

Sub-group report

Report from the Domestic Violence sub-group

Responding to violence against
women and children – the role
of the NHS

Taskforce on the Health
Aspects of Violence Against
Women and Children

March 2010

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Foreword

This report examines the impact of domestic violence against women, girls and children in England and how it can damage them and their families, with long-lasting wider repercussions for society. The violence endured by women from partners and family members is a violation of human rights with profound health and economic consequences.

The Taskforce of which this sub-group is a part is formally charged with considering the health needs of women and girls. We recognise that women and teenage girls suffer disproportionately from violence because of their gender. We also recognise that women survivors of violence may have their needs overlooked where their children are also victims, since child safety is paramount and legally enforced so the children's needs may come before those of the non-abusive mother. However, we are concerned that the NHS should meet the needs of both women and children as victims of violence, and we feel strongly that this should be done in an integrated way since child survivors' interests may be best served by protecting their non-abusive parent. We also recognise that vulnerable teenagers of both genders need protection from violence. We have therefore included both women and children in our remit, and we call on the Taskforce to recognise this in its main report.

Domestic violence is often a taboo subject which people find hard to talk about. The term includes physical, sexual, psychological and economic violence within intimate partner relationships, whether between married and cohabiting adults, ex-partners or people in non-cohabiting relationships, including teenagers.¹ Domestic violence against women is a pattern of coercive and controlling behaviour, reflecting societal gender inequality. Survivors of domestic violence are often made to feel guilty and responsible for the violent situation, while the abusers remain invisible.

The sub-group has considered how health services, and the NHS in particular, can improve the help they give to female and child survivors of domestic violence. This report makes proposals to the Taskforce on the Health Aspects of Violence Against Women and Children for policy recommendation to the Department of Health (DH).

Our sub-group has concentrated on domestic violence against women and its impact on children who witness it. We recognise that domestic violence is also experienced by men. However, the frequency and severity of domestic violence perpetrated against women, and the long-term health consequences, are substantially greater. Men are more likely to be victims (and perpetrators) of violent

¹ Domestic violence normally includes forced marriage, crimes in the name of honour, violence from the wider family, and female genital mutilation. These issues have been examined by another sub-group of the Taskforce.

crime overall and government initiatives for the prevention of other violent crimes directly benefit men.²

We recognise the strong correlation between domestic violence and child maltreatment. Children may directly suffer violence themselves or they may witness it. The Adoption and Children Act 2002³ extended the legal definition of harming children to include harm suffered by seeing or hearing ill treatment of others, especially in the home. Living with domestic violence distorts children's perceptions of relationships, blame, cause and effect, and it has a profound impact on their cognitive, psychological, social and educational development. Other government initiatives address safeguarding and child protection, including those implementing the recommendations of Lord Laming⁴ following the death of 'Baby Peter' and the earlier Victoria Climbié inquiry. This report identifies and promotes links to that work and its relevance to the work of this sub-group, without seeking to repeat it here.

Our report considers the prevalence of domestic violence, and the impact on the women and children who suffer it. The report reflects the sub-group's understanding of the health dimension of domestic violence and effective responses from health services to support women and children experiencing domestic violence. We have looked at available evidence to support our conclusions and have identified areas where more research should be undertaken.

The production of this report would not have been possible without the expertise and commitment of the members of the sub-group. Their experience covers a wide range of backgrounds: service use, service provision and development, and clinicians and academics with first hand experience of working with victims and survivors of domestic violence. We are very grateful to them for their enthusiasm and significant time commitment. A full list of members is at Annex 1. We also acknowledge and thank the members of the DH secretariat team who have supported the production of this report.

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² There are some services for male victims of domestic violence, which should be subject to monitoring to see if they are sufficient and appropriate.

³ The Adoption and Children Act 2002 came into force in 2005.

⁴ Lord Laming (2009) *The Protection of Children In England: A Progress Report*.

Summary recommendations

Prevention: Healthcare professionals need to work locally in partnership, especially with the education sector, challenging the acceptability of domestic abuse among young people.

Identification and management: Clinical teams need training and supervision to ensure they use safe enquiry to identify domestic violence, offering the correct services to their patients and making appropriate risk assessments and links or referrals to specialist domestic violence services for practical support, and ensuring safe discharge. There should be a rolling programme of training to provide for rapid turnover of staff.

Key services and successful pathways: Commission intervention programmes for women survivors and their children, and review links with existing services, differentiating services according to the woman's own assessment of her needs and relevant risk requirements. Services may include refuge support services, independent domestic violence advisers (IDVAs), other outreach and floating support services for women who remain in or return to their own homes, and specialist support services for children and young people. Those who commission services should take account of the guidance on commissioning domestic violence services recommended below.

Integration of psychological support and treatment for survivors and their children into mainstream health services in primary and secondary care and specialist agencies, with domestic violence issues included within Improving Access to Psychological Therapies training and competencies.

Improving availability of and access to services: Provide national guidance on commissioning (for both the NHS and the third sector) of a specialist domestic violence service for women and children that can be accessed from primary care, women's health and emergency health settings. These services should be commissioned in partnership with the local authority and the Crime and Disorder Reduction Partnership (CDRP), subject to available resources.

Information sharing: Integrate child protection and partner domestic violence information sharing, so that there is a two-way flow of information between these two services. Include updated guidance for health professionals attending Multi-Agency Risk Assessment Conferences (MARACs) about sharing information in relation to the victim(s), children and perpetrator(s), and information for health professionals about S-flagging to prevent casual access to survivors' personal details.

Workforce: Set up standardised training in domestic violence with identified funding and adequate professional supervision at the following levels:

- undergraduate;
- pre-registration;
- postgraduate/post registration, incorporated into CPD for all clinicians and advanced training; and
- non-clinical staff in-service training.

Require that NHS employers/contractors have a domestic violence policy to assist and support staff who are experiencing domestic violence and to give guidance on the employment of perpetrators.

Systems and incentives: Provide national commissioning guidance based on national outcome-based standards for all grades of clinicians in all settings and for specialist domestic violence leads, developing qualifications and new service standards where necessary. This will require common definitions for the collection of data where violence against women has been disclosed and will require all services to collect it.

1: Context

Legal context

- 1.1 Domestic violence infringes fundamental human rights, as recognised in international United Nations (UN) Conventions and given national status in the Human Rights Act 1998. This includes particularly the Right to Life (Article 2), the Prohibition of Torture (Article 3) and the Right to Liberty and Security (Article 5). Parallel rights are included in the UN Convention on the Rights of the Child (Article 6 states the right to life, Article 19 the right to protection from violence, injury, abuse, neglect and maltreatment).
- 1.2 Domestic violence happens disproportionately against women and girls. In 89% of criminal domestic violence repeated four times or more the victims were women,⁵ with a similar gender difference for sexual or severe physical violence. Action to address this inequality is part of the Gender Equality Duty laid on public bodies by the Equality Act 2006, compliance with which is monitored by the Equality and Human Rights Commission.
- 1.3 The UN's Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Global Platform

for Action link this approach to tackling violence against women with commitments made by the UK Government. CEDAW is an international convention, adopted by the UN General Assembly in 1979. It has been described as an international bill of rights for women and was ratified by the UK in 1986.

- 1.4 UK legislation also provides a framework with obligations for public bodies to work together to reduce violent crime, including domestic violence, through Crime and Disorder Reduction Partnerships (CDRPs) set up by the Crime and Disorder Act 1998, as part of a wider framework of legislation applicable to victims of domestic violence including the Family Law Act 1996, the Protection from Harassment Act 1997 and homelessness legislation from 1996 onwards. The Domestic Violence Crime and Victims Act 2004 extended the scope of domestic violence legislation to include survivors within same-sex relationships, cohabitants and those in intimate non-cohabiting relationships, and introduced domestic violence homicide reviews as a means of learning from past cases to improve support for future survivors.

⁵ Walby S and Allen J (2004) *Domestic violence, sexual assault and stalking: Findings from the British Crime Survey*. Home Office.

- 1.5 Public bodies have obligations under the Children Acts 1998 and 2004 to safeguard children and young people (in this context those affected by domestic violence), to embed safeguarding children into the daily functioning of their services and also to co-operate to provide protection for children and promote their welfare.

Definitions

- 1.6 The UN Declaration on the Elimination of Violence Against Women defines violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women”.
- 1.7 An alternative definition is provided by the UN’s CEDAW, as “violence directed at a woman because she is a woman or acts of violence which are suffered disproportionately by women”.
- 1.8 The Home Office⁶ defines domestic violence as: ‘Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.’ It also includes violence within teenage intimate partner relationships, and abuse of older women, including abuse by adult children, the wider extended family, and carers: women at both extremes of the age spectrum are more vulnerable.

Domestic Violence: Domestic violence can take many forms including psychological/emotional violence, physical violence, restriction of freedom including both deprivation of movement and restriction of social networks, sexual violence and financial abuse. A term which is increasingly used to refer to domestic violence is ‘domestic abuse’, which is perceived to enable a better understanding of the impact of non-physical violence. However survivors have made the point that the term ‘abuse’ tends to soften the impact of non-physical violence which is no less damaging than physical violence. For this reason we have preferred the term violence throughout. The main characteristic of domestic violence is that the behaviour is intentional and is calculated to induce fear and misuse power to control how the victim thinks, feels and behaves.

Laming report response

- 1.9 The sub-group has been concerned to ensure that its proposals are consistent with the broader DH response to safeguarding children and promoting their well-being, which currently has a focus under the Government’s response to the recent Laming Report.⁷ The Laming recommendations relevant to the DH are listed in the Annex to the Report.
- 1.10 There are also current DH work strands on children and young people with sexually harmful

behaviours⁸ and serious youth violence. The DH has also recently published a practical toolkit for frontline practitioners to help them deal with children, young people and domestic violence.⁹ This supplements DH’s existing handbook for health professionals giving advice on routine clinical enquiry about domestic violence in healthcare settings.¹⁰

- 1.11 The Taskforce sub-group has taken the above overall UN CEDAW definition to interpret its task, but has also borne in mind that some aspects (sexual violence against women, sexual abuse of children, and harmful traditional practices) are being examined more fully in other Taskforce sub-groups. Additionally the way in which domestic violence affects children is already an integral part of the safeguarding children agenda.
- 1.12 The sub-group is aware that the remit of the Taskforce is to focus on help for survivors of violence against women and children, rather than addressing interventions targeted at perpetrators. The sub-group nevertheless acknowledges that one important area for further health service related policy work is action to work with perpetrators to help them to stop offending, which will reduce the incidence of

domestic violence and reduce the suffering of survivors.

