details of how to contact the Trust Idvas can be found here:](#)

[Details of how to contact the local Safeguarding Lead can be found here:](#)

[Details of how to contact the local DAL/DA Champion can be found here:](#)

### j. Action

#### Actions Following Disclosure and Risk Assessment

Practitioners must be supportive to the survivor in the decisions that they choose to make. Never advise a survivor to leave their partner. It is important that an individual reaches their own decision on what they want to do and that if they do choose to leave that they are supported in doing this (ideally by a specialist organisation). **Separation is a time of increased risk for both the survivor and other family members.**

Staff should provide support and information on local and national support agencies in order to enable individuals to make a decision on what to do next. The Women's Aid Survivors Handbook (a link is available in the Support Services section at the end of this policy) is a useful guide on available support. Information on local support and Idva contacts are available at the end of this policy.

It is essential, at the point of disclosure, that staff assess the level of risk and need for immediate action. Following a disclosure, you should **immediately obtain safe contact details** for the survivor in case you are interrupted, called away, or in case they have to leave suddenly.

Staff can offer a range of support options to survivors and can take action themselves to support a survivor to remain safe. In considering survivor options the principal responsibility of staff is to support them to make their own decisions and choices (whilst also ensuring the safety and protection of other adults at risk and children).

**High-Risk:**

Refer to the Multi-Agency Risk Assessment Conference (Marac)

Referrals to the Marac are made for high-risk cases and on the basis of the following;

- **Professional judgement:** The 'SPECSSS' indicators listed in the policy assessment section above can help staff use their professional judgement to determine high risk cases.
- **Visible high risk:** The SafeLives DASH RIC listed in the policy assessment section has been completed and 14 'yes' ticks or more have been identified [the criteria for your local Maracs may be different and thus need to be checked] (more guidance available in the risk assessment). Professional judgement is always valid in using the DASH, as well as actuarial process.
- **The perpetrator's abuse appears to be escalating in frequency and/or severity.** Each Marac will have different criteria for an apparent escalation e.g. there have been four incidents by the same perpetrator on the same survivor in the last 12 months and they are increasing in severity or frequency.
- **Repeat:** Typically cases will only be discussed once at Marac as it is a multi-agency meeting rather than an organisation and so does not 'hold' cases. However, if a survivor has been discussed at Marac within the last year and there is an incident of physical/sexual violence, and/or pattern or stalking and harassment and/or threats to harm/kill, or ongoing risk, from the same perpetrator then the survivor must be automatically re-referred to the Marac.

Marac is a multi-agency meeting that convenes in each area (exact geography will vary) to provide safety planning for domestic abuse cases in which the perpetrator poses a high risk of serious harm or murder. The frequency and duration of a Marac will differ depending upon the area. Maracs are typically coordinated by the police or local Idva service but can be coordinated by other agencies and the full participation of all agencies is critical to seeing the full picture of the risk a perpetrator poses and what a safety plan needs to contain.

Staff from any agency can refer cases. Service users cannot self-refer. Consent of the survivor is preferred but not required for a Marac referral to be made given the level of risk to life which has been identified for a case to be referred. **The perpetrator of abuse should not be informed of the Marac referral.**

Agencies represented within the Marac forums usually include – police, probation, mental health, adult and children's social care, drug and alcohol services, housing, community health visitors, education and domestic abuse specialist support – the Idva.

Relevant and proportionate information is shared amongst the agencies present with a view to developing a multi-agency protection/action plan in order to increase the safety of the survivor(s) and their family and manage the behaviour of the perpetrator.

Any staff member can refer to the Marac in the area in which the patient/service user resides. Hence;

1. A Marac referral should be made to the area in which the survivor resides if they are an adult (16+) at high risk of domestic abuse from their adult (16+) partner, ex-partner or family member, regardless of gender or sexuality.

2. Sharing of information is further explained in the Department of Health and Social Care (2012) document 'Striking The Balance' Practical Guidance on the application of Caldicott Guardian principles to Domestic Violence and Maracs.

The seven Caldicott principles, with regards to the handling of **patient-identifiable** information, are:

- Justify the purpose(s) of every proposed use or transfer
- Don't use it unless it is absolutely necessary
- Use the minimum necessary
- Access to it should be on a strict need-to-know basis
- Everyone with access to it should be aware of their responsibilities, and
- Understand and comply with the law
- The duty to share information can be as important as the duty to protect patient confidentiality

For further guidance on sharing information without consent, see the SafeLives document 'The legal grounds for sharing information'<sup>26</sup>. Health staff have legitimate reasons to share information to protect the wellbeing of an adult or child. Relevant, timely and proportionate sharing of information has often been lacking in domestic abuse cases and the Trust recognises the need to support staff with this process.

If a staff member is unsure whether the case meets the Marac threshold, the Trust Marac representative(s) for the service/area, or the local Marac co-ordinator, can be contacted for advice. Contact details for Marac representatives can be found **XX** or by contacting a member of the Safeguarding team. Trust Marac representatives should receive training on the Marac process in order to properly fulfil the role, feel supported in that role, and to know how to handle Marac information appropriately.

If a staff member makes a referral then this will be presented at the Marac by a Trust Marac representative, who will also fully participate in other parts of the meeting. The representative can then feedback the actions from the meeting and the referring staff member can discuss them with the survivor (where safe). It is also possible for the team member making the referral to attend the Marac meeting in person where this seems more appropriate. Additional specialist expertise may also be useful in helping the Marac reach a fully informed decision about appropriate safety plans which meet the needs of the individual survivors.

Marac referrals should be sent from and to a secure email address and should cc in the Trust Idva/s where this provision exists. Trust based Idvas will also make Marac referrals and contribute information about those on the 'At Risk' list where appropriate. Information received through the Marac should be recorded in an appropriate place in patient notes. This can then be used to assess risk and safety-plan. Staff should be careful not to record confidential third party information in the patient records such as the criminal history of the perpetrator.



More detailed information on the Marac process, how to make referrals, referral forms and contact details for Marac representatives and coordinators can be found [here](#) [insert location for where this can be found in your Trust]. Refreshed guidance and information is also regularly posted on the SafeLives website and questions can be asked about Marac best practice through the online, free to use SafeLives Community.<sup>27</sup>

### Refer to an Independent Domestic Violence Advisor (Idva)

A referral to an Idva/domestic abuse service should be offered to all patients who disclose domestic abuse or where domestic abuse is identified. An Idva is independent from statutory agencies, such as the police or social care. They will work with survivors to assess the level of risk, discuss their options and support them to make safety plans. Idvas can support survivors with housing, criminal and civil options, benefits, counselling etc. Idvas are non-judgmental and non-directive with a goal of empowering a survivor to make their own decisions. **Idva's play an extremely important role in helping to keep survivors and their families safe whilst coordinating a multi-agency action plan.**

Unlike Marac referrals, survivors must consent to a referral to the Idva. Once consent is gained, the staff member should contact the Idva via telephone or email. Upon successful contact with a survivor, the Idva will complete a detailed risk assessment and safety plan and can work in liaison with staff to support the survivor. Survivors can also self-refer to Idva services. Local Idva contact details are available at the end of this policy.

Insert here any information about Health Based Idvas

### All Levels of Risk:

#### Provide Information and Refer to Services

If a survivor does not want support from an Idva and is not, at the time of assessment, considered to reach the threshold of 'high risk' (i.e. at serious risk of further harm or homicide), staff must still follow safeguarding procedures if there are children/other adults at risk, or if the survivor themselves is an adult at risk or under 18. Risks around this will need to be continually monitored. Idva services will often have other accompanying services such as outreach, counselling, and children's specialist workers, which may be suitable.

However, if there are no safeguarding concerns it is important that the survivor's wishes are respected. Staff members should let them know that they can revisit this discussion at any stage.

Staff should consider the following:

- Offer to make a direct referral to or provide information about local domestic abuse services or Trust-based Idvas including specialist services for survivors who are part of the BME or LGBT+ community or disabled (details included at the end of the policy)
- Provide the National Domestic Violence Helpline (details at the end of the policy)
- Give the survivor resources with numbers and information where it is safe to do so ([these resources can be found XX](#))
- Provide information about counselling services
- Provide details of local substance misuse services
- Carry out basic safety planning with the service user (a checklist of what to include in a safety plan can be found in addendum below)

- Share pertinent information with other relevant services in line with data protection legislation. See examples under 'Confidentiality and Information Sharing' below.

**Staff must always ensure it is safe for a survivor to take home any information or resources.**

### k. Assessment of Risk and Referral for Children and Young People

The risks to the survivor and any children in contact with them are increased at the time around separation and at subsequent 'contact'. The impact of domestic abuse on all ages of children (less than 18 years of age) must be considered including for young people experiencing abuse from their partners. Safeguarding Children Procedures must be followed in all cases where there may be a risk to their mental/physical health or development. **All children who experience persistent domestic abuse will be impacted (irrespective of whether they are perceived to be the direct target or not. Domestic abuse is child abuse). If you are unsure of the impact, discuss with a children's safeguarding lead.**

You must always refer to Children's Services where there is:

- a high risk to the adult survivor
  - any indication that the children have suffered or are at risk of suffering significant harm
- and where there is any level of risk plus:
- A pregnant woman
  - A baby aged less than one
  - A child who is disabled
  - The adult survivor does not have mental health capacity

### l. Carers Experiencing Domestic Abuse

In an analysis of 32 domestic homicide reviews (DHRs), 44% involved victims who were either cared for by perpetrators or were carers of perpetrators<sup>28</sup>. Within the Care Act 2014, carers are defined as a person that 'provides or intends to provide care for another adult' (but not as a volunteer or contracted worker). Many service users will either be carers or be cared for by family members. It should be noted that carers who are not partners or family members will not fall under the definition of domestic abuse (abuse should be addressed through safeguarding procedures). Staff should seek advice on how to support a survivor if:

- a patient discloses acting abusively towards a carer
- a carer discloses abuse from a patient
- a patient discloses abuse from a carer

### m. Survivor Discloses Sexual Abuse in a Domestic Abuse Context

If a patient, employee or family member discloses recent (in the previous 12 months) sexual abuse from an ex-partner, partner or family member, the above procedures should be followed. However, additional support can be offered through specialist sexual assault referral centres (SARCs) located across the country which provide 24 hour support.

