

Domestic abuse

June 2007 (Updated September 2014)



A report from the BMA Board of Science

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A publication from the BMA Professional Policy Division and the Board of Science

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Abbreviations

A&E	accident and emergency
BAEM	British Association for Emergency Medicine
BCS	British Crime Survey
BMA	British Medical Association
BME	black and other minority ethnic
CCG	clinical commissioning group
CEM	College of Emergency Medicine
CEMACH	Confidential Enquiry into Maternal and Child Health for England and Wales
CSA	childhood sexual abuse
CSEW	Crime Survey for England and Wales
DAF	domestic abuse forum
DDV	destitution domestic violence concession
DH	Department of Health
DVEC	domestic violence enforcement campaign
HMIC	HM Inspectorate of Constabulary
IDVA	independent domestic violence advisors
IPV	intimate partner violence
GMC	General Medical Council
GPC	General Practitioners committee
LGBT	lesbian, gay, bisexual and transgender
MALE	Men's Advice Line and Enquiries
MARAC	multi-agency risk assessment conferences
MHF	men's health forum
NICE	National Institute of Health and Care Excellence
NICS	Northern Ireland Crime Survey
NPC	New Philanthropy Capital
PCT	primary care trust
PDG	programme development group
PHCT	primary healthcare team
PTSD	post-traumatic stress disorder
RCGP	Royal College of General Practitioners
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists

RCPsych	Royal College of Psychiatrists
SCJS	Scottish Crime and Justice Survey
SDVC	specialist domestic violence court
STIs	sexually transmitted infections
VAWG	violence against women and girls
VVAPP	victims of violence and abuse prevention programme
WHO	World Health Organization
WMA	World Medical Association

Case studies are drawn from:

- Woman's Aid
- Eliminate Domestic Violence, The Global Foundation
- The Welsh Branch of Mankind Initiative
- Research carried out to evaluate four projects in health service settings that piloted routine enquiry for domestic abuse: Tackett AR, Beringer A, Irvine A & Garfield S (2004) *Tackling domestic violence: exploring the health service contribution*. Home Office Online Report 52/04. Available at: www.homeoffice.gov.uk/rds/pdfs04/rdsolr5204.pdf

All names used are pseudonyms

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Chapter 1. Introduction

1.1 Domestic abuse as a health concern

Domestic abuse is well-recognised as a public health issue that affects at least one million people in the UK. Across the devolved nations, in 2011/12, there were 59,847 incidents of domestic abuse reported to the Scottish police,¹ 745,105 recorded incidents of domestic violence in England,² and 51,830 domestic abuse incidents recorded by police in Wales,² while the Police Service of Northern Ireland recorded 25,196 domestic abuse incidents in 2010/11.³ It is estimated that one in four women, and one in five men, experience domestic violence in their lifetime. Obtaining accurate prevalence figures is hampered by numerous barriers: domestic abuse occurs within relationships, often hidden from view, where emotions are highly entwined. The typically 'private' nature of such abuse contributes to the culture of silence that can surround the issue while heightening a victim's reluctance to report their experiences. For these reasons, as well as others described later in the report, it is a crime that is largely under-reported (see **Chapter 2**).

There is no statutory definition of domestic abuse or domestic violence in the UK. In 2004 the then Labour Government introduced a gender-neutral definition of 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,^a regardless of gender or sexuality'.⁴

A consultation was launched in late 2011 to consider if this definition should be amended and, from March 2013, a new, cross-government definition of domestic violence and domestic abuse was agreed (see **Box 1**):

Box 1: The 2012 cross-government definition of domestic violence and abuse

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

- psychological
- physical
- sexual
- financial
- emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape, and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Source: Home Office (2012) *Cross-government definition of domestic violence – a consultation. Summary of responses*. London: Home Office.

a An adult is defined as any person aged 18 years or over. Family members are defined as mother, father, son, daughter, brother, sister, and grandparents, whether directly related, in-laws or stepfamily.

It is worth noting that both definitions refer to either 'adults' or 'those aged 16 or over', and therefore do not cover abuse against children.

For the purpose of this report, domestic abuse is defined in accordance with the Government's revised definition. It is acknowledged from the outset, however, that the cross-government definition is not without its limitations and may muddy the waters further about where the boundaries between child abuse and domestic abuse lie. These limitations are considered in detail in **section 2.1**.

Each type of abuse outlined in the cross-Government definition is significant and may occur in combination, escalating over time. All types are known to have long-term impacts on the physical and mental health of victims. A major global review, published by the World Health Organization (WHO) in 2013, reported that 42 per cent of women who have been physically and/or sexually abused by a partner have experienced injuries as a result of that violence.⁵ Physical injuries can range from bruising, a black eye and scratches, to broken teeth and bones. Domestic abuse also increases the risk of chronic physical conditions, gastrointestinal disorders, unwanted pregnancy, complications during pregnancy, sexually transmitted infections and substance misuse.⁶

In some cases – particularly when psychological and/or financial abuse is concerned – the impacts on a patient's health can be overlooked as they do not present themselves as openly as the physical signs of abuse. Adverse effects on a victim's mental health range from post-traumatic stress disorder and panic attacks, to depression, eating problems, self-harm and suicide attempts, all of which can persist after the abuse has ceased. The physical and psychological effects of domestic abuse on a victim's health were estimated to cost the NHS £1.7 billion in 2009, an increase of £500 million since 2004.⁷ In extreme cases, abuse can be fatal. On average, two women in England and Wales are killed every week by a current or former male partner. In Scotland, 53 per cent of homicide cases over the last ten years involved a female victim aged 16-69, where the main accused was the woman in question's partner.⁸ Others may be driven to suicide. Figures produced in 2004 estimated that just over 500 women who had experienced domestic violence in the previous six months commit suicide annually.⁹