Policy context

- 1.13 A cross-government Strategy¹¹ on Violence Against Women and Girls was published on 25 November 2009 and is the first co-ordinated government approach to combating all forms of violence against women and girls.
- 1.14 The framework for government action on domestic violence had previously been set out in the cross-government National Domestic Violence Delivery Plan 2009–10. The Delivery Plan’s objectives cover earlier identification, prevention, capacity and sustainability of advice and support services, an improved justice system response, and cross-cutting issues to support delivery of the plan.

⁶ Home Office (2005) *Domestic Violence: A National Report*.

⁷ Lord Laming (2009) *The Protection of Children in England: A Progress Report*.

⁸ See Draft Guidance *Children with Inappropriate or Harmful Sexual Behaviours: A Framework for Service Commissioning*, DH.

⁹ DH (2009) *Improving Safety, Reducing Harm: Children, young people and domestic violence*.

¹⁰ DH (2006) *Responding to Domestic Violence: a handbook for health professionals*.

¹¹ www.homeoffice.gov.uk/documents/vawg-strategy-2009/

2: Prevalence and impact

Prevalence

2.1 Headline evidence¹² of the prevalence of domestic violence shows the extent of the problem.

- One in four women will be affected by domestic violence in their lifetime.
- On average, two women in England and Wales are killed every week by a current or former male partner.
- One incident of domestic violence is reported to police every minute.
- Domestic violence accounts for 16% of all violent crime, rising to 24% in certain local authority areas.
- It is the major cause of injury to women under 60 years of age and a major risk factor for psychiatric disorders, chronic physical conditions and substance abuse.
- Of people aged 66 and over living in private households, 2.6% reported in 2007 that they had experienced mistreatment involving a family member, close friend or care worker during the past year – which equates

to about 227,000 older people across the UK.¹³

- In a recent surveys of 13 to 17-year-old girls in intimate relationships, one in six girls said they had been hit by their boyfriends (4% regularly)¹⁴ and one in sixteen said they had been raped.¹⁵
- At least 750,000 children a year witness domestic violence. Nearly three quarters of children on the 'at risk' register live in households where domestic violence occurs.¹⁶ In 75% to 90% of incidents of domestic violence, children are in the same or the next room.^{17,18}
- The link between child physical abuse and domestic violence is high, with estimates ranging between 30% and 66% of households where domestic violence occurs depending upon the study.¹⁹

13 The term 'mistreatment' covers both abuse (psychological, physical, sexual and financial) and neglect.

14 Body Shop/YouGov survey, 2004.

15 NSPCC and the University of Bristol, September 2009.

16 Department of Health (2002) *Women's Mental Health: Into the Mainstream. Strategic Development of Mental Health Care for Women.*

17 Hughes H (1992) Impact of spouse abuse on children of battered women. *Violence Update*, 1 August, 9–11.

18 Abrahams C (1994) *The Hidden Victims: Children and Domestic Violence.* NCH Action for Children.

19 Humphreys C and Thiara R (2002) *Routes to Safety: Protection issues facing abused women and children and the role of outreach services.* Bristol: Women's Aid Federation of England.

- In a study of 173 children subject to serious case review, domestic violence was an issue for 47 (27%).²⁰
- The cost of violence against women in 2008 is estimated at £1.7 billion in healthcare costs plus an additional £15.7 billion in human and emotional cost.²¹
- Fewer than 1% of domestic violence victims who require emergency department treatment subsequently obtain a conviction for their assault.²²

2.2 A review²³ of partner violence prevalence studies of UK populations found that the estimates of women in the general population experiencing partner violence over their lifetime ranged from 13% to 31%, and the range of women in clinical populations (surveyed in healthcare settings) was 13% to 41%. The range of women in the general population who had experienced partner violence in the previous year was 4.2% to 6%, and the range for women in clinical populations was 4% to 19.5%. Survivors are more likely to access health services than women who have

not experienced partner violence. In general practice populations up to 40% of women patients experience physical abuse from a partner or ex-partner over their lifetime.²⁴

- 2.3 Most epidemiological studies report a higher prevalence of domestic violence among younger women, and those who were separated or single, in the general population. Prevalence of physical assault alone decreases with age.
- 2.4 In order to determine the costs and benefits of improving NHS and other health services for survivors of domestic violence, a full analysis of the costs, risks and benefits of the recommendations eventually put forward by the Taskforce should be carried out. This will demonstrate priorities for the investment of available resources.

Impacts on women

- 2.5 A systematic review of reviews of health impact reported a wide range of detrimental effects on women's health, consistent with the findings of previous overviews.²⁵ Repeated victimisation can compound the effect on survivors on whom the impacts may continue for years. The more frequent and severe the abuse, the greater the risk that

20 Ofsted (2009) *Learning lessons from serious case reviews: year 2.*

21 Walby S (2004, 2009) *The Cost of Domestic Violence.* London: Women and Equality Unit.

22 Boyle A, Kirkbride J and James P (2005) *Journal of Epidemiology and Community Health.* <http://jech.bmj.com/content/59/10/909.extract>

23 Feder G, Ramsay J, Dunne D, Rose M, Arsene C and Norman R *et al.* (2009) How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technology Assessment*, 13(16).

24 Richardson J, Coid J, Petrukevitch A, Chung WS, Moorey S and Feder G (2002) Identifying domestic violence: cross sectional study in primary care. *BMJ*, 324(7332), 274–278.

25 Campbell J (2002) Health consequences of intimate partner violence. *The Lancet*, 359 (9314), 1131–1136.

12 Home Office data unless otherwise stated.

survivors will develop mental health problems.²⁶

2.6 The health impact of partner violence on women may affect:

- physical health: injuries, chronic pain, neurological responses, gastrointestinal disorders and cardiac symptoms;
- reproductive health: trauma including fetal and maternal death, gynaecological problems, increased risk of STD, HIV, unintended pregnancy, greater use of alcohol and smoking and a lower birth weight; and
- mental health: depression, post-traumatic stress disorder (PTSD), substance abuse, anxiety, insomnia, suicidality and social dysfunction.

Impacts on children

2.7 The impact on children of both experiencing and witnessing domestic violence affecting parents and their partners may include:

- physical damage;
- behavioural problems;
- mental health problems;
- exposure to multiple adversities: violence, mental health, substance abuse;
- developmental delay;

- academic problems leading to diminished educational attainment; and

- lower take up of healthcare, such as risk of under-immunisation.

2.8 The longer term impact on child witnesses and children who experience domestic violence is wide-ranging. It includes a tendency towards self-harm and depression in some, and in others an increased tendency to become abusive themselves, and to be aggressive or stressed in their own parenting. Fundamental changes to the core self, demonstrated by a loss of hope, faith or trust in others, are also seen in those abused over the course of their life.

Society

2.9 The scale and cost of the immediate effect of domestic violence are compounded by its contribution as a risk factor in long-term mental and physical ill health for survivors and family members.

2.10 There is no consistent demographic association other than deprivation, although there is still high prevalence in all socio-economic strata, across all ethnic groups and regardless of sexual orientation.

2.11 There is a need for a full cost-benefit analysis which will examine the cost of investing in preventative action, and in services for women and children who experience domestic violence. We are confident that

this would demonstrate how more appropriate action or services which may not always be available now would improve the outcomes and quality of life for survivors and children affected by domestic violence, and would reduce costs currently incurred on treating the long-term effects of their abusive experience. This should be underpinned by comprehensive data collection and analysis, using commonly-agreed definitions of violence, to aid accurate identification of prevalence and effective outcomes.

2.12 A cost-benefit analysis should support prioritisation of service improvements to make the best use of available resources, including redeployment of resources to best effect.

2.13 Existing service provision is patchy, so many victims' and survivors' needs are not being met, fully or at all. Many such services are run by the voluntary sector. Women's Aid co-ordinates and supports an England-wide network of over 500 local support services.²⁷

2.14 Despite this provision:

- over one in four local authority areas in Britain have no specialised domestic violence support services;

- only one in ten local authority areas in Britain have a specialised service for ethnic minority women, such as those fleeing forced marriage or female genital mutilation; and

- 60% of new specialist services set up in 2008 were in statutory immediate response services for the minority of women that have contact with the criminal justice system. These services include independent domestic violence advisers (IDVAs), who work with families at high risk of domestic violence, typically through Multi-Agency Risk Assessment Conferences (MARACs). In 2008, MARACs dealt with 30,000 people in 2008, about a third of high risk victims reporting to the police.²⁸ Most of these women will also have accessed support services run by independent women's voluntary sector organisations, part of the Women's Aid Federation.

²⁶ Golding JM (1999) Intimate partner violence as a risk factor for mental disorders: a meta-analysis, *Journal of Family Violence*, 14(2), 99–132.

²⁷ The majority of these services are listed on *UKrefugesonline*, a UK-wide online directory of specialist services which forms a basis for the UK Gold Book. Within England, Women's Aid member organisations offer the following services: outreach, advocacy, floating support, sexual abuse support services, resettlement services, as well as refuge accommodation and support, and services for children affected by domestic abuse, *Women's Aid Annual Report*, 2009.

²⁸ The majority of victims do not report to the police, however.

3: What women told us

3.1 Evidence was gathered during the course of the Taskforce's work from a wide range of service users, survivors and their representatives. The Taskforce commissioned the Women's National Commission to organise and facilitate 14 follow-up focus groups with women who are survivors of violence and who have recently used health services. An open survey attracting responses from the general public was run by NHS Choices, and views were gathered from a range of NHS staff from many different professional groups at a deliberative event, and from staff focus groups in South Birmingham Primary Care Trust (PCT). Information from the Home Office consultation 'Together we can end violence against women and girls', March–May 2009, was also considered.

Women

3.2 All women thought that the NHS (health visitors, GPs, hospitals, dentists, sexual health services, practice nurses) has a vital role in early identification and response to violence – particularly for those who are isolated and therefore more vulnerable – and also should have a key role in supporting and safeguarding women and children.

3.3 Survivors saw the main issues and barriers to getting the help they needed as:

- healthcare staff not having time to let them disclose violence and see how to meet their needs;
- healthcare staff not knowing what to do with the problems of women who have experienced domestic violence, whether currently or in the past;
- healthcare staff not believing they had a problem, thinking it was part of their lifestyle or culture; and
- healthcare staff listening to accompanying abusive partners or family members instead of to the woman herself, or not understanding violence issues for lesbian and transgender women. Similar issues exist for other groups of women who might have had difficulty in communicating them: older women, women with learning disabilities or mental health issues, and women with language barriers, particularly if dependent on violent partners for translation.

3.4 Some comments:²⁹

"If you keep going back and you have bruises or

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

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

More comments are at Annex 3.

3.5 Specific issues were highlighted by people with particular characteristics:

"It's not just the classic image of a male perpetrator we need to worry about. It's the mother-in-law; it's the uncle from down the street. We need to educate

our communities so they are aware that what they are doing is wrong and it won't be tolerated, violence against women is an offence and you will be punished."