If the sexual abuse occurred within the last week, a SARC can carry out forensic medical examinations of the survivor in order to gather evidence. Survivors can report to the police with medical samples or alternatively the samples can be stored at the SARC until they decide what they wish to do. This would always be with the consent of the survivor.

Staff can refer a survivor to a SARC directly or they can self-refer. More information and a locator to find your nearest SARC is [here](#).

If the sexual abuse is non-recent, then it can still be reported if the survivor wishes to do so. The website listed above provides information on support available for non-recent cases of sexual abuse for both survivors and friends/family members. Alternatively, discuss how to report non-recent sexual abuse with Safeguarding Children Leads.

#### n. Perpetrators

Data from Maracs and DHRs reveal that health services come into contact with a large proportion of domestic abuse perpetrators. The Trust's priority is to increase safety for survivors of domestic abuse and this necessarily involves working with perpetrators. Perpetrators, just like survivors, are individuals and go through different 'stages of change' in terms of readiness to accept responsibility for their own behaviour. Some will be open to the suggestion of seeking support for things they have done or think they might do. Others will be completely unwilling to accept responsibility.

Staff should be aware of potential indicators of abusive behaviour:

- Presenting with injuries consistent with perpetrating abuse
- Disclosures relating to issues of management of anger (although when explored these are usually directed to very specific people as opposed to uncontrolled anger).
- Witnessing controlling, highly manipulative, domineering or abusive behaviours (in clinic, waiting room etc)

A disclosure of domestic abuse may occur spontaneously or as a result of direct questioning.

If a disclosure of domestic abuse is made by a perpetrator:

#### Do:

- Acknowledge any disclosure as an important step towards accessing support to change behaviour.
- Be respectful but do not collude. Abusive behaviour is a choice and a perpetrator can choose to stop. Domestic abuse is unacceptable and many behaviours are against the law. It is important to hold perpetrators to account for their actions.
- Give the patient the Respect Phonenumber (0808 802 4040) and ensure they understand that this is a confidential information and advice line for people worried about their abusive behaviour.
- Consider whether a safeguarding or Marac referral needs to be made for adult and child survivors and any associated children based on any disclosures of abuse perpetration.

#### Do not:

- Assume that there is a causal relationship between a person's mental health issues and their abusive behaviour.
- Assume that accessing help for substance misuse will stop a person's violent or abusive behaviour. Support for substance misuse should occur alongside help to address the abusive behaviour.
- **Assume that anger management, individual or couples counselling are appropriate. These are potentially dangerous interventions where there is domestic abuse.**
- Assume that medication is the solution.
- Discuss the issue in joint appointments with the survivor and perpetrator.

Staff should make a Marac referral if they believe the perpetrator's behaviour places the survivor(s) at high risk of serious harm or homicide irrespective of whether the survivor is their patient/service user. The perpetrator should not be made aware of any safeguarding or Marac referrals made as a result of their disclosure as this could increase the risk to the survivor(s). The survivors should normally be told about the referral even if they do not consent to it, unless this could increase the risks to them or others involved.

#### o. Confidentiality and Information Sharing

Confidentiality is essential for creating the conditions in which individuals feel comfortable disclosing domestic abuse. A patient's safety can be dependent on it. It is however important to discuss with patients the boundaries of confidentiality with regards to domestic abuse. **For example, where there are safeguarding concerns for a child or adult at risk and where there are high risk behaviours, a referral will be made to Marac irrespective of consent. Similarly, it may be necessary to make a referral to children's services/adult services without the agreement of the survivor.**

However, it is very important to clarify that this is not a punitive measure but a means by which to increase support for the family – otherwise the survivor is likely to feel that they are being further victimised. Protective steps the adult survivor is already taking should be fully noted in referrals to children's social care. Responsibility for abuse should always be clearly flagged as resting with the perpetrator(s).

Health professionals should be aware that they should usually only share information after an individual has given their permission. Accordingly, it is important to be aware of the circumstances under which information can be shared without consent.

**For circumstances in which sharing confidential information without consent can normally be justified, for the purposes of preventative interventions please see the SafeLives document 'The legal grounds for sharing information' for guidance.**

As an example, information should be shared with the midwife if the survivor is pregnant. Where there are school aged children within the household, information should be shared with the School Nurse. General Practitioners may be treating other members of a family, including a perpetrator, who may seek to use information to locate a partner who has left him; therefore the General Practitioner should also be informed of domestic abuse.

Information should always be shared where there may be a safeguarding risk concerning children/adults at risk and if there is a high risk then a referral should be made to Marac.

**The balancing of confidentiality against the interests of disclosure is not easy; in these circumstances health professionals should seek guidance from the Adult/ Children's Safeguarding Team, Managers or Caldicott Guardian. They will ordinarily be discussed on a case by case basis. The only acceptable reason for sharing information is to increase a survivor's safety and that of their children/family. However, relevant and proportionate information sharing can save lives and/or prevent significant harm, so the risks of not sharing information should always be taken into account.**

#### p. Record Keeping

Records should be accurate, detailed and clear. They may ultimately assist a survivor in living a safer life e.g. in obtaining an injunction or court order against a perpetrator. Records may also be used in criminal proceedings where a perpetrator of abuse faces charges.

Documentation should be as detailed as possible. Avoid the use of statements such as 'the patient was assaulted'. Instead, where possible, use the direct words of the survivor. Document in a factual/neutral manner. A record should be made of all injuries. Where training has been provided, use drawings or body maps.

To maintain confidentiality, care needs to be taken to ensure that any recording of domestic abuse should be kept in an

appropriate place on the patient record system which perpetrators cannot access (including cases where a member of Trust staff may be the perpetrator). Health records should also be appropriately marked with domestic abuse alerts so that staff members working with the survivor are aware that this is potentially an ongoing issue which needs to be explored.

**Consent is not required to record a disclosure of domestic abuse.** Health professionals should clarify that there is a duty of care to record disclosures. Letters and assessments that are copied to the patient should never mention the domestic abuse as this may increase the danger for the survivor.

Professional record keeping processes should be adhered to for domestic abuse documentation. A domestic abuse data set for notes should include:

- Routine/selective enquiry and the response
- If staff suspect domestic abuse but don't get a disclosure, documentation of the concerns and the reasons behind them
- Relationship to perpetrator
- Whether the woman (if female) is pregnant
- Presence of children in or regularly attending the household or presence of adults at risk
- Nature of violence and injuries
- History of abuse; whether first episode, and if not – what frequency and over what period
- Enhanced risk factors/risk assessment
- Indication of information provided on local sources of help and indication of any action taken, for example referrals made

- Make note of any referrals made without consent and clearly document the basis for doing so

**If you have any doubts or concerns around domestic abuse always discuss with your line manager/safeguarding lead/Idva/Domestic Abuse Lead/Coordinator.**

#### q. Further Reading

- [SafeLives: The legal grounds for sharing information](#)
- [Information Sharing: Guidance for Practitioners and Managers H M Government 2008](#)
- The organisation AVA (Against Violence and Abuse) provides [online training tools](#) for health professionals.

#### r. Domestic Abuse Services (Local and National)

It is important to note that where specialist services exist, staff should not assume that survivors will want to access particular services. A full range of services should be offered so that the survivor can choose for themselves which they think would be most appropriate.

[List local domestic abuse services here including any specialist services supporting survivors who are disabled, older, younger, part of the BME or LGBT+ communities etc.](#)

#### National Helpline numbers:

- National Domestic Violence Helpline: 0808 2000 247
- Paladin National Stalking Advocacy Service: 0207 840 8960
- Galop (National LGBT+ domestic abuse helpline): 0800 999 5428
- Childline: 0800 1111
- Forced Marriage Helpline: 020 7008 0151

Rape Crisis England and Wales:  
0808 802 9999

Rights of Women (for legal advice):  
020 7251 6577

Men's Advice Line (for male victims):  
0808 801 0327

Respect (help for male and female perpetrators and male victims):  
0808 802 4040

Jewish Women's Aid: 0808 801 0500

Aanchal (Helpline for Asian women experiencing domestic violence. Languages spoken include: Bengali, Hindi, Punjabi, Gujarati, Tamil and Urdu; available 24/7):  
08454 512 547

FORWARD (FGM support): 020 8960 4000

Karma Nirvana (Supports victims of forced marriage and 'honour'-based abuse):  
0800 5999 247

Women's Aid online chat tool:  
<https://chat.womensaid.org.uk/>

As referenced in the 'Managing Disclosures' section of the policy above, Women's Aid have published a 'Survivors Handbook' providing practical support and information for women experiencing domestic abuse. The handbook is available in print and audio versions and in different languages. The link is as follows: [www.womensaid.org.uk/the-survivors-handbook](http://www.womensaid.org.uk/the-survivors-handbook)

## 8. Monitoring compliance and effectiveness

Detail here how the Trust will monitor compliance with the policy.

## 9. Consultation

- Trust safeguarding committee
- Safety leads
- VAWG networks

## Addendum I: Safety Planning Considerations

### Immediate safety action:

When there is an immediate risk of harm to a survivor or someone else, staff must escalate to: the lead in the department at that time, Domestic Abuse Champions, safeguarding teams and the Idvas.