While anyone can be a victim of domestic abuse, certain groups are in a more vulnerable position than others (see **Chapter 4**). The Confidential Enquiry into Maternal and Child Health (CEMACH), for example, found that 30 per cent of domestic abuse begins during pregnancy, with pregnant women more likely to have multiple sites of injury, indicating that the fetus and the woman herself are the focus of the perpetrator's abuse.¹⁰ Disabled people are also at a greater risk of abuse. Research published in 2013 reported that the odds of being a victim of violence were two-fold higher for those with a physical disability, and three-fold higher for those with a mental-illness related disability, when compared to those without disability.¹¹

Despite the hidden nature of such crimes, healthcare professionals can be well-placed to identify abuse and intervene. It is estimated that between 4 and 19.5 per cent of women attending healthcare settings in England and Wales – particularly psychiatric, obstetrics and gynaecology, and emergency departments – may have experienced domestic abuse in the past year.^{12,13}

1.2 Government policy and legislation

Over the last decade domestic abuse has risen up the political agenda and is considered a cross-government priority. The Home Office's consultation paper *Safety and justice*,¹⁴ published in 2003, set out the strategic approach to domestic abuse, building on the domestic abuse proposals laid out in the 2002 *Justice for all* white paper.¹⁵ The 2003 consultation paper brought domestic abuse into the limelight and resulted in the *Domestic Violence, Crime & Victims Act 2004*.¹⁶ Applying to all the devolved nations, the Act remains the most comprehensive piece of legislation on domestic abuse for over 30 years. In March 2005 the Home Office produced *Domestic violence – a national report*,¹⁷ which provided an overview of its achievements in implementing the proposals outlined in *Safety and justice*, as well as setting new objectives for dealing with domestic abuse through early identification, prevention and improved response. Performance indicators were also listed to measure progress in these areas, with yearly reviews and annual progress reports published between 2006 and 2009. Despite making significant improvements, including rolling out 'routine enquiry' about domestic abuse to women using maternity services, this approach was criticised by the House of Commons Home Affairs Committee in 2008 for focusing 'disproportionately [...] on criminal justice responses at the expense of effective prevention and early intervention.'¹⁸

Both *Safety and justice* and the *Domestic Violence, Crime & Victims Act 2004* stand out as 'gender-neutral' documents; they recognise that domestic abuse occurs across society, regardless of age, gender, race, sexuality, disability, wealth and geography, while also acknowledging that it is predominately women who suffer as a result of it. Subsequent strategies, have not adopted such an inclusive focus on gender. The former Labour government published *Together we can end violence against women and girls: A strategy*¹⁹ in late 2009 with the aim of implementing a more coordinated, integrated approach to tackling violence against women. Proposals included promoting healthy relationships in schools and colleges, providing 'end-to-end' support for all victims going through the criminal justice system, and exploring better training for frontline staff.

Following the change in administration in 2010, the coalition government published its own, cross-departmental strategy *Call to end violence against women and girls (VAWG): Action plan*, in 2011.²⁰ Committing £28 million to specialist VAWG services over the next four years, the Home Office emphasised the need for prevention, provision of support to victims, partnership working and risk reduction. The Action Plan also acknowledged that 'there is still a need to address the needs of men and boys who may be affected by domestic and sexual violence', though the Plan does not target them specifically, instead noting that '[S]ome of [the] work to end VAWG will directly benefit them; in particular our preventative activity and the service signposting that we are developing with partners'.

Similar strategies have been introduced across the devolved nations. In Scotland, the 2009 initiative *Safer lives: Changed lives a shared approach to tackling violence against women in Scotland* is framed around meeting ministerial priorities under the Gender Equality Duty, focusing specifically on prevention, protection of victims, provision of services, and the participation of all agencies to ensure that policy making around violence against women is informed by those who use domestic violence services. In 2012, the Department of Justice and the Department of Health, Social Services and Public Safety jointly published the *Tackling domestic and sexual violence and abuse action plan for Northern Ireland*. This marked the first time that a joint action plan had been published to deliver on the objectives first set out in the 2005 strategy *Tackling violence at home*.

Since the introduction of the *Domestic Violence, Crime & Victims Act 2004*, a number of non-legislative reforms have taken place, many of which are aimed at tackling domestic abuse through more collaborative, multi-agency working. Specialist domestic violence courts (SDVCs) were introduced in 2005, with 127 in operation by 2012 in England and Wales. They aim to make the system more 'user friendly' by bringing together police, prosecutors, court staff, and the probation service to identify and track domestic abuse cases. The partners also work with specialist support services for victims to ensure that witnesses, who may feel vulnerable and intimidated, are supported throughout the process. All those involved, from the magistrates to the court ushers, are specially trained in domestic abuse issues. Feedback on the effectiveness of SDVCs has been positive, particularly in relation to increasing the number of successful prosecutions: in 2005, 59 per cent of overall domestic violence cases recorded by the CPS led to convictions. By 2007/08 this figure had risen to 71 per cent of cases tried in SDVCs.¹⁸ At the time of writing, a SDVC was being piloted in Derry, Northern Ireland while Scotland had one SDVC in Glasgow, with similar courts due to be set up across the country.²¹

Another non-legislative shift saw the introduction of multi-agency risk assessment conferences (MARACs) in 2006/07, initially in those areas with an established SDVC. These MARACs are monthly meetings held between a range of statutory and voluntary agencies (such as the police, victim support agencies, probation, social services, housing, and health services) with the aim of providing a coordinated response for high-risk victims (those at risk of murder or serious harm) of domestic abuse and their children. The meetings help to ensure that all the agencies involved are communicating regularly about the case, that they are sharing information, and that safety plans are in place in order to lower the risks to the victim (and any children). Over 250 MARACs are operating across England, Wales and Northern Ireland managing over 50,000 cases a year.²² They also exist in some parts of Scotland, notably North Lanarkshire, while other areas – such as Perth and Kinross – are currently piloting the scheme.²³ Funding for MARACs comes directly from the Home Office, and is budgeted for until March 2015. The new Police and Crime Commissioners took commissioning services for victims at a local level in 2013.