"I can't register with a GP, as I have no papers. My teacher on my course has tried to help me to get a doctor, because now the hospital I go to has said I can't go back there, that I need to get a GP, without asking me why I can't do this."

"I'm a bi person and if I experience violence from a male partner then there's an option to get help, if the partner is female you go unsupported."

"Trans people have to put up with constant low-level verbal abuse. This constant abuse is demoralising, and intimidating; this mental and emotional abuse is worse and more difficult to recover from than physical violence."

²⁹ Taskforce on the Health Aspects of Violence Against Women and Children: WNC: Women's Focus Group Report (2010).

- 3.6 Women said that they wanted the following help to overcome these barriers:
- GPs and other health professionals to know how to signpost appropriately women who have experienced violence to specialist services;
 - clear referral protocols for consensual information sharing between health professionals and other services which maximise safety and confidentiality;
 - health services to address the overwhelming culture of disbelief by health professionals towards all women who disclose violence;
 - compulsory training on violence against women for all health professionals – identifying the signs, asking about experiences of violence, how to provide support on disclosure, and how to refer women to services;
 - health services to recognise the crucial role of specialist women's services in providing longer-term individual and group support for women, which promotes empowerment as a means of preventing violence in the short and longer term;
 - health services to contribute to healthy relationships education in all schools, and integrate violence against women into all health promotion and prevention work; and

- more effective publicity in health services about the availability of women's support services and help-lines.

- 3.7 Some comments they made³⁰ about what would help were:

“There should always be a choice of women GPs available for women to see, which would help them talk about the violence. It is a good idea to have access to women GPs for women patients. Women for women services can help women get help.”

“I think having a specialist drop-in, in a surgery, or specialist domestic violence workers in A&E would make a big difference. A women's centre within a hospital could work, like a specialist unit, or trained domestic violence workers that you could speak to, after you saw the consultant.”

More comments are at Annex 3.

Girls (teenage relationships)

- 3.8 The Department of Health (DH) commissioned the National

³⁰ Ibid.

Children's Bureau (NCB) to ask young people (14–19 years) for their views on violence against women and girls. The Taskforce commissioned two consultants to co-ordinate and undertake the gathering of views from children and young people in focus groups of young people from a variety of backgrounds, geographical spread and ability, held in youth clubs, schools, special interest groups, support groups and groups specifically targeting young people with specific needs and abilities.

- 3.9 Teenagers expressed views³¹ such as:

“I think the issue [domestic violence] has to be talked about rather than brushed under the carpet.”

“A girl can get hit because she has her own opinions and her boyfriend don't like it. Lots of boys just hit girls because they don't like what they say.”

“We live in a violent society and everyone hardly bats an eyelid when anything happens, like a girl getting hit by her boyfriend. People just think she must have done

something to deserve it. Schools should be teaching students and parents because most of the students learn their aggression from their families.”

Children

- 3.10 Anonymised case notes³² provide an insight into children's experiences:

“Dad been hitting her mum for a long time. Witnessed dad hitting mum today with three year old sister. Dad told mum ‘if you tell anyone I will kill you’. Mum is covered in bruises on arms and chest. Mum had to go to hospital last month because dad stabbed her in the back with a poker.”

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

³¹ Together we can end violence against women and girls: Young People's consultation response, collated by National Children's Bureau, May 2009.

³² Case notes from calls by young people to ChildLine, NSPCC, 2009.

4: What NHS staff said

4.1 South Birmingham Primary Care Trust (PCT) worked with a facilitator provided by the Department of Health (DH) to co-produce evidence from NHS staff on dealing with domestic violence. They held focus groups and a deliberative event to explore within one health locality the experiences of staff in supporting victims and survivors of violence, including domestic violence. This included drawing out the barriers they face in identifying or responding to victims of violence against women and children, their ideas on addressing these and examples of good practice.

4.2 As part of this work, staff explored a set of short case studies that highlighted different aspects of violence against women and children. The case studies were drawn from real life situations where NHS staff have been involved in identifying, preventing and treating the symptoms of violence. The groups were asked to draw on the key elements of the case studies in order to identify both what good practice looks like and the most significant barriers to that good practice being delivered.

4.3 There was a strong degree of congruence from NHS staff when asked about what they found hard in dealing with survivors of domestic violence:

- not having time to deal with the results of asking about abuse;
- being too embarrassed or uncomfortable to ask;
- not knowing what help to offer;
- being unable to face patients' issues which staff themselves were experiencing in their own lives;
- being worried about being unable to offer appropriate help, and being unable to face the consequences; and
- feeling frustrated with victims of domestic violence, because of likely recurring needs.

4.4 Other studies have examined this issue, with similar findings. They have additionally shown that staff may feel they are not trained to deal with domestic violence, or that doing so is not part of their role.³³

4.5 Suggestions from staff about what would help them to offer a better service included:

- time to build up a rapport with women, to ask about violence early on and not to expect an immediate answer;

³³ www.kcl.ac.uk/schools/nursing/research/themes/women/projects/maternal/domesticviolence.html

- training in how to respond, how to intervene, what local services or help were available for signposting;
- counselling and support for staff working with women survivors;
- multi-agency training, liaison and support; knowing how to find a place in a refuge outside office hours;
- a staff domestic violence policy to address the needs of staff as victims and perpetrators; and
- a system which allows the whole needs of a woman or family to be taken into account to be met holistically: this could address separate individual needs arising from lifestyle, culture, family dependants, sexual orientation, locality, other health needs, occupation, age and other relevant factors including their relationship with their abuser.

4.6 DH commissioned a call for evidence from the wider NHS. The following summarises what were perceived to be the main issues:

- training of healthcare professionals;
- greater co-operation between organisations;
- routine questioning about violence and abuse by trained staff, and only when the patient is alone;³⁴

³⁴ It is essential to provide interpreters for those women who need them so that family members are not used for this purpose.

- establishment of standard procedures to deal with violence and abuse, developed in consultation with local domestic violence specialist organisations;
- specialist staff to lead services;
- specialised and personalised services to address inequality;
- recognise the relationship between alcohol and other substances and abuse, including the different ways in which substances may be used by perpetrators and victims;
- prevention;
- NHS staff domestic abuse policy; and
- improved data collection for monitoring services.

4.7 To sum up, there is a strong correlation between staff's own perception of their inability (or in some cases, unwillingness) to meet the needs of survivors of domestic abuse and the lack of adequate or appropriate services within and without the NHS in many parts of the country. A high-profile domestic violence policy for staff introduced by NHS employers and contractors, including those providing specialist services, would bolster engagement with patients on this issue.

5: What works

- 5.1 A review of the literature referenced throughout this report suggests that:
- There is insufficient evidence to support screening/routine enquiry of all women for domestic violence in healthcare settings, with the possible exception of maternity care.
 - There is indirect evidence that women presenting with psychological distress, mental health problems and physical injuries benefit from being asked about violence.
 - Training of clinical teams increases identification of survivors, but without direct services to refer onto, this makes little difference to survivor safety.
 - Training which includes risk assessment and safety planning work equips staff with a distinct process which takes forward action when disclosure has been made. The risk to children as well as to the abused adult should be assessed both as part of the same process and separately to ensure that the needs of both women and their children are fully met.
 - There is growing evidence that advocacy interventions can decrease violence and increase quality of life for survivors and their children.
 - There is compelling evidence that psychological interventions for survivors and their children are effective in dealing with mental health problems arising from abuse.

Routine enquiry

The sub-group considered the use of routine enquiry in some depth. There is no consistent evidence that survivor access to specialist services requires universal screening, or that routine enquiry increases referral above clinical enquiry in most healthcare settings. The majority of clinicians do not support routine enquiry and implementation is patchy when it becomes policy. Moreover, routine enquiry can be unsafe if not supported by training and with access to expert domestic violence services. The experience of the sub-group is that **safe enquiry, with a low threshold for asking women about abuse, linked to referral to appropriate services** can be effective in identifying and providing interventions for people who need such services. Safe enquiry should be part of an overall approach encompassing training for frontline staff to raise their awareness of domestic violence, support for them from specialist domestic violence practitioners on site, possibly by expanding the screening role of alcohol and other specialist workers, to enable them to ask about domestic violence safely and link enquiry with safe discharge.

6: Overlaps with other related initiatives

- 6.1 The sub-group supports existing government initiatives under the safeguarding children agenda in relation to child witnesses of domestic violence, children directly harmed by domestic violence and the difficulties faced by mothers in parenting their children while experiencing violence and abuse themselves.
- 6.2 Recommendations are therefore limited to those not already in place, such as activity in response to the report by Lord Laming *The Protection of Children in England: A Progress Report* (March 2009). This includes recommendation 2 that a National Safeguarding Delivery Unit (NSDU) be established with a remit that includes gathering best practice on referral and assessment systems for children affected by domestic violence, adult mental health problems, and drugs and alcohol misuse, and providing advice to local authorities, health and police on implementing robust arrangements nationally.

7: Our recommendations

7.1 Bearing in mind the evidence we have examined, referenced throughout the report, and the expertise we have had at our disposal from a variety of sources, we have considered each aspect of the design and delivery of better health services for survivors of violence against women and children and make the following proposals for recommendations for the Taskforce Steering Group to consider.

(i) Prevention: raising awareness, identification and early intervention

7.2 Our view is that there is a need for prevention to take place on several levels, but we are aware that the health service is not the only or even the main agency working to prevent domestic violence. We are also aware that in many areas, the NHS has not contributed as fully as it should have to this agenda. We see other agencies as having a prime part to play, in particular education with its responsibility for influencing the views of children and young people about healthy relationships, gender equality and mutual respect. We also see that local government, police and criminal justice services, as well as independent specialist voluntary services, have a joint role in managing and changing the local climate in which violence takes place.

7.3 We recognise that health services have a part to play both in advising and working jointly with partners in other agencies to reduce the likelihood of domestic violence, for instance school nurses promoting healthy relationships in schools and health visitors working with young families. Of course this requires continued funding for school nurses and health visitors, and in some areas these services could be jeopardised as budget pressures on commissioners grow. There is a dual role, both working with those who have already been abused and working to make safer those who have not yet been abused. We recognise a role for secondary prevention in health settings: every intervention given to a woman survivor may prevent further violence. Other actions targeted at those at risk, such as Family Nurse Partnerships, alcohol and drug abuse programmes, and long-term psychological support for children and survivors, all help to prevent the consequences and possible repetition of domestic violence for those who have already experienced it.

7.4 Main issues in this area:

- general lack of awareness of domestic violence among health professionals, and an unwillingness to engage with it, including reluctance to take

steps to deal with behaviours such as substance misuse which may be an indicator that a woman is at particularly high risk of abuse;

- staff with no time, knowledge or confidence to ask women who may be at risk, or to follow up with a practical response; and
- a lack of services and clear referral and care pathways to refer on to for both women and children.