Patients at risk of immediate harm should be considered for short-term admission (where possible) while a robust risk assessment and safety plan are made or until secure accommodation can be found. Patients should not be discharged when they are at risk of being seriously harmed or killed. If the Idva is unavailable/out of hours, then staff must contact the duty Site team lead to arrange this. However, if the patient declines to remain in the Trust, ensure you have made provisions for follow up and contact the Idva as soon as possible.

Staff must consider if there is safeguarding risk to a child, unborn or adult at risk and if so, follow Trust safeguarding procedures including notifying the relevant safeguarding team.



## Safety Planning Information

### Safety planning while on Trust site:

Staff must consider safety planning with the survivor and other staff whilst they are on Trust sites. Below is a list of some examples of safety planning; it is not an exhaustive list and safety planning will depend on the survivor's individual risk and situation. Staff can seek advice on safety planning actions whilst a survivor is on Trust sites from Domestic Abuse Champions, safeguarding teams and Trust Idvas.

- Ask the survivor if they want anyone prevented from visiting them.
- Make a clear plan with the survivor of what they should do if they feel at risk while on Trust sites, for example whether there is an alarm they can press to alert staff.
- Ask the survivor if they want security to be present/near-by.
- Place the survivor in a bed near the doctor/nurses'/midwives station.
- Remove the survivor's name from boards visible to the public.
- Make regular checks on them.
- Ask the survivor to provide a photo of the perpetrator to staff.
- Ensure that any safety plans are clearly documented and handed over when shift patterns change.

### Safety planning when leaving Trust site:

If a survivor has declined Idva support or is leaving the Trust with a follow up from the Idva, staff can provide them with safety planning advice. Below is a list of some examples of safety planning; it is not an exhaustive list and safety planning will depend on the survivor's individual risk and situation. Staff should discuss options and support the survivor to decide what is safe for them. They can seek advice on safety planning from Domestic Abuse Champions, the safeguarding team and Trust Idvas.

### Some safety planning advice to offer to survivors (Women's Aid, 2015):

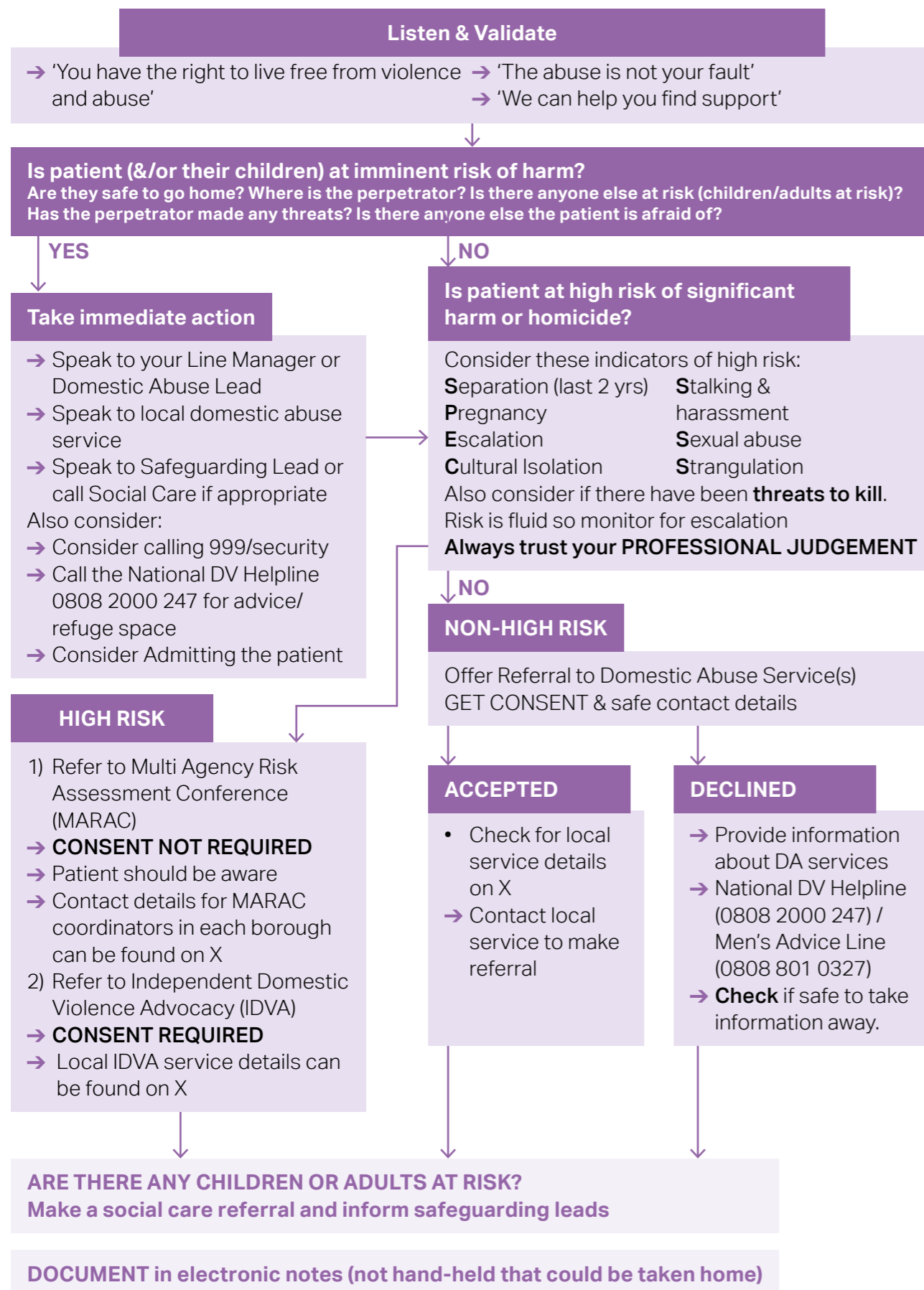
- Plan in advance how you might respond in different situations, including crisis situations.
- Think about the different options that may be available to you.
- Keep with you any important and emergency telephone numbers (for example, your Idva contact details; the police domestic abuse unit; your GP; your social worker, if you have one; your children's school; your solicitor; and the Freephone 24 Hour National Domestic AbuseViolence Helplines: 0808 2000 247, [add other relevant support services](#)).
- Teach your children to call 999 in an emergency, and what they would need to say (for example, their full name, address and telephone number).
- Are there neighbours you could trust, and where you could go in an emergency? If so, tell them what is going on, and ask them to call the police if they hear sounds of a violent attack.
- Rehearse an escape plan, so in an emergency you and the children can get away safely.

- Try to keep a small amount of money on you at all times – including a topped up travel card (where relevant).
- Know where the nearest phone is and if you have a mobile phone, try to keep it with you and charged.
- If you suspect that your partner is about to attack you, try to go to a lower risk area of the house – for example where there is a way out and access to a telephone. Avoid the kitchen or garage where there are likely to be knives or other weapons and avoid rooms where you might be trapped, such as the bathroom, or where you might be shut into a cupboard or other small space.
- Be prepared to leave the house in an emergency.
- Pack an emergency bag for yourself and your children, and hide it somewhere safe (for example, at a neighbour's or friend's house). Try to avoid mutual friends or family. Consider packing:
  - Some form of identification.
  - Birth certificates for you and your children, passports (including passports for all your children), visas and work permits (you could make copies of these if you cannot safely take the originals).
  - Money, bankbooks, cheque book and credit and debit cards.
  - Keys for house, car, and place of work. (You could get an extra set of keys cut, and put them in your emergency bag).
  - Cards for payment of Child Benefit and any other welfare benefits you are entitled to.
  - Driving licence (if you have one) and car registration documents, if applicable.

- Prescribed medication.
- Copies of documents relating to your housing tenure (for example, mortgage details or lease and rental agreements – you could make copies of these if you cannot safely take the originals).
- Insurance documents, including national insurance number.
- Address book.
- Family photographs, your diary, jewellery, small items of sentimental value.
- Clothing and toiletries for you and your children.
- Your children's favourite small toys.

You should also take any documentation relating to the abuse – e.g. police reports, court orders such as injunctions and restraining orders, and copies of medical records if you have them.

## Addendum II: Example Flow Chart of the Trust Response to Domestic Abuse



## Appendix 9: Domestic Abuse Coordinator Job Description

Employing Agency:	X NHS Trust
Job Title:	X NHS Trust Domestic Abuse Coordinator
Responsible to:	X
Salary:	X
Leave Entitlement:	25 days per year pro rata
Working Hours:	35 hours per week
Work Location:	X Hospital

### Job Purpose:

- Lead on the coordination of a whole-Trust domestic abuse model within *acute/mental/community health* settings to improve the safety and wellbeing of patients and staff experiencing domestic abuse, and their dependents.
- Improve identification and responses to domestic abuse by engaging health professionals, building capacity, developing an infrastructure of policies and procedures, and training staff within a Coordinated Community Response (CCR) framework.
- Work with key internal and external stakeholders to develop an embedded and sustainable best practice response to domestic abuse.