The Home Office, in association with non-governmental organisations, also fund independent Domestic Violence Advisers (IDVA) who can represent victims at MARACs. These are trained specialists providing independent advocacy and support to high-risk victims. As well as being the victim's primary point of contact, helping them to navigate the support services available, IDVAs are responsible for assisting with the implementation of their safety plans. This may involve obtaining civil injunctions to protect the individuals affected, improving home security, support with mental health problems or alerting schools to the risks that the children face. *Safety in Numbers*, – the first large scale, multi-site evaluation of IDVA services across England and Wales – produced promising results. Almost 80 per cent of victims said that they felt safer after support from an IDVA, with 57 per cent experiencing a complete or near cessation in the abuse they were suffering following around three to four months of contact with an IDVA.²⁴ The BMA acknowledges the importance of domestic abuse advisers, and considers they are well placed to work within hospitals.

Early in 2012, the Westminster Government conducted two consultations on domestic abuse. The first focused on whether the cross-government definition of domestic violence should be amended, while the second considered if changes were needed to enable people to find out if a prospective partner has a history of domestic abuse. Following these consultations, several developments have taken place. From March 2013, a revised definition of domestic violence will

be implemented across government departments to inform policy development and by other agencies such as the police, the Crown Prosecution Service and the UK Border Agency, to help identify domestic violence cases (as outlined in **Box 1**). The Domestic Violence Disclosure Scheme (also known as Clare's Law) – the subject of the second consultation – was piloted by police forces in Greater Manchester, Gwent, Nottinghamshire and Wiltshire for a year. It tested a process for enabling the police to disclose to the public information about previous violent offending, by a new or existing partner, where this may help protect them from further violent offending. In November 2013, it was announced that the scheme would be extended nationwide and in March 2014, the scheme was brought into effect in England and Wales.

In addition to the cross-government work on domestic abuse, the Department of Health (DH) has undertaken a range of work on this topic in recent years and has produced the following reports; *Responding to domestic abuse: a handbook for health professionals* (2005),²⁵ *Tackling the health and mental health effects of domestic and sexual violence and abuse* (2006),²⁶ *Interventions to reduce violence and promote the physical and psychosocial wellbeing of women who experience partner violence: a systematic review of controlled evaluations* (2005).²⁷ The 2009 *National domestic violence delivery plan* examined the health service response to domestic abuse.²⁸ It found that 'routine enquiry' about domestic abuse when taking a social history was being rolled out to antenatal clinics, mental health services as well as emergency departments, with the aim of providing women with an opportunity to talk about domestic abuse in a safe and confidential environment. Further recommendations to improve the response of the NHS to domestic abuse were set out in *Responding to violence against women and children – the role of the NHS: The report of the Taskforce on the Health Aspects of Violence Against Women and Children* – also known as the *Alberti report*.²⁹ This was followed by a detailed DH Action Plan in late 2010, aimed at improving services for women and child victims of violence.

Guidance produced by the National Institute for Health and Care Excellence (NICE) on preventing and reducing domestic violence was published in February 2014. *Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively* emphasises that 'multi-agency partnerships', combined with 'initial and ongoing training' in how to respond to domestic abuse, are two of the most effective ways to approach the issue.³⁰ Seventeen recommendations are made in the guidelines and these have informed the recommendations made by the BMA in **Chapter 10**.

Further afield, the World Medical Association (WMA) issued a statement on family violence (including domestic violence), which was last amended in 2010, together with a resolution on violence against women and girls. In addition to making several recommendations to doctors dealing with cases of abuse, the statement encouraged national medical associations to press for a multi-agency approach to facilitate coordination of action against family abuse and to facilitate research to understand the prevalence, risk factors, outcomes and optimal care for victims of family abuse.³¹ Religious bodies working at the global scale have also declared their support for ending domestic abuse and violence against women. The World Council of Churches and the World Communion of Reformed Churches, for example, have encouraged members, in partnership with others, to address the causes and consequences of domestic abuse.³²

Why is the BMA republishing this report?

As the major professional organisation representing doctors in the UK, the BMA, through this report, aims to lead the way in encouraging all health professionals in all disciplines to raise awareness of domestic abuse and to develop strategies to identify and reduce the substantial impact upon the health and welfare of society. The report has been informed by, and builds on, the 2013 BMA President's seminar: 'The role of health professionals in identifying and responding to domestic abuse, including child and elder abuse' (a note of this seminar is provided in **Appendix 7**). The seminar formed an integral part of a series of round table discussions, hosted by the then BMA President, Professor Sheila the Baroness Hollins, that examined many of the issues faced by vulnerable groups. The seminars reflect Baroness Hollins' commitment to gather a wide range of stakeholders to consider policy options in order to tackle some of the hidden health challenges facing vulnerable groups. While the seminar identified clear progress in tackling the prevalence of domestic abuse – including the establishment of a stronger legislative and regulatory framework, a more cohesive approach to identifying and managing high risk victims, and improved risk assessment and evaluation – domestic abuse continues to occur in one in 10 households at any given time, while two women per week, and one man every 17 days, are murdered as a result of domestic abuse.