7.5 To be able to identify those at risk or experiencing domestic violence, so that they may be offered or helped to find appropriate support, healthcare staff need to be aware of domestic violence, how it may present, what signs to look out for, and also to know how to ask sensitively to help women, girls and children to disclose their issues. Awareness will also enable staff to work proactively with existing patients and clients and the general public, to help raise awareness generally about domestic violence, to spread the message that it is not acceptable, and to help people come forward for the support they need to overcome its effect on their lives. Awareness will help staff to believe women's own assessment of the risk that they are under, and to act accordingly.

7.6 The sub-group makes the following recommendations:

- ensure effective partnership between education and health, in recognising and dealing

effectively with substance abuse and mental health issues for children experiencing domestic violence; and in leading on changing attitudes through promoting healthy relationships and gender equality, including among very young children;

- ensure that staff working in substance misuse (including alcohol) services are trained in domestic violence awareness to help them to respond to clients who may be survivors or perpetrators of domestic violence. This may include identifying experience (or perpetration) of domestic violence among their clients, who will be at higher risk than other clinical populations, and having referral links to expert domestic violence agencies, as well as ensuring that the services they offer directly are appropriate to these client groups, for example women-only services, one-to-one support, etc.

Identification and management of domestic violence survivors

- Clinical teams need training and supervision to ensure they are identifying domestic violence, offering the correct services to their patients and making appropriate risk assessments and links/referrals to specialist domestic violence services for practical support. Training needs to be continuous to provide for rapid turnover of staff.
- Set up quality standards for service provision, and competencies for staff,

differentiated by role and profession where necessary, to ensure staff know what to do and where to refer once domestic violence is identified.

- Full-time domestic violence co-ordinator/lead posts should be established in every hospital and community-based service and within Primary Care Trusts (PCTs), as and when resources permit. Their role would include training staff and raising awareness of violence against women and children, promoting identification and action by health professionals, and risk assessment and signposting or referral to specialist support services, either in the third sector or in the NHS, for instance psychological services with trained domestic violence specialists. They should have access to funding and a role in decision-making about service delivery. They should lead a safety-based approach to domestic violence by ensuring that staff within their service are able to provide safe enquiry linked to referral to appropriate services, and safe discharge.

(ii) Key services and successful pathways

- 7.7 Services within the NHS for women who experience domestic violence are often non-existent, inappropriate or delivered in such a manner as to put off take-up by those who need them. In particular, services with which survivors are most likely to engage, such as accident and emergency, reproductive health, sexual health,

and primary and secondary mental health services, may lack staff with an awareness of the underlying issues of domestic violence and may miss the chance to offer services needed by women. This is also important in pre-hospital care; ambulance staff who may be 'first on scene' need to be aware of domestic violence and able to offer appropriate support. Services for teenagers are variable, and there are opportunities for links with areas such as teenage pregnancy services. For some involved in serious youth crime the issue may be peer violence rather than domestic violence, and services may need to be tailored accordingly. Where people disclose that they are perpetrators as well as victims there is a need for specialised services which may need to be at regional or sub-regional level, rather than locally provided, because of the size of demand.

- 7.8 Many children who experience domestic violence are supported in refuge services,³⁵ and/or benefit from a wide range of outreach services, including specialist children's and young people's services developed in the third sector. Many refuges have links with health visitors, and children have support both from their mothers and specialist children's workers and family support staff working in refuges. Indeed families in refuges may have more

³⁵ 19,005 children were resident in refuge accommodation during the year 2008/09, and a further 20,125 children and young people were directly supported in specialist outreach services or similar; 196 specialist children's services are listed on <http://refuge.org.uk/>

access to health visitors and family support, possibly after a short period of disruption, than by staying in the family home. Retention and expansion of current provision of health visitors is vital, as well as more ongoing support from social workers which is often withdrawn once the family enters the refuge.

- 7.9 Main issues in this area:

- insufficient provision of appropriate NHS, other statutory or third sector services, tailored to meet the needs of individual women;
- lack of knowledge of what is available locally, including what is provided by partners in other agencies and sectors; and
- lack of alignment with interconnected services, such as safeguarding.

- 7.10 Interconnection of services and agencies, especially where this will enable access and take up by women and children, is crucial to successful service delivery. Many survivors have no confidence in statutory agencies because they often do not meet their needs, and as a result may delay seeking help. Removing the barriers between mental health services, primary care and acute care would go a long way to improving survivors' experience and confidence in the service. Research on effective interventions has been undertaken in a range of settings and its

results should be considered when developing services.^{36,37,38,39}

- 7.11 The sub-group is aware that the current diversification of services for children and for women, with an emphasis on the former, can have an adverse effect on women survivors, as the improved vigilance and protocols for child protection may result in the non-abusing parent's needs being overlooked – usually the mother. Similarly those working exclusively with abused women may overlook the impact of domestic violence on their children. Integrated services for women and their children, which recognise that both may be 'at risk' or are experiencing violence, would be a great improvement. The sub-group's view is that an important element in protecting children is to protect their non-abusive parent, and there is a need to develop creative tension between women's and children's services so that all sets of needs are met to best effect.

- 7.12 The sub-group makes the following recommendations:

- ensure that NHS organisations have in place local mechanisms to address the mental and social health and well-being of

³⁶ Aitken R (1998) *A Review of Children's Service Development*. Refuge.

³⁷ Dutton MA (1992) *Empowering and healing the battered woman: a model for assessment and intervention*. New York: Springer.

³⁸ Herman JL (2001) *Trauma and Recovery*. London: Pandora.

³⁹ Howard LM, Trevillion K, Khalifeh H, Woodall A, Agnew-Davies R and Feder G (2009) Domestic violence and severe psychiatric disorders: prevalence and interventions. *Psychological Medicine*.

survivors in addition to dealing with the medical consequences of domestic violence;

- ensure effective links with existing care pathways and multi-agency arrangements to safeguard adult victim and children, such as MARACs, Local Safeguarding Children Boards, Multi-Agency Public Protection Arrangements (MAPPA) and Protection of Vulnerable Adults. This should include compulsory representation of Acute Trusts at MARACs;
- commission intervention programmes for women survivors and their children, and review links with existing services, differentiating services according to the woman's own assessment of her needs and relevant risk requirements. The emphasis should be on care pathways which meet individuals' needs; and
- set up a system of safe discharge so that the NHS understands and delivers its responsibility to victims, by establishing pathways to support the relatively uncommon but important occasions when a woman does not feel safe to go home.

A suggested sample care pathway model is at Annex 4.

(iii) Improving availability of and access to services

7.13 The availability of services is very much linked to knowledge of

effective interventions and the needs and preferences of those who would use them. It is also dependent on the economic case for providing them. The sub-group sees a need for robust data collection using commonly-agreed definitions to demonstrate the need for and likely take-up of services, and to evaluate their effectiveness. This would support the provision of services at the local level in accordance with local needs. More sophisticated assessment of need through better use of the Comprehensive Area Assessment (CAA) and Joint Strategic Needs Assessment (JSNA), and evaluation of services and links through local partnerships via Total Place, would be helpful in determining overall effective provision using all available resources.

7.14 Main issues in this area:

- shortage of commissioned services;
- insufficient specialist staff; and
- lack of specialised leadership to develop and deliver services.

7.15 Although there is much good practice and good services are available in some localities, they are not universal. In order to provide a service there must be enough people able to design and deliver specialist services and able to advise and support mainstream staff. There must also be an understanding by service commissioners of the needs of their local population for such

services, knowledge of what is provided by a variety of partners locally, and a willingness to explore effective ways of making such services available.

7.16 The sub-group makes the following recommendations:

- commission a specialist domestic violence service for women and children in each area in partnership with the local authority and CDRP, to be accessed from primary care, women's health, children's health and emergency health settings, and also available for self-referral, subject to available resources;
- all mental health services should consider the need for psychological support in the context of current or past domestic violence;
- PCTs should develop a proactive access strategy to provide information and outreach to survivors and children;
- provide national guidance on commissioning (for both the NHS and the third sector), procurement, assessment and exploring the use of CAA; and
- PCTs should identify champions or designated leaders to set and maintain quality of service.

(iv) Information sharing

7.17 This is a sensitive and controversial area, where survivors' views of what may be harmful to them may influence, for good or ill,

healthcare staff's knowledge and judgment of how they should or could share information with other agencies. The need to gain and keep the trust of survivors, who may have little reason to trust others, must be balanced with the need to meet legal obligations to pass on information in order to safeguard and promote the welfare of children. Effective and precise protocols, and support for staff applying them, should be developed.

7.18 The main issue in this area:

- lack of authority to share information where necessary, or a lack of understanding about the circumstances in which such information should be shared.

7.19 There is a lack of understanding about the scope for restricting access to survivors' personal details, including their addresses, to prevent perpetrators from tracking them down. The Personal Demographic Service (PDS) is the national electronic database of NHS demographic details. It allows NHS staff to identify patients and associate them quickly and accurately with their medical records. The basic information held for each patient includes their home address and temporary addresses, and the system includes scope for a sensitive record indicator (an S-flag) to prevent casual access to a patient's address details, for instance in cases of domestic violence. Blocking access by other clinical staff may carry some clinical risk to the patient,

who has to sign a consent form acknowledging this in order to activate the S-flag; it then prevents their details from being viewed on the NHS information spine. Any adult can ask for an S-flag to be put on the record of a child for whom they are responsible. The PDS links with the local authority online directory ContactPoint, which provides a quick way for authorised practitioners to find out which practitioners in other services are working with the same child. If an S-flag is put on a child's health record it will lead to the child's ContactPoint details being shielded from common view, subject to regular review of the child's circumstances.

7.20 The sub-group makes the following recommendations:

- health service providers to identify high level responsibility for information sharing with domestic violence specialist services, to give staff the confidence that they have support to share information where necessary and to ensure that breaches of confidentiality do not become commonplace;
- to ensure that each victim of domestic violence is offered information on their right to ask that electronically-held information about their case is S-flagged as sensitive, since personal details about victims could otherwise be widely accessed;
- integrate child protection and partner domestic violence

information sharing, so that there is a two-way flow of information between these two services. This is particularly important where services for abused adults and children are delivered separately, although ideally they should be integrated;

- to prepare updated guidance for health professionals attending MARACs about sharing information in relation to the victim(s), children and perpetrator(s) to ensure consistency of response across the country.

(v) Workforce

7.21 Main issues in this area:

- lack of awareness and specialist skills and knowledge to deal effectively and sympathetically with victims of violence against women and children; and
- lack of support for NHS staff who themselves experience (or perpetrate) violence against women and children, which undermines the message that violence against women is never acceptable or tolerable within the NHS or wider society.