### Description of Duties:

#### Coordination

1. To work closely with:
  - a. Key practitioners and stakeholders working directly with patients accessing the hospital (Trusts to specify which teams/services the coordinator will be working with here)
  - b. Providers of specialist services to survivors of abuse (e.g. Independent Domestic Violence Advocacy Services) serving the catchment areas of the Trusts
2. To develop staff awareness of domestic abuse and capacity to work to best practice guidance in partnership with the Safeguarding leads
3. To monitor the Trust's response to domestic abuse and report as required

#### Development Work and Management

1. To service the steering groups, including terms of reference, preparation of papers, taking minutes, following up on actions and disseminating information

2. To identify, develop and coordinate clear and safe referral pathways to specialist services for survivors and their children
3. To support the trust to engage with the Multi Agency Risk Assessment Conferences (Maracs) in relevant boroughs
4. To coordinate and develop policies, procedures and guidelines which guide the hospital's response to domestic abuse
5. To arrange, assist with and/or deliver training and briefing sessions to Trust staff to enable effective implementation of procedures, protocols and best practice responses based on an assessment of training and information needs expressed by staff
6. To remain up to date on relevant research, reports, Domestic Homicide Reviews and Serious Case Reviews, and share this expertise and learning with the Trust
7. To develop and disseminate resources that support staff to respond to domestic abuse and survivors to access support within the Trust
8. Where relevant, to contribute to identifying and securing funding and other resources necessary to implement projects. This may include drafting project proposals and funding applications
9. To represent the Trust at relevant meetings locally and at out-of-borough events as appropriate, including public speaking engagements
10. To embed an intersectional approach to all project work undertaken by the coordinator and ensure that the needs of all survivors are considered
11. To lead discussions around domestic abuse within multi-disciplinary teams/ reflective practice forums

### Information and Monitoring

1. To monitor delivery on agreed operational and working group actions and develop performance management frameworks as necessary
2. To collect and monitor data showing the impact of the coordinator role
3. Maintain data for the Trusts and report as required including monitoring reports
4. Ensure consultation with key stakeholders, including health professionals, service users and wider agencies are carried out and built into project monitoring and practice improvement
5. To advise, guide and support the collation and presentation of Trust performance indicators and other relevant data on domestic abuse and mental health and ensure they are delivered to the relevant meetings, acting as a spur to reflection and further change

### Operational Groups: support development and service meetings

1. To service operational and working groups of the domestic abuse partnership as appropriate, including taking minutes, preparation of papers and follow up on actions
2. To write reports for meetings, seminars, conferences, news bulletins and briefings as appropriate
3. To work with chairs of operational groups to prepare the group agenda, terms of reference, minutes and disseminate papers for each meeting

# Appendix 10: Business Case for Health Based Idva Service Provision

## Vision for a Health Based Independent Domestic Violence Advisor (Idva) Service

### Introduction

Domestic abuse has a devastating effect on the health and wellbeing of survivors and their families. The latest figures from the Crime Survey for England and Wales show little change in the prevalence of domestic abuse in recent years. In the year ending March 2018, an estimated 2 million adults aged 16 to 59 years experienced domestic abuse (1.3 million women, 700,000 men). More than 100,000 of these are adults experiencing high and imminent risk of murder or serious harm. The death rate for women killed by their current or ex-partner devastatingly remains at two a week, while it is estimated that three women a week take their own lives due to domestic abuse<sup>208</sup>. It is estimated that one in five children grow up experiencing domestic abuse and over 130,000 children live in households where survivors are at the highest risk<sup>209</sup>.

Many survivors will be using services in hospital Trusts – SafeLives' Cry for Health report<sup>210</sup> found that, in the year before getting effective Idva support, nearly a quarter of survivors at high risk of serious harm or injury, and one in ten survivors at medium risk, went to an Emergency Department due to their injuries.

In the most extreme cases, some survivors reported that they had attended an Emergency Department 15 times before they accessed effective Idva support. The Crime Survey suggests that nearly 500,000 survivors of domestic abuse use health services every year<sup>211</sup>. The Department of Health in 2011 stated that the NHS spends more time dealing with the impact of violence against women and children than almost any other agency and is often the first point of contact for women who have experienced abuse. Too frequently, survivors are 'patched up' by health services, only to be sent back into the arms of their perpetrators. The abuse – which is at the heart of survivors' use of health services – does not stop.

The Home Office estimates the annual cost of domestic abuse to the NHS is £2.3bn while its total cost to society is £66bn<sup>212</sup>. SafeLives estimates the annual potential cost savings of Health Based Idva provision to be £2,050 per survivor<sup>213</sup>. NHS England has recommended in its four-year Domestic Abuse Plan that all Trusts ensure that patients who are experiencing domestic abuse should have access to Idva services.

208 Refuge, Domestic Abuse and Suicide – Ruth Aitken and Vanessa Munro (2018)

209 SafeLives, A Cry For Health (2016)

210 SafeLives, A Cry For Health (2016)

211 Office for National Statistics (ONS), Domestic abuse: findings from the Crime Survey for England and Wales 2018

212 Home Office, The economic and social costs of domestic abuse – Rhys Oliver, Barnaby Alexander, Stephen Roe and Miriam Wlasny (2019)

213 SafeLives, A Cry for Health (2016)



## What are Idvas?

**“Idvas are like lifelines – they enable you to survive when you’re feeling very alone”**  
– Survivor

Established in England and Wales in 2005, Idvas are trained specialists who act as a single point of contact to help survivors who are at the highest risk of serious harm or death to become safe, ensuring their voice is heard by statutory agencies. An Idva carries out a risk assessment to identify the level of risk to a survivor (high, medium or standard) and supports them with immediate safety plans, such as helping to increase security at their home through target hardening, sanctuary schemes, protection orders or accompanying them to court hearings (family, criminal and civil), and implementing longer-term interventions to ensure their safety, such as accessing counselling, drug or alcohol misuse or mental health services.

Idvas amplify the survivor’s voice and act as their advocate at multi-agency risk assessment conferences (Maracs) which are meetings where statutory and voluntary agency representatives share relevant and proportionate information about cases in which one or more survivors is at high risk of serious harm or murder. They then produce a co-ordinated action plan to increase survivor safety. Crucially, an Idva is independent of statutory agencies and can help to navigate the many processes a survivor may have to go through before they are free from harm. The Idva’s job is to champion the survivor’s needs, holding agencies to account.

We know that as an intervention, Idvas are highly effective. Outcomes assessed at the closure of survivors’ cases revealed significant reductions in abuse and positive changes in safety and quality of life following support and interventions from an Idva service.

For example, 57% of survivors reported cessation of abuse, 84% of survivors reported feeling safer and 81% of survivors felt their quality of life had improved<sup>214</sup>. These outcomes are further improved if there is an effective intervention with the perpetrator, which is why we advocate strongly for an approach which tackles the perpetrator as well as supporting adult and child survivors.

Co-locating Idva services into hospitals reduce costs by upskilling hospital staff to understand the impact of domestic abuse on survivors and their families, to recognise potential survivors, to enquire and offer referral into specialist domestic abuse services which support survivors by promptly addressing their safety and supporting them to rebuild their lives and recover.

### The impact of domestic abuse on health and wellbeing

Domestic abuse should be considered as a national health epidemic. Research suggests that nationally we are missing four out of five survivors (83%) of domestic abuse who never speak to the police<sup>215</sup>, particularly the most vulnerable or those often hidden from services, such as survivors with high levels of complex or multiple needs related to mental health, drugs and alcohol, older survivors aged 55 or over, survivors who do not have children living with them, survivors from high income households, survivors who remain in a relationship with their abuser, and pregnant survivors.

Domestic abuse has clear detrimental implications for survivors’ health. The physical – and often more obvious – implications can be short-lived, or long-lasting. These can include: broken bones, sprains, cuts, bruises, digestive issues, eating problems, pain of the back, neck, abdomen, stomach or genital area, headaches, fainting, seizures, hypertension, urinary tract or vaginal infections, sexually transmitted diseases, and sexual dysfunction<sup>216</sup>.

Although often less obvious, psychological implications of domestic abuse can pose an equally harmful threat to survivors’ health. A targeted sample of 260 women who had sought help from domestic abuse services within England and Wales completed baseline questionnaires as part of an intervention study<sup>217</sup>. According to the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM), which is used in counselling services as a screening tool, over 70% of these women reported clinical levels of psychological distress. Their mean score (18) was almost four times higher than that of the general population<sup>218</sup>. The study also indicated more than three-quarters of the women (77%) had been suffering post-traumatic stress disorder (PTSD), in addition to high levels of depression and anxiety – of which the severity was positively correlated to the severity of abuse experienced.

## Models of hospital-based Idvas

Idvas can help NHS Trusts to provide more effective identification and support for survivors accessing their services. It is vital that hospital staff receive training in line with [2016 NICE Guidance](#) to enable them to identify survivors of domestic abuse sooner, in order to break the cycle of abuse and refer into support that could save or transform their lives. Hospital-based Idva services help NHS staff to meet the requirements of that NICE Guidance.

There are potentially three options NHS Trusts could take:

- Co-location of Idvas within hospitals
- Standalone Idva service within hospitals
- Referral into local community-based domestic abuse service.

The table below reviews these options.

### Service options review

	Increased identification	Increased referrals to domestic abuse services	Increased support for survivors	Likelihood of meeting NICE guidance
Co-located (Idva employed within a local domestic abuse service but located within hospitals)				
Standalone Health Based Idva service				
Referral to local Idva/ domestic abuse service				

214 SafeLives, Survey of Independent domestic violence advisor provision in England and Wales (2016)

215 ONS, Domestic abuse: findings from the Crime Survey for England and Wales 2018

216 JC Campbell, The Health consequences of intimate partner violence (2002)

217 G Ferrari., R Agnew-Davies, J Bailey , L Howard L, E Howarth, TJ Peters, L Sardinha, GS Feder. Domestic violence and mental health – Global Health Action, 8 February 2016 (29890), 1654–9716,

218 J Connell – Distribution of CORE-OM scores in a general population, clinical cut-off points and comparison with the CIS-R (2007)

### 1. Co-location of Idvas within hospitals

The first option would be to hire and co-locate Idvas from a local specialist domestic abuse service into the hospital. While the local specialist service would second the Idvas, they would be physically situated within the hospital. This is important for three reasons. First, co-location enables a faster response to survivors, allowing Idvas to act in the “golden window of opportunity”. When a patient discloses domestic abuse, it is important to act immediately because they may only be admitted for a short period of time, for example in A&E if their injuries are not extensive. Not having an Idva on site risks the survivor going home without getting any specialist help or support.