One of the consequences of the raised physical and psychiatric morbidity associated with domestic abuse is that victims have an increased use of health services compared with those not abused.³³ The burden domestic abuse places on the health of the victim, their families, and on the NHS, all serve to highlight the impetus behind this report – namely that domestic abuse is a health concern; one which health professionals have an important role in tackling. Healthcare may be the first or only point of contact survivors have with professionals; research conducted by Boyle and colleagues highlighted how those experiencing abuse are more likely to contact health services than any other agency.³⁴ As Feder explains in the context of intimate partner violence:

'[T]he isolation that abused women experience as a direct result of their partner's control over their relationships with friends, family and professionals, means that their GP may be one of the few people that they can turn to.'³⁵

Despite the progress and new guidance since the BMA published its report, *Domestic abuse*, in 2007, more effective multi-agency working, where healthcare professionals are fully engaged, is needed. Healthcare professionals are in an ideal position to identify the indicators of domestic abuse before a 'crisis point' is reached. On average, female victims are subjected to 35 incidents of domestic abuse before they involve the police³⁶ yet many of these women have come into contact with their GP long before seeking help from the authorities.

Chapter 5 considers the dual role that health professionals can play, first by providing a source of care for a victim's physical and emotional injuries, and second by offering an essential route through which to identify and respond to abuse. Being alert to domestic abuse, and knowing how to intervene when it is suspected, raises a multitude of ethical questions for healthcare professionals. These are considered in detail in **Chapter 6**, while **Chapters 7, 8 and 9** make the case for approaching domestic abuse from a multidisciplinary and multi-agency standpoint. **Chapter 10** outlines the progress made towards implementing the recommendations from the BMA's 2007 report, on domestic abuse and sets out new recommendations in light of the developments made over the past six years.

Chapter 2. The nature and prevalence of domestic abuse

2.1 Defining domestic abuse

There is no single definition of domestic abuse and it is important to stress from the outset that there are several terms for such types of behaviour. The most commonly used alternative is domestic violence. Domestic violence can be misleading because violence is interpreted as being confined to the use of physical force against another individual, although it has a wider meaning.³⁷ Abuse, however, can include psychological abuse, which involves no physical force. This report uses the term domestic abuse (except when directly quoting) because it clearly encompasses the physical and psychological aspects of abuse. Other terms which are associated with domestic abuse include family violence, intimate partner violence/abuse, child abuse, elder abuse, and sexual abuse.

While the differences between some of the defining terms are slight, they can have important consequences for the range of interventions that it would be appropriate to consider. Two different positions can be identified on the definition of domestic abuse, which it is important to distinguish.

1. Domestic abuse defined as being about the use of coercive control within an intimate or family relationship.
2. Domestic abuse defined as covering a much wider field of difficulties within an intimate or family relationship. This may include forced marriage and so called honour-based violence.

Both positions recognise that, in the majority of domestic abuse cases, the perpetrator is male; however, the existence of female perpetrators of domestic abuse, and the existence of domestic abuse in same sex relationships is also acknowledged. The first position is exemplified in the definition of domestic violence used by Women's Aid³⁸ and in the RESPECT guidelines (see **Box 2**).

Box 2: Definition of domestic violence by RESPECT

'Domestic violence is a pattern of controlling behaviour against an intimate partner or ex-partner, that includes but is not limited to physical assaults, sexual assaults, emotional abuse, isolation, economic abuse, threats, stalking and intimidation. Although only some forms of domestic violence are illegal and attract criminal sanctions (physical and sexual assault, stalking, threats to kill), other forms of violence can also have very serious and lasting effects on a person's sense of self, wellbeing and autonomy.

Violent and abusive behaviour is used in an effort to control the partner based on the perpetrator's sense of entitlement. This behaviour may be directed at others – especially children – with the intention of controlling the intimate partner.

Social and institutional power structures support some groups using abuse and violence in order to control other groups in our society eg institutional racism, heterosexism, and parents' violence to children. The unequal power relations between men and women account for the fact that the vast majority of domestic violence is perpetrated by men against women rather than vice versa.'³⁹

The WHO employs the term 'intimate partner violence' to describe 'any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.' Examples of the types of behaviour include:

- **acts of physical violence**, such as slapping, hitting, kicking and beating
- **sexual violence**, including forced sexual intercourse and other forms of sexual coercion
- **emotional (psychological) abuse**, such as insults, belittling, constant humiliation, intimidation (e.g. destroying things), threats of harm, threats to take away children
- **controlling behaviours**, including isolating a person from family and friends; monitoring their movements; and restricting access to financial resources, employment, education or medical care.⁴⁰

The *Council of Europe Convention on preventing and combating violence against women and domestic violence* adopts a similar definition to that used by the WHO. Article 3b of the Convention states that:

'[...] domestic violence covers acts of physical, sexual, psychological or economic violence between members of the family or domestic unit, irrespective of biological or legal family ties [...] Domestic violence includes mainly two types of violence: intimate-partner violence between current or former spouses or partners and inter-generational violence which typically occurs between parents and children. It is a gender neutral definition that encompasses victims and perpetrators of both sexes.'⁴¹

The United Nations uses a gender-based definition:

'Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life.'⁴²

The boundaries between the different types of abuse identified in the definitions above are not clear cut and it is unusual for one form of abuse to occur in isolation. Domestic abuse is rarely a one-off incident and should be viewed as a pattern of abusive and controlling behaviour used by one person to control and dominate another with whom they have, or have had, a close or family relationship.⁴³ There is, however, no statutory definition of domestic abuse or domestic violence in the UK. For the purpose of this report, domestic abuse is defined in accordance with the Government's definition, as outlined in **Chapter 1** and in **Box 1**. The BMA, however, would extend it to include any incidents regardless of 'disability, race or religion', as well as gender or sexuality. This recognises that there are other scenarios where people live in small groups in a 'family style' but not be related, eg disabled people where abuse may happen.