7.22 There is a widely-held perception from both patients and staff that staff frequently lack knowledge, skills and understanding of domestic violence. This clouds their ability to provide effective intervention, or even show an awareness of the issues and how survivors may feel, which means that staff cannot respond supportively at a very basic level.

However, many victims would benefit from the opportunity simply to talk about their experiences and have their reactions understood.

7.23 Provision of domestic violence training for NHS employees is patchy and poorly integrated into pre-registration or undergraduate clinical training.

7.24 In seeking views from NHS organisations, it was apparent that where employers make training available for staff working in areas where they are most likely to deal with survivors of domestic violence, where they employ a training adviser or co-ordinator, and where they make use of specialist input from partners in other agencies, satisfaction with the training and confidence in staff's ability to improve their practice rose.

7.25 The sub-group makes the following recommendations:

- set up standardised training in domestic violence with identified funding and adequate professional supervision at the following levels:
 - undergraduate;
 - pre-registration; and
 - postgraduate/post-registration, including both advanced training and continuing professional development (refresher) training.

7.26 For doctors, this means inclusion of domestic violence in medical school undergraduate curricula approved by the General Medical Council (GMC); in medical Royal Colleges' curricula for postgraduate training, for both specialist and continuing professional development (CPD) programmes, including refresher training where appropriate. For other regulated professions, this means inclusion of domestic violence required by regulatory bodies in pre-registration programmes run by higher education institutions; and in post-registration programmes and courses for CPD, whether approved by the regulator or not, including refresher training where appropriate. For staff who are not in regulated professions, this means inclusion of domestic violence in their initial training or in subsequent CPD and refresher training as appropriate. These staff include receptionists, administrative staff, interpreters and any others who may encounter survivors of domestic violence in frontline work.

- train NHS leaders and managers responsible for commissioning, policy setting, service and process planning in general domestic violence awareness, confidentiality and interaction with partners, including service users, to ensure that links are made and used in ensuring that appropriate services are delivered;
- provide basic awareness training for all frontline staff who may

need it – including awareness training, general skills training (basic and advanced), and specific skills training, in line with National Occupational Standards in relation to care pathways or referral protocols. It should include training in asking about abuse, appropriate responses, and referral to specialist support, including third sector provision; and

- ensure that all NHS employers/contractors have a policy to assist and support staff who are suffering or have suffered domestic violence and to respond to known perpetrators.

(vi) Systems and incentives

7.27 There is a clear need for strong leadership throughout the system to ensure that domestic violence is taken seriously, identified as the cause of widespread and long-term health problems, and that services are commissioned and developed appropriately. The health regulatory framework should be used to ensure that this happens.

7.28 Main issues in this area:

- the need to use existing available data to inform needs assessment and, where necessary, implement additional or better data collection and analysis to aid more accurate needs assessment;
- the lack of commissioning expertise to provide services that meet local needs;

- the lack of service standards to underpin domestic violence services' commissioning and provision; and
- the need to identify where additional research is needed in specific areas and to build on the existing research base where possible, in order to identify what is effective intervention.

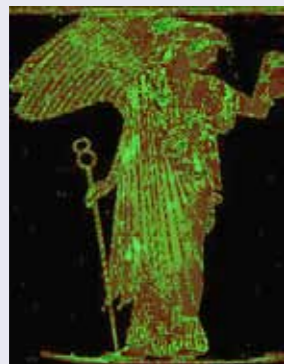
7.29 Accurate assessment of local needs based on dialogue with service users and the general public is important in determining what level of services should be provided, and how they should be adapted to meet the needs of groups within the local population or individuals who may have particular or complex needs. It would be supported by evidence of what is successful for different groups in the population, and also by training of commissioners to improve their knowledge of service commissioning for people with very specific needs, compounded by different characteristics. Quality service standards to guide commissioners in what they should be seeking as a minimum, and for more specialist services, would be beneficial.

7.30 The sub-group makes the following recommendations:

- provide national commissioning guidance defining explicit expectations and outcomes for domestic violence services, based on existing service standards;
- review the existing national data set for better commissioning of services and monitoring of outcomes, as a driver for improved needs assessment, including assessing the needs of women and children of all ages and of diverse, including minority, groups;
- use existing national standards for domestic violence support services where these exist, and develop them for other specialisms that can be commissioned by PCTs, focusing on competencies (using National Occupational Standards), performance and outcomes;
- carry out additional research on:
 - impact of mandatory, as against voluntary, domestic violence training in healthcare contexts;
 - impact of nurse and health visitor home visits on prevention of domestic violence and child abuse; and
 - cost-effectiveness models of domestic violence care pathways;

- improve the knowledge base by developing definitions and recording mechanisms to capture prevalence and incidence data in a commonly-understood format to help develop multi-agency services.

Good practice example – IRIS: Identification and Referral to Improve Safety



Forty-eight general practices in Bristol and Hackney, London, were randomly allocated into intervention and control groups to test a training and support programme to improve the quality of care given to women experiencing domestic violence. Intervention practices were supported by two 2-hour sessions of practice-based training, electronic medical record prompts to ask about abuse, and resources including posters and cards. The success of the programme depended on a clear, easily accessible referral pathway to a named advocate educator based in local domestic violence services, who worked closely with the practice and was central to the training. Doctors and practice nurses were encouraged to use clinical enquiry, address barriers to conversations about domestic violence, respond with key messages and offer referral to a specialist domestic violence worker. The advocate educators offered feedback to clinicians on their work with clients and provided quarterly audit data on identification and referral across practice teams. All intervention practices increased the identification of women experiencing violence, and referrals. The trial has now ended and the findings, along with a cost-effectiveness analysis will be reported in 2010. The IRIS programme will be configured so it can be commissioned by PCTs from domestic violence specialist agencies.

For more information contact medina.johnson@nextlinkhousing.co.uk or AHowell@niaproject.plus.com.

Good practice example – Mozaic: an innovative multi-agency domestic violence service at Guy's and St Thomas' NHS Foundation Trust

This research-based multi-agency service was designed and set up in 2005. It comprised training for health professionals in maternity and genitourinary medicine to enable them to carry out routine enquiry. Women who disclose are offered referral to an 'in-reach' domestic violence advocacy service (Mozaic) from the local voluntary sector 170 Community Project. As awareness and confidence have been raised, disclosures come equally from routine enquiry and ad hoc questioning, and from other services. Risk assessment is used, but all women are supported to process their experiences, explore options and pave the way for future change as risk can change rapidly because of pregnancy and its implications. Advocates attend local Multi-Agency Risk Assessment Conferences (MARACs) and trust social services and safeguarding meetings. An evaluation in 2007 identified worsening levels of violence post-birth, but a reduction at six months in violent and controlling behaviours and injuries and improvements in women's self-esteem, anxiety and depression and self-efficacy. Harm can be caused, particularly from inappropriate responses to disclosure and breaches of confidentiality. Guidelines, governance, risk assessment, supervision and audit are vital to the maintenance of a safe service. Volunteer-led 'pampering' days and a survivor group, Mozaic Voices, have been established as well as developing a user-centred development plan.

For more information on the 2007 evaluation: www.kcl.ac.uk/schools/nursing/research/themes/women/projects/maternal/domesticviolence.html

Good practice example – Integrated specialist advocacy and support services, Women’s Aid

Recent developments in a co-ordinated community response, the expansion of advocacy services for high risk victims, and more formalised education and resettlement programmes have expanded the range of services provided by local Women’s Aid services across the country, an example of which is West Mercia Women’s Aid (WMWA).

With a range of integrated advocacy and support services for women and children (helpline, refuge, outreach, floating support, independent domestic violence advisers (IDVAs), resettlement and children’s services), and working in partnership with organisations that support male victims, the organisation has a structured and responsive referral system that ensures effective risk management and enables all victims to receive the service that they need, and which changes over time. All consenting victims referred through the police to WMWA are risk assessed by their IDVAs who respond to victims at immediate high risk (including placement in refuge if required) while others are supported by floating support advocates. Self-referrals to WMWA refuge and outreach services are similarly risk-assessed and referred to IDVAs and MARACs if high risk support is required.

Alongside these core services, WMWA now also provides a range of programmes and groups to support the needs of abused women and children. They focus on pattern-changing and developing self-esteem, confidence building, developing skills to return to work, and help to access training and employment to enable financial self-sufficiency, including support to improve literacy and numeracy. The programmes are open to all victims of abuse using their refuge and outreach services.

www.womensaid.org.uk/

Good practice example – Refuge

Work with children affected by domestic violence has its roots in the refuge movement, and has also influenced significantly the development of statutory sector responses and led to greater opportunities for co-ordinated partnership work across many agencies. One important lesson learned at Refuge is that domestic violence often impacts on a woman and her children in complex, overlapping ways so it is vitally important to offer services that respond to them together, rather than separately as is most often the case.

Given appropriately trained staff, refuges can intervene early and offer timely responses to a wide range of needs presented by children and their mothers such as:

- risk – both immediate and longer term physical and psychological risks;
- the impacts of trauma – post-traumatic stress disorder (PTSD), anxiety, depression, hopelessness, relationship difficulties – and can offer skilled support for children and mothers in exploring and managing the immediate consequences of trauma;
- the impacts of domestic violence, understanding how it has affected children and their mothers as individuals and in relation to each other; managing and overcoming these impacts; and
- specialist assessments, reports and advocacy – to enable children and their mothers achieve justice in the court system and have their needs met by housing departments, and educational, social care and health systems.

<http://refuge.org.uk/>

Services to meet individuals' needs

Services may include refuge support services, IDVAs, other outreach and floating support services for women and children who remain in or return to their own homes, specialist support services for children and young people, and inreach services whereby independent sector expertise may be shared with the NHS. Advocacy services have been shown to be effective in reducing repeated violence.

Services should take account of the needs of women, girls and children from diverse backgrounds. For instance:

- domestic violence and gender inequality may be more prevalent and less challengeable in some cultures;
- there may be additional dimensions to violence experienced by people with disabilities who may not be able to anticipate, understand or tell about violence which happens to them;
- lesbian and gay people may face additional threats of 'outing' to friends and work, may fear discrimination from staff providing services and may face violence in the form of homophobic hate crime from ex-partners; and
- trans people may have their hormone treatment medication hidden or thrown away by a partner or family member, may be subject to humiliation and indignity including threats of 'outing' and may have difficulty in accessing single sex services.