Second, the co-location of an Idva is important because it enables them to forge relationships with health professionals in the Trust. An Idva can build trust with health staff encouraging them to feel confident in asking about potential abuse, knowing that there is a domestic abuse professional to support that survivor should they disclose. Staff feel safer sharing knowledge about their patients if the domestic abuse professional is seen as ‘one of us’.

Third, co-location enables Idvas to access hospital safeguarding portals, enabling them to flag important information about patients, as well as ensuring outcomes and referrals are noted. Co-location also ensures Idvas can be set up with an NHS email, making communication within the hospital and wider health service more effective.

The reason why it is important for Idvas to be linked to local community services is threefold. First it ensures they are able to access all of the referral routes which would be available to them if they were located in the community, including recovery programmes, specialist programmes for any children etc. Second, it ensures that Idvas receive the clinical and case supervision necessary from a domestic abuse perspective as well as regular CPD so that they keep up to date with the latest developments in domestic abuse

and the wider violence against women and girls arena. Third, it enables Idvas to retain the ‘independence’ in their job title which is crucial if they are to build trust with their clients.

### 2. Standalone Idva service in hospitals

The second option would be for NHS Trusts to set up their own Idva services without a direct link to their local community specialist domestic abuse service. Whilst this is better than not having an Idva service at all, it creates a risk that the Idva would not be a domestic abuse specialist. It removes the valuable links that community-based services already have to a wide range of other multi-agency partners. It also makes it more difficult for domestic abuse professionals to receive the clinical supervision necessary to ensure they are providing a service in line with recognised best practice. Local community-based services often provide support for survivors across their journey, including recovery programmes, outreach and counselling support. Ensuring Health Based Idvas can access these programmes for hospital survivors seamlessly is important to ensure they don't fall into gaps in provision.

### 3. Referral into a local community-based domestic abuse service

Another option would be to ask health staff to refer into a local specialist domestic abuse service. This option might provide a recognised referral pathway into an appropriate and expert domestic abuse service, but staff will be much less likely to enquire about domestic abuse if they do not feel supported by an expert to deal with the outcome. This option would mean that NHS staff will still have limited understanding of domestic abuse, therefore enquiring, risk assessing and the number of referrals into the community domestic abuse services are likely to be low. There is also likely to be a delay between referral and the community-based service being able to provide support to the survivor. The capacity of most specialist services is already overwhelmed so they may not be able to provide a referral pathway without the resource to cope with this increase in referrals. Finally, without an Idva

based on site you would likely miss the crucial window of opportunity to access and support survivors who may only present once.

## Co-location of Health Based Idvas

This section covers:

- Key features of the model
- Cost overview of the preferred model
- Risks of the preferred model

### Key features

In order to make co-location of Idvas cost-beneficial and effective, some key features must be included:

1. **No lone-working.** We recommend that all hospitals employ a minimum of two Idvas. While this ensures that a seven-day week is covered in a hospital-setting, it also means that Idvas are able to consult and learn from their colleagues. SafeLives' Cry for Health evidence showed that lone Idvas were more prone to burn-out and isolation, compared with services which employed more than one Idva.
2. **Idvas must be employed by the NHS.** They must be provided with a contract/ honorary contract, or service level agreement (SLA) which should be used if the Idvas are seconded from a specialist community service, which will outline the Idva's responsibilities, the Trust's responsibilities and the expected outcomes of the service. This will also provide Idvas with clinical supervision, NHS secure email to be used for communicating with other staff and access to patient records.
3. **Idvas must be part of the overall safeguarding spine.** The Idvas should be included in safeguarding meetings and feed into safeguarding policies – this will ensure that the specialist knowledge of the Idva is utilised and that domestic

abuse is appropriately addressed from the top-down with effective policies and buy in from management. This should develop into a stand-alone domestic abuse policy (covering adult, teen and child survivors and perpetrators) for patients and staff.

4. **Idvas must be able to have Trust-wide impact.** This will include the Idva feeding into training sessions and briefings to practitioners throughout the Trust and possibly supporting the set-up of a Champions scheme (in which designated members of staff become Domestic Abuse Champions and support other staff in identifying and responding to domestic abuse). The Idva must also be able to feed into domestic abuse policies for the Trust as well as reporting to the Board on the operation of the policy and their service. This widens the impact of the service the Idva will provide.
5. **Idvas must be able to work across departments.** The aim is for Idvas to introduce themselves and their service to as many staff as possible. This can be difficult, due to turnover of staff and staff regularly rotating departments within the Trust. Idvas must thus work with all the different departments in order to provide an effective service across the Trust.
6. **Outcome measurement is required.** Idvas in collaboration with the Safeguarding team should collect data on the number of patients referred to their service, the number of patients supported and number of patients who declined support. In addition to that, demographics of patients should be recorded in order to better understand who is being affected by domestic abuse, which survivors are able to access support, and most importantly who is not able to access support. Outcome measurement data should be made available so the Trust and NHS England can measure effectiveness including wellbeing and safety outcomes. Marac attendance should be integrated into patient records.

**Cost overview of the preferred model**

SafeLives' A Cry for Health report identified that there could be a cost saving for health services once survivors have accessed the Health Based Idva service. On average, an individual accessing the Health Based Idva service costs £4,000 in healthcare services during the six months before the Idva intervention. After receiving support these costs reduced on average by 41% per client, that's equivalent to an estimated £2,050 annual reduction in health service per client. In a separate pilot of the Idva service at St Mary's Hospital, Manchester the evaluation team calculated that the 28 high risk cases referred to Maracs as part of the pilot saved the public sector approximately £170,800<sup>219</sup>.

The expertise of the Idvas not only saves hospital staff time and resources, such as beds and cubicles, making them economically worthwhile to the organisation. They also support staff to identify survivors earlier in their abusive relationships. This enables the Idva to support survivors to leave abusive relationships, reducing their risk, maintaining their safety and not enter into further abusive relationships, subsequently reducing the survivor's need for heightened levels of ongoing health care.

**Emergency department analysis**

This section focuses specifically on the Emergency Department and provides a simple cost overview of co-locating two Idvas into an NHS Trust. It is not recommended that Idvas are co-located into one department only (as stated above, Idvas must be able to work across departments). However, looking at specific departments enables us to do more effective cost analysis, as we are able to make calculations based on admissions.

Assumptions are made regarding the caseload an Idva will hold – we expect a Health Based Idva to be able to receive 100 referrals annually, with a caseload of 75 engaged survivors. We believe this to be a safe and realistic number of cases for one Idva to hold<sup>220</sup>, as in a complex community like a hospital environment, it is likely that a number of the survivors the Idva will be working with will not be at high risk but will still benefit from their ability to make connections into their community based service. It must also be kept in mind that a survivor is likely to use other health services and this is only one example of the cost benefit made possible by a hospital-based Idva. A co-located Idva may be able to work across departments and thus increase the net benefit further.

The Emergency Department is one of the most common health sites for survivors/ survivors of domestic abuse to use. SafeLives' Getting It Right First Time<sup>221</sup> report found that nearly a quarter (23%) of survivors at high risk and one in ten survivors at medium risk went to Accident and Emergency (A&E) because of acute physical injuries. Staff within the department are therefore well placed to identify survivors of domestic abuse.

The total number of attendances at A&E departments in NHS Trusts in England were 23.4 million in 2016/17<sup>222</sup>. It is estimated that 5.9% of the population experienced domestic abuse in the same year<sup>223</sup>, equating to approximately 1,379,000 attendees in the A&E department who had experienced abuse in the 12 months prior. Domestic abuse is a course of conduct offence – one in which someone lives with abusive behaviours by the perpetrator daily, which will at various points necessitate the use of services.

As a result of this, a domestic abuse survivor will need health services to an extent that costs estimating £4,000 accrue on average in the six months before they get effective help<sup>224</sup>. This means that costs relating to domestic abuse incurred by A&E departments were approximately £5,516 million in 2016/17. This is a huge ongoing cost and only likely to increase, as the number of attendances into A&E departments increases year-on-year with 23.8 million attendances in 2017/18<sup>225</sup> and 24.8 million in 2018/19<sup>226</sup> (an increase of 4%). If the number of attendees continues to rise at the same rate, we expect costs relating to domestic abuse to increase to £6,540 million by 2020/21.

Supplying two Idvas in each of the 134 hospitals in NHS Trusts with an A&E department in England (268 Idvas in total) would cost £13.4 million – this is calculated based on the unit cost of employing an Idva being £50,000 per year (with pay of £35,000 and associated costs, including training, administration, accreditation, provision of resources of £15,000 per year). For simplicity we have assumed the same employment cost for all three years and no inflation.

Hospital-based Idvas in every A&E department in an NHS England Trust would save approximately £54.94 million per year (calculated on a hospital-based Idva saving £2,050 per survivor as calculated in the Cry for Health report<sup>227</sup>) and provide a net benefit of £41.5 million per year.