The BMA also recognises that by defining domestic abuse as something that can occur between those aged 16 and over, the cross-Government definition may muddy the waters further about where the boundaries between child abuse and domestic abuse lie. For example, the National Society for the Prevention of Cruelty to Children (NSPCC) notes that while England, Scotland, Northern Ireland and Wales each have their own guidance setting out the duties of organisations to keep children safe, they 'all agree that a child is anyone who has not yet reached their 18th birthday'.⁴⁴ Those aged 16 and 17, alongside vulnerable adults (such as people with intellectual disabilities), may therefore be covered by domestic abuse and child abuse legislation.

While this report does not focus on child abuse,^b it is recognised that children can be exposed to domestic abuse and that this may impact upon their health, development and educational attainment. Section 120 of the *Adoption and Children Act 2002*, for example, extends the legal definition of harming children to include ‘impairment suffered from seeing or hearing the ill-treatment of another’.⁴⁵ Since 2004, it has also been formally recognised that children may be the victims of domestic abuse. Under the *Domestic Violence, Crime and Victims Act 2004* a new offence was created of ‘causing or allowing the death of a child or vulnerable adult’. This established a new criminal responsibility for members of a household where they know that a child or vulnerable adult is at risk of significant harm.⁴⁴ In 2012, the Act was amended to include ‘causing or allowing a child or vulnerable adult to suffer serious physical harm’. Children’s exposure to domestic abuse is considered in further detail in **section 4.1**.

Influences in early life can act as risk factors for becoming a victim or perpetrator of violence, and developing health problems, in later life. The work of the WHO Commission on Social Determinants of Health, and the Marmot Review team, has shown how social inequalities in health arise because of inequalities in the conditions of daily life.^{46,47} Such conditions include material circumstances, the social environment, psychosocial factors, behaviours, and biological factors which, in turn, are shaped by education, occupation, income, gender, and ethnicity: these are the ‘causes of the causes of illness’ and inequalities. To have an impact on these factors, opportunities to protect and promote good health, and reduce inequalities, must begin before birth and continue thereafter. This ‘life course’ perspective, where health and wellbeing are integrated on a continuum from pre-conception to old age, is supported by the BMA and underpins this report.

2.2 The prevalence of domestic abuse

“I regard domestic violence as the single greatest cause of harm in society”.

(Chief Superintendent John Sutherland, Metropolitan Police, speaking at the ‘Tackling Britain’s Gang Culture’ conference, 12 January 2013)

The Crime Survey for England and Wales (CSEW, formally known as the British Crime Survey - BCS) is the largest source of data on crime and victimisation in the UK. It measures the extent of crime in England and Wales by asking people about crimes they have experienced in the last year, including crimes which are not reported to the police. The most recent survey, published in January 2013, interviewed 50,000 people aged 16 or over and reported the occurrence of approximately 2.1 million violent incidents over a one-year period. Over 30 per cent of women and 18 per cent of men stated that they had experienced at least one incident of domestic abuse since the age of 16. Non-sexual partner abuse was the most common type of intimate violence referred to by both genders. Focusing only on the previous year, 7.3 per cent of women and 5 per cent of men reported having experienced domestic abuse, equivalent to an estimated 1.2 million female victims and 800,000 male victims. By way of comparison, the police recorded almost 800,000 incidents of domestic abuse in England and Wales over the same period, up to one third of which were classified as ‘repeat’ incidents.⁴⁸ The discrepancy between the CSEW and the police figures is likely to be indicative of the under-reporting of domestic abuse to the authorities.

^b The Board of Science report *Growing up in the UK*, published May 2013, explores the maltreatment of children.

The reluctance of victims to discuss their experiences of abuse is also apparent in the CSEW. Since 2004, the BCS / CSEW has included a self-completion module on 'intimate violence'. This covers experiences of emotional, financial and physical abuse by partners or family members, as well as sexual assaults and stalking by any person. When compared with face-to-face interviews, the self-completion module produced a prevalence rate of domestic abuse that was approximately five times higher than was ascertained prior to the introduction of the module. This trend is also apparent in the 2011/12 figures: only a small proportion of respondents (5%) who reported being victims of domestic abuse in the self-completion module also reported this in the face-to-face interviews. Estimated levels of domestic abuse experienced in 2011/12 were lower than the level in 2004/05 when the self-completion module was first included in the CSEW: between 2004/05 and 2011/12, prevalence of any domestic abuse in the last year declined for men and women (from 8.9% to 7.3% for women and from 6.5% to 5% for men).