Service design should draw on toolkits, guidance and good practice examples, for instance:

- the Greater London Domestic Violence project Toolkit for Faith Leaders, Faith Organisations and Members of Faith Communities;
- the Ann Craft Trust, providing help for people with learning disabilities who have been abused;
- the Salford Domestic Abuse guide, designed for people with learning disabilities;
- Broken Rainbow, a national charity providing telephone help and advice for lesbian, gay, bisexual and transgender (LGBT) individuals experiencing domestic violence;
- Southall Black Sisters, providing a service for women experiencing violence; and
- Action on Elder Abuse, providing a helpline for older people who experience abuse.

Good practice example – Making the Links: disabled women and domestic violence

A three-year research project by the Violence Against Women Research Group and Centre for the Study of Safety and Well-being and the Universities of Bristol and Warwick in partnership with Women's Aid was the first national UK study on the needs of disabled women experiencing domestic violence, and the services available to meet these needs. The report noted examples of good practice and Leeds Inter-Agency Project was specifically highlighted and praised for its work on embedding the needs of disabled women within local strategic work on domestic violence. This included:

- the incorporation of domestic violence and disability into all relevant plans and strategies;
- all local agencies developing domestic violence and disability action plans (including incorporation into relevant local service agreements);
- the inclusion of the work on disabled women and domestic violence as a minimum standard; and
- graded 'quality marks' which agencies attain (such as on accessibility, training and direct service provision for disabled women).

As a result of Making the Links, Women's Aid has developed posters and leaflets to promote awareness of the issues as well as good practice summary guidance.

For more information on this report go to www.womensaid.org.uk/domestic_violence_topic.asp?section=0001000100220008§ionTitle=Disabled+women

Good practice example – IDVA services

IDVAs are specialist case workers who work intensively with high risk victims suffering ongoing violence. They systematically mobilise and target the resources of up to 15 agencies on their behalf, often through the forum of the MARAC. Their key goal is safety. Recent research has highlighted the impact on safety of combining intensive support for women with a co-ordinated safety plan, including a range of interventions to meet the key safety needs of the individual, with 67% of women receiving this support reporting a cessation in violence. Interventions most frequently include support with housing, children, the criminal and family courts as well as health services. IDVA services have been readily accessed by women from minority ethnic communities. Worth Services in West Sussex offers IDVA services in A&E, ante natal and the minor injuries unit as well as the Sexual Assault Referral Centre (SARC). This has given clinical staff immediate access to domestic violence experts when a woman discloses domestic violence, allowing them to focus on the medical impacts of the violence while the IDVA addresses all aspects of the risks that a woman faces. Working in partnership with other agencies, the IDVA can support a woman to negotiate the range of services that may be available to ensure her safety.

www.westsussex.gov.uk/ccm/content/community-and-living/community-safety/harm-reduction/domestic-violence/worth.en;jsessionid=ajedcGh2O6R9

Local partnerships

The starting point for service commissioning is that there should be consistent provision for survivors at every stage of their journey: crisis support first, then a continuum of other support including advocacy and outreach, and longer term support such as psychological counselling. The range and provision of services, including priorities for funding, should be agreed through local partnerships, with local health bodies playing a full part and overseen by a core person in each health area at sufficiently senior level to make sure that health engagement happens effectively. There are four elements to making this effective:

- **national** recommendation in the Taskforce report to have a core NHS person in each area with responsibility for domestic violence services;
- **locally** strategic: active involvement by health in domestic violence forums and CDRPs;
- **locally** operational: domestic violence co-ordinators, partnerships between NHS and the third sector where the expertise lies, linking with other specialists such as safeguarding and alcohol workers; and
- **local** help for frontline staff to release their talents.

Good practice example – Co-ordinated Community Response (CCR) in Hammersmith and Fulham

The Home Office has driven the policy of a CCR for some years. The domestic violence partnership in Hammersmith and Fulham (H&F) has implemented a practical approach to this complete response. A CCR must ensure that victims and their children are safe and are the focus of the response, while holding perpetrators to account. Victims must be assured of a consistent and effective response every time.

H&F's approach ensured that the crucial statutory sector agencies are represented at strategic and operational level, with strong links to the safeguarding boards and the CDRP. This has been supported by the PCT (NHS H&F) and the local authority, both agreeing joint governance arrangements for their respective agencies. NHS H&F has also provided significant funding to enhance co-ordination and to achieve healthy outcomes for victims.

The key elements of H&F's CCR are:

- strategic buy-in and influence;
- effective structures;
- accountability and protocols;
- crisis response (IDVAs, MARACs and Specialist Domestic Violence Courts (SDVCs));
- early intervention (agencies identifying and responding effectively before crisis); and
- prevention (work in schools).

The prioritisation of domestic violence has led to a concerted effort to provide specialised services for victims and a multi-agency training strategy, underpinned by an action plan overseen by the strategic leadership. The co-ordination function is performed by Standing Together Against Domestic Violence.

www.standingtogether.org.uk

Good practice example – NHS Hull and the Domestic Abuse Partnership (DAP)

Hull DAP is acknowledged as being one of the most successful in the country, and in 2009 won a Home Office Tilley Award for its work. The Partnership is jointly funded, and employs 19 staff from all relevant agencies who are co-located in the same building. Third sector agencies play a full role in the work and leadership of the DAP.

This model offers the benefits of specialist knowledge of domestic violence, coupled with the professional expertise of the key agencies, working under one roof. There is an effective and well-understood information sharing protocol which enables the rapid collation of information. This allows the service to respond quickly in circumstances where women and children are deemed to be at high risk.

While the work of the Partnership in dealing with victims and potential victims of violence has been a success, there is a clear aim to prevent domestic violence in the first place. NHS Hull recently commissioned a social marketing programme, *Strength to Change*, aimed at perpetrators and potential perpetrators of domestic violence. These men are offered the opportunity to work with specialist staff to change their behaviour and attitudes. Initial results are encouraging, and will be published in 2010/11.

www.hullpct.nhs.uk/templates/page.aspx?id=4803

8: Gaps in evidence

8.1 Robust evidence of prevalence, incidence and effective outcomes is needed to demonstrate the demand for appropriate domestic violence services. It will also enable effective planning by ensuring that they match what people need and will use, and will give value for money. There is very little evidence of prevalence of domestic violence for some minority groups, for instance trans people, which should be remedied. Data collection, applying common definitions widely across settings, for instance in safe enquiry, would provide useful data to support service planning and audit, and research into effective interventions and long-term trends. Data collection should be across agency partners where there may be multiple components. Although the value and comprehensive coverage of the British Crime Survey is acknowledged, a survey of similar frequency and quality with a health focus would be welcomed.

9: Summary recommendations with linked evidence statements

9.1 The sub-group has made a number of detailed recommendations under each theme of the work of the Taskforce, in relation to domestic violence in particular. The sub-group has highlighted nine high priority recommendations which we believe would make the most impact on improving health service response to domestic violence. (The evidence statements are shown in italics.)

(i) Prevention: raising awareness, identification and early intervention

- Healthcare professionals need to work locally in partnership, especially with the education sector, challenging the acceptability of domestic violence among young people.

School-based programmes that integrate dating violence prevention with lessons on healthy relationships, sexual health, and

substance use can reduce violence in adolescent relationships.^{40,41}

Identification and management

- Clinical teams need training and supervision of clinical teams to ensure they use safe enquiry to identify domestic violence, offering the correct services to their patients and making appropriate risk assessments and links or referrals to specialist domestic violence services for practical support, and ensuring safe discharge. There should be a rolling programme of training to provide for rapid turnover of staff.

(ii) Key services and successful pathways

- Commission intervention programmes for women survivors and their children, and review links with existing

40 Wolfe DA, Crooks C, Jaffe P, Chiodo D, Hughes R, Ellis W *et al.* (2009) A school-based program to prevent adolescent dating violence: a cluster randomized trial. *Archives of Pediatrics & Adolescent Medicine*, 163(8): 692–699.

41 Foshee VA, Bauman KE, Ennett ST, Suchindran C, Benefield T and Linder GF (2005) Assessing the effects of the dating violence prevention program 'safe dates' using random coefficient regression modeling. *Prevention Science*, 6(3): 245–258.

services, differentiating services according to the woman's own assessment of her needs and relevant risk requirements. Services may include refuge support services, independent domestic violence advisers (IDVAs), other outreach and floating support services for women who remain in or return to their own homes, and specialist support services for children and young people. Those who commission services should take account of the guidance on commissioning domestic violence services also recommended below.

Evaluations of specialist domestic violence outreach services⁴² and multi-agency services⁴³ in the UK found that they are effective in supporting women experiencing domestic violence and helping them escape violent relationships.

- Integration of psychological support and treatment for survivors and their children into mainstream health services in primary and secondary care and specialist agencies, with domestic violence issues included within Improving Access to Psychological Therapies training and competencies.

Specialist psychological interventions with survivors and their children are likely to be effective in improving mental health and behavioural outcomes respectively.⁴⁴

(iii) Improving availability of and access to services

- Provide national guidance on commissioning (for both the NHS and the third sector) of a specialist domestic violence service for women and children that can be accessed from primary care, women's health and emergency health settings. These services should be commissioned in partnership with the local authority and Crime and Disorder Reduction Partnership (CDRP), subject to available resources.

Specialist domestic abuse services, in particular advocacy, can improve mental health and quality of life outcomes for women experiencing domestic violence. They can support women and their children in escaping and recovering from a violent relationship.⁴⁵

44 Feder G, Ramsay J, Dunne D, Rose M, Arsene C, Norman R *et al.* (2009) Are interventions effective once partner violence is disclosed in a health care setting? Chapter 7 in *How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria.* Health Technology Assessment, 13: 47–58.

45 Parmar A, Sampson A, and Diamond A (2005) *Tackling domestic violence: Providing advocacy and support to survivors of domestic violence*, Home Office Development and Practice Report 34.

42 Humphreys C and Thiara R (2002) *Routes to safety: Protection issues facing abused women and children and the role of outreach services.* Bristol: Women's Aid Federation of England.

43 Parmar A, Sampson A, and Diamond A (2005) *Tackling domestic violence: Providing advocacy and support to survivors of domestic violence.* Home Office Development and Practice Report 34.

(iv) Information sharing

- Integrate child protection and partner domestic violence information sharing, so that there is a two-way flow of information between these two services. Include updated guidance for health professionals attending Multi-Agency Risk Assessment Conferences (MARACs) about sharing information in relation to the victim(s), children and perpetrator(s), and information for health professionals about S-flagging to prevent casual access to survivors' personal details.

(v) Workforce

- Set up standardised training in domestic violence with identified funding and adequate professional supervision at the following levels:
 - undergraduate;
 - pre-registration;
 - postgraduate/post-registration, incorporated into continuing professional development for all clinicians and advanced training;
- non-clinical staff in-service training.