**Table 2a: Cost of Health Based Idvas in A&E departments in England**

Costs	Number	Unit cost £	2019/20
FTE Health Based Idva	268	£35,000	£9.38million
Associated costs	268	£15,000	£4.02million
Total costs		£50,000	£13.4million

**Table 2b: Cost benefit of two Health Based Idvas for A&E departments for three years**

	2019/20	2020/21	2021/22
Cost of two Idvas in all A&Es	£13.4 million	£13.4 million	£13.4 million
Benefit of 268 Idvas	£54.9 million	£54.9 million	£54.9 million
Net benefit	£41.5 million	£41.5 million	£41.5 million

219 NHS Manchester, PATHway: An Independent Domestic Violence service at St Mary's Maternity Hospital (2010)

220 Hospital-based Idvas were consulted in making this assumption

221 SafeLives, Getting it right the first time (2015)

222 NHS Digital, Hospital Accident & Emergency Activity 2016-17

223 ONS, Domestic abuse: findings from the Crime Survey for England and Wales 2018

224 SafeLives, A Cry for Health (2016)

225 NHS Digital, Hospital Accident & Emergency Activity 2017-18

226 NHS Digital, Hospital Accident & Emergency Activity 2018-19

227 Ibid



**Maternity ward analysis**

Similarly, maternity departments are another area of the health economy that survivors are likely to use the most. Pregnancy can be a trigger for abuse – an estimated 30% of all domestic abuse starts during this time<sup>228</sup>. It is estimated that abuse has overtaken gestational diabetes and pre-eclampsia as the leading cause of foetal death<sup>229</sup>. Due to the high prevalence, maternity departments routinely enquire about domestic abuse with their patients.

Estimates for the proportion of all pregnant women who experience abuse range from 8.9%<sup>230</sup> to 17%<sup>231</sup>. For the purpose of this calculation, we will use the more conservative estimate of 8.9% based on research conducted in the North of England, which used a confidential questionnaire at an antenatal booking clinic.

There were 626,000 deliveries in NHS hospitals in England in 2017-18. Using the above estimate, this would suggest that 55,700 survivors of abuse had used maternity wards in that year across 136 Trusts which provided maternity services in England<sup>232</sup>. Idva provision in every maternity department would cost £13.6 million per year (based again on placing two Idvas in each hospital and an overall employment cost of £50,000 per Idva) with an opportunity to save £55.8 million per year.

Placing two Idvas into every maternity ward would produce a net benefit of £42.2 million per year. This is an underestimate, as it does not include costings of possible adverse birth outcomes for the baby resulting from the abuse.<sup>233</sup>

**Table 2c: Cost of Health Based Idvas in maternity wards in England**

Costs	Number	Unit cost £	2019/20
FTE Health Based Idva	272	£35,000	£9.52 million
Associated costs	272	£15,000	£4.08 million
Total costs		£50,000	£13.6million

**Table 2d: Cost benefit of Health Based Idvas in maternity wards in England**

	2019/20	2020/21	2021/22
Cost of 2 Idvas in all maternity wards	£13.6 million	£13.6 million	£13.6 million
Benefit of 272 Idvas	£55.8 million	£55.8 million	£55.8 million
Net benefit	£42.2 million	£42.2 million	£42.2 million

228 AM Weindling, The confidential enquiry into maternal and child health (2003)

229 L Parsons, MM Goodwin & R Petersen, Violence against women and reproductive health: toward defining a role for reproductive health services, Maternal and Child Health J (2000)

230 LJ Koenig, D Whitaker, RA Royce, TE Wilson, K Ethier, & MI Fernandez, Physical and sexual violence during pregnancy and after delivery (2006)

231 J.K. Johnson, F. Haider, K. Ellis, D.M. Hay, S.W. Lindow, The prevalence of domestic violence in pregnant women (2003)

232 National Maternity Review, Better Births: Improving outcomes of maternity services in England (2016)

233Prakesh S. Shah and Jyotsna Shah. Maternal Exposure to Domestic Violence and Pregnancy and Birth Outcomes: A Systematic Review and Meta-Analyses, Journal of Women's Health (2010)

**Staff**

Domestic abuse takes place at every level of society and will be experienced by both patients and staff with an estimated 50,000 of NHS staff experiencing abuse in the last 12 months<sup>234</sup>. The total cost of domestic abuse to UK employers is estimated to be £1.9 billion per year<sup>235</sup> including sick days required by survivors due to the harm caused by perpetrators and reduced productivity on their return to work. The Home Office calculated the cost of domestic abuse to an employer to be £7,245 annually per survivor of domestic abuse<sup>236</sup>.

For a hospital employing 7,000 staff members (assumed at an equal male/female split) and given the ONS estimate that 5.9% of the population has experienced domestic abuse in the last 12 months<sup>237</sup>, we could estimate that approximately 427 staff members experienced domestic abuse within the last year. Using the Home Office estimate, we could calculate that the financial impact of domestic abuse alone to a hospital would be over £3 million due to the harm experienced by a survivor.

**Cost of domestic abuse at work by staff members experiencing domestic abuse**

	Per survivor	For one hospital (427 survivors)
Cost of domestic abuse	£7,245	£3.1 million
Benefit of 272 Idvas	£55.8 million	£55.8 million
Net benefit	£42.2 million	£42.2 million

It is difficult to estimate the exact impact of Health Based Idvas on staff, as little research exists in this area. A hospital-based Idva will be able to support the safety and

recovery of NHS staff experiencing abuse, including helping them to return to work when appropriate, be more productive and live free from abuse. Staff members who have received appropriate support may be vocal advocates for effective domestic abuse response, making them highly motivating voices within the organisation in terms of changing culture and practice. This positive impact on staff and the overall impact on the NHS should thus be taken into consideration.

**Risk of the preferred model**

Whilst the benefits have the potential to be great, there are small risks this model carries. It is not possible to guarantee that all costs will be reduced. The Cry for Health report highlighted that there was a higher use of mental health and substance misuse support services post Idva intervention, which may be due to survivors being in a better position to prioritise their own health, rather than simply survive in an abusive relationship.

The potential risk to the Idvas based in A&E is that they are working in a setting where trauma is routine and often graphic. They face the challenge of working with more survivors who have complex needs and with more survivors who are at an earlier stage of change, who are more likely to return to the abuser. Thus, it is essential that Health Based Idvas have access to regular clinical supervision and support. Some services recommend therapeutic counselling due to the cumulative emotional stress of the job.

With regards to the Idva service being visible within the Trust, we need to be aware of the challenges associated with this, bearing in mind the size of the organisation and possible consequences of being prominent, for example high number of referrals/self-referrals from patients and staff experiencing domestic abuse.

234 SafeLives, A Cry for Health (2016)

235 S.Walby, The Cost of Domestic Violence, 2009

236 Home Office, The economic and social costs of domestic abuse (2019)

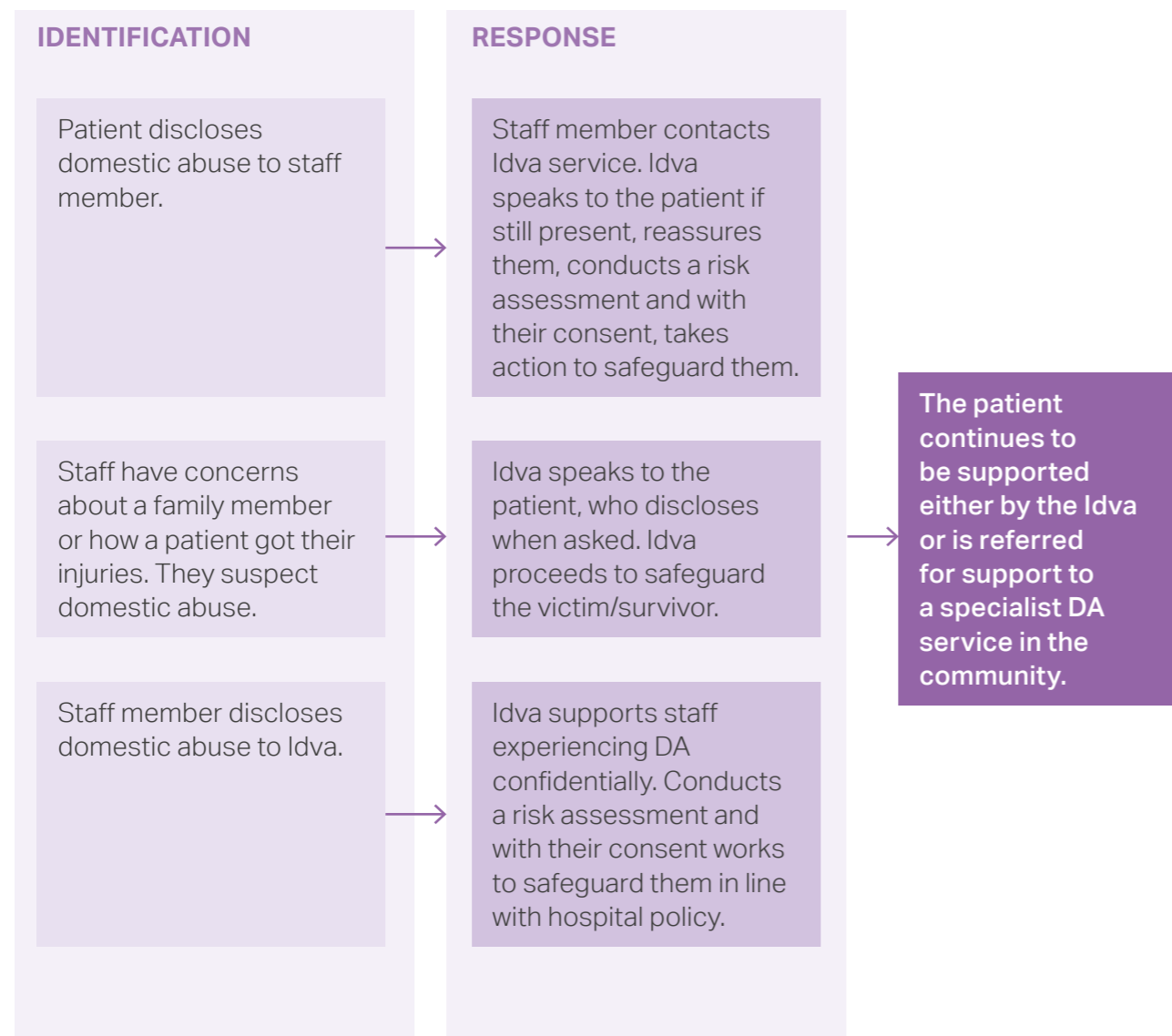
237 ONS, Domestic abuse: findings from the Crime Survey for England and Wales 2018

## Service model detail

This section will detail the end-state of the service model. It will define and detail the service experience a Health Based Idva will bring to the Trust. This section will cover:

1. Service model
2. Process view of the service model
3. Performance measures
4. Resources

### A Health Based Idva service model



The preferred model identifies, responds and safeguards survivors (both patients and staff) from domestic abuse. The first step is identification of survivors. This can happen in a number of ways. A survivor may have already been identified by police, emergency services, or other multi-agency services; a survivor may disclose their abuse to staff either at admission or while in the hospital; after sensitive targeted enquiry by a member of staff a survivor may disclose; or after a member of staff thinks someone might be a survivor and requests the Idva attend, a survivor may disclose after enquiring. It is important to note that routine enquiry is currently only mandated in maternity and mental health. This step is crucial, as survivors cannot be supported without being identified. Most health staff do not currently receive specialist training on how to enquire about domestic abuse. An Idva is trained to ask about domestic abuse in a way which elicits disclosure and will train other staff to do so as part of their role.