Applying similar methods to the CSEW, the 2007/08 Northern Ireland Crime Survey (NICS) showed that 11 per cent of respondents, aged between 16 and 59, had experienced domestic abuse during that period. A higher proportion of females (15%) than males (8%) reported being victims of domestic abuse.⁴⁹ Examining prevalence rates in Scotland, and drawing comparisons with the rest of the UK, is slightly more difficult. The Scottish Crime and Justice Survey (SCJS) also uses a self-completion module to gauge abuse but examines 'partner abuse', rather than 'intimate partner violence' or domestic abuse. Figures from the 2010/11 SCJS show that 16 per cent of people who had at least one partner since the age of 16 had experienced partner abuse. In 61 per cent of these cases, the abusive partner was male compared with 37 per cent where the abusive partner was female.⁵⁰

The statistics from across the UK crime surveys highlight that the prevalence of domestic abuse is uneven: in addition to differing across geographical regions, it also varies by demographic group and socio-economic status.⁵¹ Based on figures from the 2011/12 CSEW, women and men with a long-term illness or disability were more likely to be victims of domestic abuse in the last year (12.8% and 7.3% respectively), compared with those without a long-term illness or disability (4.6% and 6.1%). Unemployed women were also more than twice as likely to have experienced domestic violence or abuse in 2011/12 when compared to those with a job (15% versus 6%).⁵² One response to such figures is to argue that they are artefacts of reporting bias and that women from higher socio-economic groups are less likely to report domestic abuse to the police. There has been little research into class effects in reporting domestic abuse.⁵³ While it is clear that domestic abuse is not confined to certain socio-economic groups, there is an equally limited amount of evidence about domestic abuse occurring within 'professional' families, including healthcare professionals.

One US study published in 1999, found that '3.7 per cent of women healthcare professionals report domestic abuse histories, 4.7 per cent report sexual abuse histories and approximately one in 13 report having experienced either or both at some point in their lives'.⁵⁴ Another US study, published in 2012, surveyed family physicians in Massachusetts on their personal experiences of childhood and adult abuse. It reported that 33.6 per cent had some experience of physical or sexual abuse, or personal trauma (including witnessing abuse between parents), as a child, with 11.2 per cent of adults reporting abuse as an adult. Women were more than twice as likely as men to have reported abuse as an adult (15.9% and 6.3% respectively).⁵⁵

Marital status and age were identified in the 2011/12 CSEW as two additional factors associated with an increased prevalence of victimisation, particularly among women. The highest risk of domestic abuse in the last year (21%) was for women who were separated, compared with all other groups by marital status. Women aged between 16 and 19 and between 20 and 24 were more likely to be victims of domestic abuse (13.7% and 12.6% respectively) or of stalking (7.9% and 7.3% respectively), while women aged between 16 and 19 were most likely to be victims of sexual assault (9.2%). These figures correspond with the findings from a Women's Aid survey of the number and age of the women resident in their refuges.⁵⁶ In 2010, women aged between 21 and 25 years comprised the majority (23%) of residents, while women aged between 61 and 65 years made up just 0.4 per cent of all residents. It should be noted that older people are likely to have more difficulty accessing refuge services and that this figure may simply reflect shelter availability. The low proportion of older women seeking help should not be interpreted as a representation of the prevalence of elder abuse (see **Chapter 4** for further information on the abuse of older people).

Ann's Story...

Ann worked for the NHS at a London Hospital as a senior nurse for five years. She was pregnant and recently her behaviour and timekeeping seemed to change which was unusual. Her manager had recently received domestic violence awareness training at the launch of the Hospital's domestic violence policy. Ann's manager met with her and asked if everything was ok, and if there was a reason for her late arrivals. Ann explained that she had recently left her partner and that she was being stalked by him. He had started by being psychologically abusive but then violence began to escalate and she was frightened. She had been trying to come to work later to make it more difficult for her partner to follow her. Ann's manager, by having the policy and toolkit of resources, was able to find information to suggest how she could help Ann through this difficult period. She referred Ann to a specialist domestic violence agency, recognising that she was at higher risk of harm.

In the short term Ann and her manager agreed that she could be escorted to and from home by one of Hospital's security team and that she could work flexi-hours so that she was not leaving and returning home at the same time every day, and take time off for court and other leave. Over the next several weeks Ann's manager worked with HR and checked that she was receiving advice and support and was safe. Ann's son was born and following maternity leave, Ann returned to work and continued to perform her specialist role and contribute to the performance of the Hospital. By taking these cost effective, simple, steps the Hospital was able to retain a talented and skilled member of staff, and keep Ann and her child safe from harm. Ann continues to thrive and be a productive member of the Hospital staff and received a promotion.

While domestic abuse persists as a crime which is perpetrated upon men and women, the UK crime surveys highlight that women are more likely to be victims than men. This difference is also reflected in UK police statistics. The Police Service of Northern Ireland recorded 9,368 domestic abuse crimes in 2011/12 in which 65 per cent of victims were women aged 18+ (6,123 offences) and 24 per cent were men aged 18+ (2,266 offences). In Scotland 59,847 incidents of domestic abuse were recorded by the police in 2011/12. Incidents with a female victim and a male perpetrator represented 81 per cent (46,439) of all domestic abuse incidents. The 2012 CSEW

found that the largest difference in intimate violence between the sexes was shown for sexual assault, with 20 per cent of women and 3 per cent of men having experienced sexual assault (including attempts) since the age of 16.⁶⁶ When these figures are coupled with the greater severity and health consequences of domestic abuse perpetrated by men against women, it helps to explain why the majority of domestic abuse literature concentrates solely on this aspect of abuse.

While domestic abuse is a crime which is perpetrated upon men and women, statistically **80 per cent** of reported domestic abuse victims are women.

Source: BCS 2005/06

Children, disabled and older people are three groups that are often overlooked when discussing domestic abuse. Children directly suffer from living in family environments where domestic abuse occurs between their adult carers (see **Chapter 4** for further discussion). The UK National Prevalence Study of Elder Maltreatment in 2006 found that 2.6 per cent of older people (aged over 65) living in private households had been maltreated by family members, close friends or care workers in the past year. This was calculated to equate to 227,000 individuals, or an estimated one in forty older patients for the average GP or family physician.⁵⁷

2.3 Barriers to measuring prevalence

It has been suggested that there are four main barriers to assessing the true prevalence of domestic abuse. They are:

- Victims feeling unable to disclose what is happening to them because of:
 - a) a fear of causing a family breakdown and/or bringing dishonour to the family
 - b) a sense of ongoing responsibility for the safety of their children or other family members
 - c) fears for their own personal safety should they report their experiences
 - d) feeling ashamed and/or responsible
 - e) a fear of not being believed, or of the experience being 'too trivial' to mention.⁵⁸

The last point is compounded by the hidden nature of the problem. Domestic abuse is a 'private crime', often taking place behind closed doors, away from the sight of others. This contributes to the culture of silence that can surround the issue while adding to the reluctance of victims to report their experiences.