Integration of training about domestic violence into the undergraduate medical curriculum improves knowledge and competence of students in managing patients experiencing

domestic violence.^{46,47} Domestic violence training of health professionals in primary and secondary care settings increases rates of identification and of referral to domestic violence services.⁴⁸

- Require that NHS employers/contractors have a domestic violence policy to assist and support staff who are experiencing domestic violence and to give guidance on the employment of perpetrators.

(vi) Systems and incentives

- Provide national commissioning guidance based on national outcome-based standards for all grades of clinicians in all settings and for specialist domestic violence leads, developing qualifications and new service standards where necessary. This will require common definitions for the collection of data where violence against women has been disclosed and will require all services to collect it.

46 Moskovic CS, Guiton G, Chirra A, Núñez, AE, Bigby J, Stahl C *et al.* (2008) Impact of participation in a community-based intimate partner violence prevention program on medical students: a multi-center study. *Journal of General Internal Medicine*, 23(7):1043–1047.

47 Ernst AA, Houry D, Weiss SJ and Szerlip H (2002) Domestic violence awareness in a medical school class: 2-year follow-up. *Southern Medical Journal*, 93(8): 772–776.

48 Ramsay J, Feder G and Rivas C (2005) *Interventions to reduce violence and promote the physical and psychosocial well-being of women who experience partner abuse: a systematic review of controlled evaluations.* London: Department of Health. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4126266

10: Conclusion

10.1 There is a great opportunity to provide better acute and long-term physical and mental healthcare for survivors of violence against women and children, by raising awareness about domestic and sexual violence, improving identification of survivors, referring to services that can support them, and by developing better collaboration with other agencies in the statutory and third sectors. Much work has been done over the last few years to articulate the needs and wishes of women survivors and those of their children. There is growing evidence for the effectiveness of identifying and supporting survivors in healthcare settings and the benefit of interventions provided by other agencies. The NHS should fully engage in local partnerships with expert domestic violence agencies, local authorities and criminal justice agencies, including Multi-Agency Risk Assessment Conferences (MARACs), to ensure a co-ordinated community response to a major public health problem and transgression of human rights.

10.2 Within NHS services named full-time domestic violence specialist trainer/co-ordinator posts should be developed to co-ordinate staff training and referral pathways within and between different health services and external domestic violence agencies. A better NHS response to women and children who experience or have experienced domestic violence should be developed within the wider context of preventative measures, including work in schools, primary care settings and programmes that address the needs of perpetrators.

Annex 1: Membership of the Domestic Violence sub-group

Gene Feder (Co-chair)	Professor of Primary Health Care, University of Bristol
Christopher Long (Co-chair)	Chief Executive, Hull Teaching Primary Care Trust
Roxane Agnew-Davies	Clinical Psychologist, Director, Domestic Violence Training Ltd
Ruth Aitken	Policy Adviser, Refuge
Kirsten Barnes	Violence Unit, Department for Children, Schools and Families
Diana Barran	Chief Executive, Co-ordinated Action Against Domestic Abuse
Susan Bewley	Consultant obstetrician Maternal Fetal Medicine, Guy's and St Thomas' NHS Foundation Trust, Mozaic
Maggie Blott	Consultant in obstetrics and maternal medicine, Royal College of Obstetricians and Gynaecologists
Adrian Boyle	Consultant emergency physician, Addenbrookes Hospital, Cambridge
Alan Coombe	Policy Adviser (Safeguarding), National Society for the Prevention of Cruelty to Children
Robert Drake	Teenage Pregnancy Unit, Department for Children, Schools and Families
Janet Fyle	Professional Policy Adviser, Royal College of Midwives
Trish Harrison	Worth Project, West Sussex
Nicola Harwin	Chief Executive, Women's Aid Federation of England
Sandra Horley	Chief Executive, Refuge
Louise Howard	Consultant psychiatrist and Clinical Reader, Section of Women's Mental Health, Institute of Psychiatry, King's College London
June Keeling	Senior Lecturer, Chester University

Briony Ladbury	Safeguarding Children Lead, NHS London
Rosalind Mead	Secretariat, Department of Health
Carol Metters	Chair of Bristol Domestic Violence Forum and Director of Next Link
Jonathan Shepherd	Professor of Oral and Maxillofacial Surgery, Cardiff University
Sharon Stratton	Detective Sergeant, Metropolitan Police
Justin Varney	Consultant in Public Health, NHS Barking and Dagenham
Sylvia Walby	Professor of Sociology, Lancaster University
Mary Whyham	Chair, North West Ambulance Service NHS Trust
Anthony Wills	Chief Executive, Standing Together against Domestic Violence

Annex 2: Domestic violence statistics

Many of these are reported cases.⁴⁹ They will therefore be underestimates of the true figures.

- Two women are killed every week by a current or former partner.
- Twenty per cent of women in England and Wales say they have been physically assaulted by a partner at some point.
- Thirty per cent of cases of domestic violence start during pregnancy.
- Fifty-two per cent of child protection cases involve domestic violence.
- Fifty-four per cent of UK rapes are committed by a woman's current or former partner.
- Seventy per cent of children living in UK refuges had been abused by their father.
- Seventy-five per cent of cases of domestic violence result in physical injury or mental health consequences to women.
- In up to ninety per cent of domestic violence incidents children are in the same or next room.
- The cost to the NHS of dealing with physical injuries alone caused by domestic violence is £1.2 billion.
- Thirty-five per cent of households that experience a first assault will experience a second within five weeks.
- In 2003/04, nearly forty per cent of all female homicide victims were killed by their current or ex-partner, compared with about five per cent of male homicide victims.
- More than fourteen per cent of maternal deaths occur in women who have told their health professional they are in an abusive relationship.
- Forty to sixty per cent of women experiencing domestic violence are abused while pregnant.
- Fifteen per cent of women report violence during their pregnancy.

Girls 13–17 years are at risk

There is a lack of data on the prevalence and profile of violence within young people's intimate partner relationships. However the NSPCC and Bristol University conducted a study in 2009⁵⁰ with the following findings.

- A quarter of girls reported some form of physical partner violence with one in nine girls reporting severe physical violence.

⁵⁰ Barter C, McCarry M, Berridge D and Evans K (2009) *Partner exploitation and violence in teenage intimate relationships*. NSPCC. www.nspcc.org.uk/inform

⁴⁹ Department of Health handbook 2005.

- All the girls interviewed who had a “much older” partner, defined by girls as being at least two years older, experienced some form of violence.
- One in three girls reported some form of sexual partner violence.
- Girls were more likely than boys to say that the partner violence was experienced repeatedly and also that it either remained at the same level of severity or worsened.

A young person’s experience of domestic violence (and peer violence) was associated with increased susceptibility to all forms of partner violence.

Children are also at risk

- In over half of known domestic violence cases, children were also directly abused.
- Over three-quarters of children ordered by the courts to have contact with a violent parent were abused further as a result of contact being set up.
- About 750,000 children witness domestic violence every year.
- Nearly three-quarters of children subject to child protection plans (previously the child protection register) live in households where domestic violence occurs.

Annex 3: Quotations from survivors of domestic violence attending focus groups run by the Women’s National Commission

Survivors’ identification of issues and problems

“Health services are too quick to hand out prescriptions, to hand over the Prozac. I don’t want to be medicated for having experienced abuse; it’s not the answer to my problems. Why can’t they get to the root of why you feel like this, why you’re depressed, why you’re suicidal?”

“It’s easier to understand violence when you have marks on you, but most of mine was psychological. He didn’t break any bones; he didn’t punch me in the face. But he traumatised me. All services need to understand what women go through

when they say they’ve been emotionally abused. It’s not abuse; it’s psychological violence. Abuse plays it down, like it’s less important than physical violence. Beatings, rape, harassment, mental torture; it’s all violence.”

“My GP was ok, but she didn’t pick up on the emotional abuse. I would have liked something more direct to be asked me. I know I didn’t say anything directly but she made me feel like it wasn’t her job to deal with emotional abuse. I would tell her things like my husband was forcing me to do things, like forcing me to take the morning after pill and she would say ‘well

you don't have to take it do you?' I felt like they just didn't want to get involved."

"Professionals like dentists and doctors need to be trained in asking the question, they should see us somewhere private, and show they understand about it, and ask all women about whether they're experiencing violence or not, and whether we need support."

"The midwife came around recently and all she cared about was that he was smoking – and I actually said to her, 'that's actually very low down the list of my concerns right now', but she's never seen me separately and asked me about domestic violence."

"My dad hit me here on my jaw with a computer chair and smashed my tooth, so I had to go to the dentist. He asked me and I just said I fell – and even though it's right at the back here, he just said ok... Now I think the dentist should have realised, how would she

fall and hurt herself there? The dentist should have recognised signs of abuse and asked more questions."

"I was attending mental health services and they didn't pick up on my postnatal depression or on my domestic violence experience. They did nothing for me; they didn't pick up on how I felt and what was causing this. It was really serious; I was suicidal...I didn't realise for ages that I was in a seriously abusive relationship. If only mental health services had picked that up. It's important that mental health services have specialists in violence against women to pick up on these issues; otherwise we'll be treated inappropriately."

"When I was still in my abusive relationship my partner came with me to every appointment and I was desperately trying to get the GP to read between the lines, to indicate to them that my health problems were down to his attacks on me. The

first time I was away from him, I was in the anaesthetic room, I actually plucked up the courage to tell them, but because it was just before they anaesthetised me, no one believed me. No-one asked me again what was going on. I just wanted someone to see me on my own, and ask me, I'd have told them."

"My friend's midwife asked her if she was suffering domestic violence in front of her boyfriend – I mean for god's sake, use your common sense! He could have beaten her up about that."

"I was questioned sensitively by my GP about an injury which was reassuring – it was unusual – she asked me gentle, intelligent questions, which showed me that she understood about the issue. The opportunity always needs to be there for disclosure. Gentle questioning is what's needed, not being silenced, not being made to feel embarrassed. A dentist

has as much responsibility as a doctor to do gentle questioning. In contrast I've had some awful responses from dentists who show no awareness of what women might have been through."

Survivors' ideas on what would help

"If they told you that we have got a woman's health worker or a domestic violence support worker in the doctor's surgery once a week or once a month, you could make your appointment then and get specialist help at the same time."

"A women's support service that specialises in violence against women, and in supporting black and minority ethnic (BME) women where appropriate, should be linked to every GP practice, and ideally provide support from the premises on a drop-in basis. This support service needs to be independent from the NHS, so that women have confidence in them."

“GPs should know where to refer women to, so that we get the help and support we need. Health services should work with agencies like [rape crisis], who should be able to go to GP surgeries and introduce themselves and what they do, and they should be funded to hold support sessions there, some kind of drop-in service. They could also do this at the A&E and at other health services where women might go. This would improve the take-up and women’s access to support.”