Ideally, the survivor is identified during their first visit to the Trust in order to support them as soon as possible and reduce their need for healthcare services as a result of the abuse. Idvas will also help to identify staff who are experiencing abuse. They will advertise their services to staff, who will be able to get support from the Idva.

The second stage is the **response** to domestic abuse. Once a survivor has been identified they will be assessed to determine the risks posed to them by the perpetrator(s) and therefore what their needs are, after which the Idva will determine what onward referrals might be needed (eg for outreach support, counselling, recovery programmes etc), any immediate safety planning, consideration of any children's needs, and multi-agency engagement if needed. If a survivor is found to be at high risk of serious harm or murder, the Idva will refer the survivor to a Marac (Multi-Agency Risk Assessment Conference) and will act as the survivor's advocate in that meeting, making sure their voice is heard and their needs are central to safety planning.

### Process view of the service model

The image below maps the main activities carried out by Health Based Idvas.

#### Process view of a Health Based Idva's activities

Support for survivors	Development of referral pathway	Awareness Raising	Governance & strategies	Data collection
Emotional and practical advice for patients	Liaising with local specialist service	Organising and delivering briefing sessions	Desktop reviews of current DA policies	Oversight of data collection tools
Emotional and practical advice for staff	Making referrals into specialist service	Advertising the service within the Trust	Attending safeguarding meetings	Collecting data
Marac and safeguarding referrals		Feeding into the development of training sessions	Feeding into DA policies	Analysis of data
Children's social care referrals		Advising on individual cases	Dissemination of DA policies	Write up quarterly reports

**Performance measures**

Key performance indicators must be outlined in order to specify what will be expected of the service. This should be in a contract or a service level agreement (SLA) if a Trust recruits an Idva from a community service. These measures can be tailored and made more specific to each Trust by setting individualised targets, though consideration should always be given to minimising burdens on both the user of the service (the patient) and the Idva, when working through what performance metrics are suitable. Only data which is going to be put to practical use should be collected. The Idva would be responsible for collecting data to measure the performance of the service and communicate this across the Trust. The performance measures we expect to be included are:

1. Outcomes data for clients (reduction in severity and frequency of abuse, DASH outcome, case length)
2. Client reported outcomes (feelings of safety, improved well-being, quality of life, feeling more optimistic and confident about the future)
3. Agencies which made a difference to survivor’s safety
4. Service outputs (additional needs, outcomes achieved)
5. Criminal and justice system outcomes

This sits alongside demographic data, which is needed in order to analyse whether and how the service is providing an effective response for all communities served by the hospital.

**Resourcing**

Once Idvas are recruited, they should be given access to all the resources required for them to provide a service within an NHS Trust, e.g. laptop/computer, pass, NHS secure email, pager/phone, desk space and office supplies. They must also be provided with clinical supervision (from a specialist domestic abuse service), caseload reviews with a service/line manager, and training (with possible accreditation opportunities). These have been considered when calculating the cost benefit and should not be ignored or disregarded. These are key requirements to enable Health Based Idvas to provide effective support to survivors, reducing their need to access healthcare services as a result of abuse.

**Determining provision for a given local area**

**Service provision** – Whatever the option chosen from Section 2, Pathfinder recommends that a minimum of 2 Idvas are employed to cover each hospital. While this ensures that a seven-day week is covered in a hospital-setting, it also helps to promote resilience and reduce burn-out.

**Location** – Patients coming into a hospital could choose to disclose abuse in any setting, from physiotherapy to Children’s Accident and Emergency departments. Health Based Idvas must therefore be able to take referrals from all teams.

There are benefits to physically locating Health Based Idvas near settings where victims and their families are most likely to be identified, notably maternity wards and A&E departments.

**Number** – SafeLives recommends that provision is supported by a robust needs assessment. Determining the exact number of Health Based Idvas required by an individual Trust will depend on the following:

1. The total patient population served by the hospital and attendances
2. Demographic analysis of the patient population (noting the gendered nature of domestic abuse)
3. The incidence of domestic abuse experienced and disclosed by patients and staff, drawing on

4. Analysis of the actual incidents disclosed by patients and staff where such information is safely recorded or using the ONS’s finding that 5.9% of the overall population experienced domestic abuse.

5. Safe caseloads for Health Based Idvas (for example using a metric that a FTE Idva could receive 100 referrals).

We provide overleaf a template for use for Health Based Idvas using the costs and benefits outlined for patients in Section 2.

A worked example is provided for Hospital ABC, which is located in England covering a total population of 1.8 million people and has determined it initially needs 3 FTE Idvas to support its patients and staff per year.

**Health Based Idva provision template**

<b>Business Case Template for Health Based Idva provision</b>	<b>Example</b>	<b>£</b>
Number of FTE Idvas required	3	A
Survivors referred per Idva	100	B
Survivors supported per Idva (assuming 75% engage with support)	75	C
Total number of survivors supported by FTE Health Based Idva provision	225	C x A
Costs saved in healthcare use per survivor supported	£2,050	£2,050
Total costs saved	£461,250	C x A x £2,050
Total cost of FTE Health Based Idva provision (@£50,000 per FTE)	£150,000	A x £50,000
Net benefit to Hospital ABC (total costs saved less total costs)	£311,250	(C x A x £2050) - (A x £50,000)

**Further reading**

- SafeLives A Cry for Health (2016)
- Home Office, The economic and social costs of domestic abuse (2019)
- SafeLives, Safe and well: Mental health and Domestic abuse (2019)
- National Institute for Health and Care Excellence (NICE) Domestic violence and abuse (2016)

- National Institute for Health and Care Excellence Costing statement: Domestic violence and abuse (2014)
- Home Office Domestic Abuse, Transforming the Response (2019)
- The Council of Europe Encouraging the Participation of the Private sector and the Media in the Prevention of Violence Against Women and Domestic Violence (2016)



# Appendix 11: Health Based Idva Service Service Level Agreement Template

This is a template document designed to be tailored to reflect local circumstances.

Date prepared:        /        /

**Prepared for:**

Name:

Position/Job title:

Organisation:

Address:

Contract period:  
From:        /        /        To:        /        /

**Prepared by:**

Name:

Position/Job title:

Organisation:

Address:

## 1. Agreement overview

This Service Level Agreement (SLA) specifies the arrangements for the provision of a comprehensive Health Based Idva service to {name of purchasing organisation}, hereafter referred to as the purchaser, by {name of domestic abuse service}, hereafter referred to as the provider.

This Agreement remains valid until superseded by a revised agreement mutually endorsed by the stakeholders.

This Agreement outlines the parameters covered by the Health Based Idva Service as they are mutually understood by the stakeholders.

## 2. Goals and Objectives

The **purpose** of this agreement is to ensure that the proper elements and commitments are in place to provide consistent Health Based Idva support and delivery to the purchaser by the service provider.

The **goal** of this agreement is to obtain mutual agreement for a Health Based Idva provision between the service provider and the purchaser.

The **Objectives** of this agreement are to:

- Provide clear reference to service ownership, accountability, roles and/or responsibilities.
- Present a clear, concise and measurable description of service provision to the customer.
- Match perceptions of expected service provision with actual service support and delivery.

## 3. Stakeholders

The following service provider and purchaser will be used as the basis of the agreement and represent the primary stakeholders associated with this SLA.

Idva service provider: {organisation name} (provider)

{Name of purchasing organisation i.e. mental health trust, CMHTs} (purchaser)

## 4. Periodic Review

This agreement is valid from the **effective date** outlined herein and is valid until further notice. This agreement should be reviewed at a minimum once per {insert time} year(s).

The Business Relationship Manager (document owner) is responsible for facilitating regular reviews of this document. Contents of this document may be amended as required, provided mutual agreement is obtained from the primary stakeholders and communicated to all affected parties. The document owner will incorporate all subsequent revisions and obtain mutual agreements/approvals as required.

Business Relationship Manager: {insert organisation name}

Review period:

Previous Review date:

Next review date:

## 5. Service Agreement

The following detailed service parameters are the responsibility of the service provider in the ongoing support of this agreement. A minimum complement of two Idvas is recommended to ensure that Idva staff are not lone working across a seven-day service (particularly one which extends across busy evening periods)<sup>238</sup>.