- Many people do not regard the abuse they are suffering as a crime. Figures from the 2010/11 SCJS found that 29 per cent of those who had experienced physical partner abuse in the last 12 months considered what happened on the most recent (or only) occasion to be a crime.⁵⁰
- The absence of a single crime offence covering domestic abuse means that there are relatively little data available directly from the criminal justice system, particularly since the categorisations of crime in official statistics tend to reflect legal definitions.⁵⁹ Domestic abuse may be incorporated into statistics and reports on violence in general, as opposed to being specifically singled out. It is also difficult to separate occurrences of domestic abuse into discrete 'incidents': abuse may be continuous (e.g. living under constant threat), or may occur with such frequency that the victim cannot reliably count the instances.

- Domestic violence research is hampered by lack of an agreed definition.⁶⁰ There are numerous terms and definitions used to describe domestic abuse and this can lead to major differences in the prevalence figures reported. In one study on domestic violence in a UK emergency department the definition used for domestic violence was 'illness or injury resulting from the deliberate actions of an intimate partner'. This would rule out some forms of domestic abuse, such as abuse of an older person by their adult child.⁶⁰

The SCJS found that 19 per cent of female victims of domestic abuse, and 42 per cent of male victims, had told no-one about the incident other than the survey in question.⁵⁰ Victims do not report the abuse to the police due to a range of feelings, with the most common perception being that the abuse is too trivial to disturb the police.⁶¹ One survey of men found that just under half never sought help from the police after an incident of domestic abuse as they felt that the police would be unsympathetic or disbelieve them. When male victims had contacted the police for help, 89 per cent reported a feeling that they were not being taken seriously.⁶²

Gareth's story...

Gareth's wife was a divorcee with a son aged nine and a daughter aged five from her previous marriage. Together they had a daughter aged three. Despite leading a comfortable life his wife started to borrow money without his knowledge. The abuse started with his wife becoming physically violent towards him. She would also complain about the way he spoke, the way he dressed and tried to undermine his self-esteem.

During his marriage, he suffered a number of abusive incidences including: having hot chip fat thrown on him, being stabbed with a potato knife and on one occasion being hit with an iron bar that resulted in a broken arm.

Gareth was reluctant to leave the marriage for fear of not having access to his daughter as well as losing his home. He was humiliated by his wife, in front of visitors, on many occasions.

The end point for him was arriving home one day after work to find his wife preparing his meal. He sensed something was wrong, but did not know what. As he ate his meal by himself, he noticed blood coming from his mouth. His wife had put ground glass in his food. Gareth left the house and his wife in fear for his life.

The police did not believe his story and he spent many years and incurred heavy legal costs fighting to gain visitation rights to his daughter. Social services initially believed him to be the perpetrator, as this is what his wife had reported.

A report published by HM Inspectorate of Constabulary (HMIC) in 2014 suggests that the response from many police forces towards domestic abuse cases remains poor for male and female victims. *Everyone's business: Improving the police response to domestic abuse*, found 'alarming and unacceptable weaknesses in some core policing activity, in particular the quality of initial investigation undertaken by responding officers when they are called to a scene'. The report also indicates that officers can lack the necessary supervision, knowledge and skills to tackle domestic

abuse effectively, with some officers displaying poor attitudes towards victims. While the majority of forces stated that domestic abuse was a priority, the HMIC report found that translating this priority into an 'operational reality' was not occurring in most forces.⁶³

A further barrier to self-identification is the attitudes and action of healthcare professionals. It is of utmost importance to detect and address domestic abuse in the healthcare setting and it is crucial that healthcare professionals are equipped with the skills to do so. Barriers preventing doctors from enquiring about, and reporting, domestic abuse include uncertainty of what to do following a disclosure and fear of offending the patient when enquiring about an individual's personal life.⁶⁴

- For further information about the views of patients and healthcare professionals on the detection of domestic abuse in a healthcare setting please refer to **Chapter 5**.

Attrition rates – the number of cases that fail to make it through the criminal justice system and do not, therefore, result in criminal conviction – should also be considered as a barrier to measuring the occurrence of domestic abuse. Evidence compiled by the Association of Chief Police Officers in 2009 suggests that 'about a quarter of [domestic violence] incidents recorded by police result in arrest, while only 1.5-5% of incidents result in conviction.'⁶⁵

2.4 The economic cost of domestic abuse

The WHO report *The economic dimensions of interpersonal violence* explains that the costs attributable to domestic abuse can be grouped into direct and indirect costs.⁹ Direct costs are those costs incurred directly from acts of abuse and include the cost of legal services, medical costs, perpetrator control costs, policing and the costs of emergency housing. Indirect costs include lost earnings and lost time for victims, lost investments in human capital, life insurance, and psychological costs.