“Health services just don’t seem to know what to do and where to refer. I’ve tried talking to my GP, my nurse, a health visitor, but nothing. If you don’t get offered any help it must be because they don’t know what help to provide. They need some kind of guidance, how to pick up on women’s abuse, how to ask questions, what support is available for us, they need to be told.”

“When you get to that point of telling your doctor, you are that low and have so little confidence that you just want someone to do something for you, to get you the help you need. Instead of giving you these numbers to call and sending you off to do it yourself – you’ve just got your head around seeing the doctor about it, then they just say ‘go and tell someone else’.”

“Health services could be really useful if they could record your injuries or if they could record the impact of the abuse on your mental health, until you were ready to go to the police. Or if you didn’t want to report to the police, but needed an injunction, or needed evidence for cases when he tries to see your kids. Health services could be really useful if they understood more about violence against women, instead of pretending like it never happens.”

“I needed my GP to give evidence of the bruises to my solicitor to help with the court case. The delays to the court case were caused by the time and money it cost to fax the information from my doctor to my solicitor. The GP charged me to send the evidence of my abuse by a fax to my solicitor and I couldn’t afford to pay for it.”

“Rise [domestic violence service] has helped me a lot, much more than any health service. I wouldn’t have gone to my doctor about domestic violence. I didn’t even know that’s what I was going through, because it was emotional violence. I found out through work, there happened to be a leaflet at work so I phoned them up, and I was invited to a drop-in the next day. It was good that there was something available really quickly, otherwise I might not have come.”

Annex 4: Possible care pathways for victims of domestic violence

The table below examines two broad categories of violence – current and historic – in terms of the possible points of identification. Clearly in practice there will be overlaps between the two categories. This is relevant because it highlights where we need to train professionals and raise awareness

among the general public so that if a disclosure is made, it can be acted on appropriately. This table is not intended to be fully comprehensive, but rather to raise some areas for further investigation. It does perhaps serve to highlight how difficult it is to identify/disclose historic violence.

Possible points of identification	Current on-going violence	Historic violence
Friend/family	*	?
Employer	?	?
School/higher education	*/?	?
A&E	*	?
GP	*/?	?
Midwife	*	?
Health visitor	*	?
Mental health service	*/?	*
Specialist helpline/service	*	*
Police	*	?
Children and young people's services	*	*
Vulnerable adults teams	*	*

The next two tables set out briefly some of the main areas of practical and health-related help that a victim of different types of violence might need. Clearly, not all victims will choose to take up the services listed below, either because they are not available locally or because they do not wish to do so.

The asterisks are designed to show where we know that services are either universally needed or welcome, with three *s indicating most needed and one * indicating that they are typically less important. An 'X' suggests that a particular service is not usually relevant or commonly requested.

Practical	Current on-going violence	Historic violence
Independent domestic violence adviser (IDVA)/advocacy	***	**
Outreach support	***	***
Criminal Justice System	**	?
Family courts	**	X
Financial	**	X
Housing/refuge	***	X
Immigration	***	X
Multi-Agency Risk Assessment Conference (MARAC)	***	X
Specialist service	***	***
Vulnerable adults teams	**	*
Education welfare officers		

Health-related	Current on-going violence	Historic violence
A&E	***	X
Forensic medical examination	**	X
STDs	**	X
Counselling	X	***
Mental health	**	***
Substance misuse services	**	**
Sexual Assault Referral Centre (SARC)	*	X
GP	***	***
Midwife/health visitor	***	**
School nurse	***	**

The final table (below) attempts to define a ‘successful’ outcome for each type of violence. This is particularly difficult for all forms of sexual violence where perhaps the best we can aim for is to minimise

the psychological and physical impacts as well as ensure that neither the health service nor the criminal justice system add further to the trauma suffered.

What does ‘success’ look like?

Current on-going violence	Historic violence
Safety for adult and child victims	Limit and reduce existing psychological and physical harm
Minimisation of long-term psychological and physical harm	
Prevent perpetrators from re-offending	Prevent perpetrators from re-offending
Hold perpetrators to account	Hold perpetrators to account
Change cultural attitudes that accept violence against women and children	Change cultural attitudes that accept violence against women and children

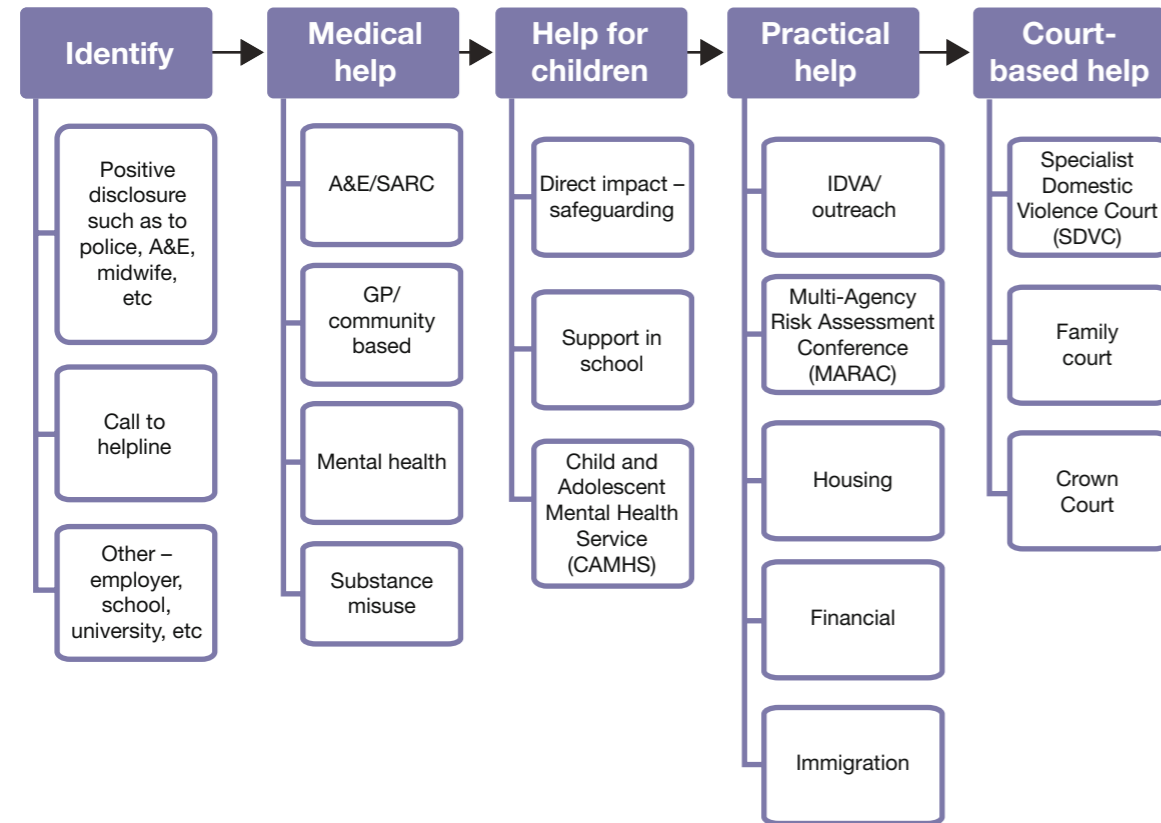
Potential Care Pathways

By analysing the different forms of violence against women in this way we believe that we can begin to identify clear and distinct ‘care pathways’ for different types of violence. This in turn should allow us to specify the role of different statutory agencies, the private sector (as employers) and the non-profit sector who play an important part in service delivery. While there are common elements to every care pathway, their relative importance differs between the different types of violence, as can be seen from the table above. The role of practical support and the courts is typically more important for those victims facing on-going violence than it is to a survivor of historic violence, while the importance of specialist mental health services might be much more important to the latter group. Conversely, the need for specialist sexual health services is more important for those suffering a recent rape or sexual assault than for those suffering historic domestic violence where perhaps sexual violence was not always a factor.

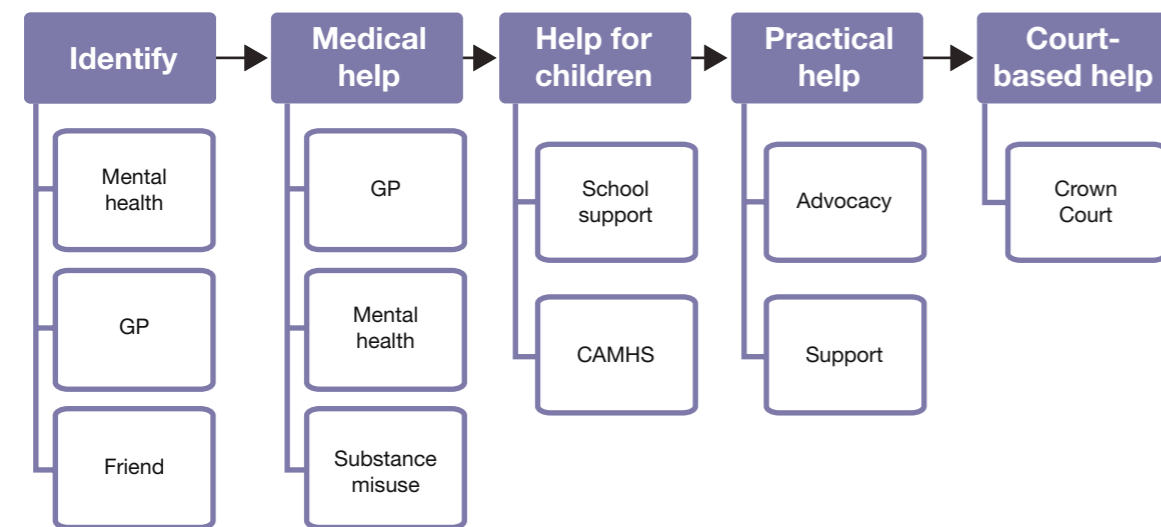
It is important to note that, in practice, violence is committed at very different levels of severity and the ability to engage with a victim of violence will differ as a function of this. Thus, while we may agree that certain behaviours are unacceptable, victims of these behaviours may not wish to take action to hold the perpetrator to account or to accept offers of help.

The common theme for all groups of survivors of violence is the need to identify the impact on their children, either directly as, for example, in the case in domestic violence, or indirectly as a result of mental health and other problems that might arise after a single episode or from historic violence. Once that impact has been identified, the children may need counselling and/or support from specialist staff as well as safeguarding from the situation.

Simplified care pathway for victim of on-going violence^{51,52}



Simplified care pathway for adult victim of historic violence



51 This diagram and the one which follows are not intended to be comprehensive, but to indicate areas of need.

52 This diagram could apply both to those suffering current violence only and those who have also suffered violence as a child or as an adult in a previous relationship. In the latter case, more emphasis would be placed in the mental health related services.