### 5.1 Service Scope

The following services are covered by this agreement: (this is an indicative but not exhaustive list)

**Survivors**

- To identify, engage and support survivors of domestic abuse.
- To offer appropriate emotional and practical support to survivors of domestic abuse. (Some services may choose just to identify and refer onto a community-based service, whilst others may carry a caseload, others may only support victims at high risk and refer all other cases onto other services).
- To risk assess and offer safety planning, including referrals to Marac. (some services may carry out all risk assessments and Marac referrals, whilst others will be in a supportive role for health practitioners to do this).
- To refer onto ongoing support offered by voluntary and statutory services/agencies.

### Training and support

- To identify and communicate clear referral pathways to health staff.
- To work with {the purchasing organisation to} provide systematic training on domestic abuse to health staff (Some services may offer this to particular teams such as assertive outreach, whilst others can offer this to all staff. A number of training sessions could be specified, such as 12 per year. Best practice would support delivery of an introduction to the service at new staff induction conferences, within mandatory safeguarding training delivered to hospital staff and refresher sessions throughout the year).
- To support health staff to identify potential survivors, to risk assess and safeguard.
- To provide health staff with support and guidance when needed.
- To support health staff with safeguarding obligations (including adult/child safeguarding referrals and Marac referrals).
- To support safeguarding leads with writing of domestic abuse policies.
- To raise awareness of domestic abuse and the Idva service to health departments/ staff and patients.

### Monitoring and governance

- The service will **be working to the standards set out as best practice in the domestic abuse sector's Shared Core Standards document<sup>239</sup> and be subject to a regular, independent quality assurance process. Any service providing a response to perpetrators should hold or be working towards the Respect accreditation standard<sup>240</sup>.**
- Regular audits to ensure obligations for safeguarding are being met (and any barriers are being overcome).
- To implement and communicate a clear referral process, including documentation (this could be Trust wide or designated departments).
- Information sharing (will require an additional information sharing agreement).
- To collect appropriate data and take part in a process of analysis to support effective practice improvement and delivery of service.
- To provide an annual report of the service.

### 5.2 Purchaser requirements

Purchaser responsibilities and/or requirements in support of this agreement include:

- Embedding the service within the health setting including providing support from senior clinical staff and named champions in each ward.
- Payment for service at the agreed interval.
- Appropriate access to patients (including covering travel costs), patient notes, IT systems including NHS secure email.
- To provide a host manager to support the role of the Idva(s), ongoing management of the relationship and caseloads.
- To provide an honorary contract (if the Idva is not employed by the hospital) and relevant identification passes.
- To work with the service to deliver a systematic package of training to health staff.
- A central office base from which to provide the service, for example a private room near to the emergency and/or maternity department.
- To allow for appropriate advertisement of the service.

### 5.3 Service provider requirements

Service provider responsibilities and/or requirements in support of this agreement include:

- Provision of a Health Based Idva Monday to Friday 9am to 5pm (ideally more than one will be employed in order to provide coverage across shift patterns and cover for annual leave and sickness).
- Provision of supervision, clinical supervision, counselling service for Idvas.
- An allocated first point of contact for the Idvas and procedure in case of advice or guidance needed.
- Provision of programmes for Idvas to refer service users to (these programmes/courses will vary depending on the service).
- Provision of regular case management.
- Opportunity for regular training (CPD) appropriate for the role.
- Provision of equipment needed for role, mobile phone, laptop, etc.
- Payment to the individual carrying out the role.
- Collection of data and contribution to analysis of this data, feeding into a process of practice improvement.
- Secure holding of information/files regarding service users.
- Secure emails.

239 <https://safelives.org.uk/commissioning-support/vawg-sector-shared-core-standards>

240 <http://respect.uk.net/what-we-do/accreditation/the-respect-standard/>

## 6. Service Management

Effective support of in scope services is a result of maintaining consistent service levels. The following sections provide relevant details on service availability, monitoring of in scope services and related components.

### 6.1 Service Availability

Coverage parameters specific to the services covered in this agreement are as follows:

These relate to the number of Idvas provided and the number of sites covered. Idvas availability for evenings, weekends, bank holidays have been shown to be effective in identifying and supporting survivors.

Idva support: 9.00am to 5.00pm Monday – Friday

Calls/referrals received out of hours: eg will be answered/picked up the following working day.

### 6.2 Absence Management

During times of Idvas absence (sickness and annual leave related), all concerns raised by health staff should be forwarded to the specialist community Idva service (purchaser may create their own absence management procedures based on the number of Idvas being provided.)

### 6.3 Service Requests

In support of services outlined in this agreement, the service provider will respond to referrals and requests of support within the following time frames:

- 0–48 hours (during business hours) for survivors at high risk
- Within 72 hours for survivors at medium risk
- Within 5 working days for communication, emails, etc.

### 6.4 Service Objectives

The below objectives are basic and can be developed to be more specific and expansive. Performance indicators could also be set out stating target referral numbers, number of staff trained and impact measures for this training.

- To increase the identification of service users/patients who are experiencing domestic abuse from the age of 16 years and above.
- To increase referrals for service users/patients into specialist domestic abuse services and/or Marac.
- To increase awareness, knowledge, motivation and confidence of health staff in understanding and responding appropriately to domestic abuse.
- To evaluate the effectiveness of domestic abuse training in increasing awareness, knowledge, motivation and confidence in responding to domestic abuse.
- To improve the way health staff document disclosures of domestic abuse and subsequent actions taken on service user/patient records.
- To understand barriers and limitations to accessing domestic abuse services.

## 7. Intellectual Property

Intellectual property includes the rights of ownership of all manner of intellectual property rights including, without limitation, patents, trademarks and service marks, copyrights and design, and know-how.

The intellectual property of each organisation will not be shared outside the purchaser and the provider.

# Appendix 12: Domestic Abuse Training Assessment Tool

This checklist lists the content to be included in various levels of training. Pathfinder recommends that NHS services use this to ensure that the service’s current training offer is robust enough and meets the learning objectives, criteria and outcomes set out and to help identify where there are gaps (using RAG rating).

Training Level	Requirements for the Training Level	RAG Rating
Level 1	To know the government definition of domestic abuse	
	To understand the health professional’s role in tackling domestic abuse including links to mental health, alcohol and drug abuse and associated legal duties	
	To understand the dynamics of power and control in domestic abuse	
	To understand the health impact of domestic abuse	
	To understand the links between domestic abuse and different forms of VAWG including so-called ‘honour’ based abuse, forced marriage, sexual violence and harassment, sexual exploitation, stalking, and female-gential mutilation	
	To understand the concept of shame and other barriers associated with domestic abuse and so-called ‘honour’ based violence	
	To understand domestic abuse is not caused by a particular culture, religion, or socioeconomic status	
	To understand equality and diversity in the context of domestic abuse	
	To be able to respond appropriately to a disclosure of domestic abuse sensitively and in a way that ensures people’s safety	
	To understand how to respond to someone who is in immediate dan-ger and document the incident safely and appropriately	
	To understand the need for multi-agency working	
	To be aware of the Trust’s policy on domestic abuse procedures	
	To understand Trust safeguarding procedures in relation to domestic abuse	
	To be aware of local specialist domestic abuse services	
	To know how to signpost to local and national domestic abuse ser-vices	
	To be aware of the Trust’s staff policy on domestic abuse	
To understand that domestic abuse issues apply to the workforce as well as patients		



Training Level	Requirements for the Training Level	RAG Rating
<b>Level 2</b>	To understand local and national prevalence of domestic abuse	
	To recognise signs and symptoms of domestic abuse in health settings including coercive control and perpetrator behaviour	
	To understand risk indicators associated with domestic abuse and posed by the perpetrator	
	To understand children's experiences of domestic abuse	
	To understand the intersections of identity and experiences of domestic abuse stemming from groups of survivors with protected characteristics	
	To be aware of the power and control wheel and know how to use it	
	To understand how to ask about domestic abuse in a way that is appropriate to your health setting	
	To know what to do when signs of domestic abuse are present in the absence of a disclosure	
	To understand how to give messages of validation	
	To understand what risk assessment frameworks exist including the SafeLives DASH risk identification checklist and SPECSSS (Separation, Pregnancy, Escalation, Community/Isolation, Strangulation, Stalking, Sexual Violence)	
	To feel confident to provide immediate safety planning for immediate risk (e.g. call 999, keep patient in overnight if not safe to go home etc)	
	To be aware of the designated person in the Trust who can complete SafeLives DASH risk identification checklist and refer to Marac	
	To know how to refer to Marac and specialist services (depending on Trust policy)	
	To have a clear understanding of local services and referral pathways	
	To understand additional barriers stemming from protected characteristics under the Equality Act 2010 survivors may face in accessing support	
	To understand how to record information safely, appropriately and non-judgmentally	
	To understand information sharing and confidentiality procedures both internally and externally	

Training Level	Requirements for the Training Level	RAG Rating
<b>Level 3</b>	To feel confident to challenge and address misconceptions about domestic abuse	
	To be aware of the institutional power and control wheel and know how to use it	
	To understand the intersection of domestic abuse, mental ill-health and substance abuse and its links to poverty, homelessness, re-moval of children and involvement in prostitution/exploitation (multiple disadvantage)	
	To understand why health services often fail to effectively engage survivors who have faced multiple disadvantage and understand how to better meet their needs	
	To understand the links between domestic abuse, mental health and trauma and how to better respond to trauma	
	To understand the role of institutional/social trauma and consider how the health setting could retraumatise survivors	
	To understand the principles and values of a trauma-informed approach	
	To understand how to identify different forms of VAWG and respond appropriately, including so-called 'honour' based violence, sexual violence and harassment, sexual exploitation, stalking, forced marriage and FGM	
	To be aware of potential ongoing safety planning options that could be explored with support of the designated safeguarding or domestic abuse lead	
	To know how to refer to Marac	
	To understand information sharing and confidentiality procedures both internally and externally	
	To understand best practice in working with survivors who have mental ill-health and substance misuse	