There are relatively few studies on the economic effects of domestic abuse. The Women and Equality Unit report *The cost of domestic violence*⁹, written by Walby and colleagues in 2004, states that the total cost of domestic abuse to services in England and Wales (criminal justice system, health, social services, housing, civil legal) amounts to £3.1bn, and a loss to the economy of £2.7bn per annum. The criminal justice system spends around £1bn a year on domestic abuse cases, which is equal to nearly one quarter of their budget for violent crime. The cost to the NHS of physical injuries from domestic abuse is around £1.2bn, and for mental healthcare it equals £176m. This adds to a total tangible cost of £5.8bn. The report also highlights the additional 'human and emotional cost' of domestic abuse – the pain, suffering and fear inflicted by domestic abuse (which are not counted in the cost of services) – which has been estimated at a further £17bn.

The most recent data, published by Walby in 2009, indicate that the cost of domestic abuse to public services increased in line with inflation, from £3.1bn in 2001 to £3.85bn in 2008, with the cost to the NHS rising to £1.7bn over the same period.⁷ A less conservative estimate was produced by the think tank New Philanthropy Capital (NPC). Using a different methodology to Walby and colleagues, NPC calculated that the cost of domestic violence in England and Wales was £20bn per year in 2006/07 terms (see **Table 1**).

Table 1: Costs of domestic violence (committed by a current or former partner) in England and Wales, 2006/07

Type of cost	Cost (£bn per year)
Human and emotional	£13.88
Lost economic output	£2.12
Civil legal costs	£0.23
Housing costs	£0.16
Social services and children	£0.23
Mental health	£0.18
Physical health	£0.92
Criminal justice	£0.88
TOTAL (in 2003/2004 terms)	£18.59
TOTAL (in 2006/2007 terms)	£20.06

Source: Jarvinen J, Kail A, Miller I (2008) *Hard knock life: Violence against women. A guide for donors*. London: New Philanthropy Capital.

Chapter 3. Understanding domestic abuse and its health associations

3.1 Types of domestic abuse

Domestic abuse falls into four main types: physical abuse, sexual abuse, psychological abuse and financial abuse. Each is significant and all are known to have a long-term impact on the victims. While physical, sexual, psychological and financial abuse are considered separately in this chapter, it should be recognised that the boundaries between different types of domestic abuse are not clear cut and that it is unusual for one type to occur in isolation. The 'cycle of abuse' outlined in **section 3.3** illustrates the links between physical, sexual, psychological and financial abuse, and how the scale of abuse can escalate over time. The chapter concludes by examining the evidence on why adults remain in an abusive relationship, as well as the links between domestic abuse, illicit drugs and alcohol. The vulnerability of specific groups is addressed in **Chapter 4**.

When considering the health effects of different types of abuse, it is necessary to remember that the relationship between exposure to abuse and health effects is complex. There can be a tendency, as identified by the authors of a 2013 WHO report on intimate partner violence, for assumptions to be made about the immediacy of pathways; namely that abuse can increase the occurrence of a particular risk behaviour and that the risk behaviour, in turn, increases the likelihood of an adverse health outcome. The evidence base to date, however, is limited to mostly cross-sectional studies that do not allow temporality or causality to be determined.⁵

3.1.1 Physical abuse

Findings from the BCS 2010/11 show that injuries are often sustained as a result of domestic abuse, especially among women. Of the 4.6 per cent of women, and 2.8 per cent of men who experienced domestic abuse in the 12 month period preceding the 2010/11 survey, over a quarter (27%) of partner abuse victims suffered a physical injury as a result of the abuse, with almost the same percentage (28%) receiving some sort of medical attention. Minor injuries included bruising or a black eye and scratches, while severe injuries included internal injuries and broken bones or teeth. Death^c is the most severe consequence of domestic abuse.⁶⁶

Rates of physical abuse reported in primary care and other medical settings are generally higher than those reported in population-based surveys, such as the CSEW/BCS. A study of domestic abuse among 1,871 women attending GPs in Ireland highlighted that 39 per cent of the sample had experienced one or more incidents of violent behaviour from a partner. Serious violent incidents reported by female victims included being punched in the face (10%), being punched or kicked in the body, arms or legs (10%), and being choked (9%).⁶⁷ A similar study conducted in general practices in Hackney, east London, with 1,207 women found that 17 per cent had experienced physical violence in the last 12 months, while 41 per cent had been the victim of physical domestic violence during their lifetime. Forms of abuse ranged from being punched in the body (20%) and kicked on the floor (13%) to having a weapon/object used to hurt them (7%).⁶⁸

Much less research has been directed towards understanding the patterns of physical domestic abuse against men. A UK-based survey of male victims of domestic abuse found that 66 per cent said that their partner had used a weapon against them, with 22 per cent having been stabbed by a knife or sharp object. Thirty three per cent of men had been kicked in the groin and the same number had been attacked in their sleep or in bed. The latter appears to be a particular characteristic of abuse against men.⁶² Research conducted in the Netherlands between 2008 and 2009 reported that nine per cent of men had experienced physical domestic abuse. In 96 per cent of cases, the perpetrator was an ex-partner.

^c Death may result from murder, manslaughter or suicide.

The most common forms of violence experienced by men were hitting, stabbing with an object, kicking, biting, seizing the throat, and scratching. Over 50 per cent of the cases of physical violence involved the use of an object – usually a household item such as a vase or tableware. Less than 32 per cent of victims went on to speak to police about the violence, with 15 per cent officially reporting an incident.⁶⁹

The findings of the National Intimate Partner and Sexual Violence Survey, conducted by the National Center for Injury Prevention and Control in Atlanta, Georgia, indicate that 33 per cent of women and 28 per cent of men in the United States have experienced severe physical violence by an intimate partner (eg hit with a fist or something hard, beaten, slammed against something) at some point in their lifetime.⁷⁰ Male and female victims were more likely to report frequent headaches, chronic pain, difficulty with sleeping, activity limitations, poor physical health and poor mental health than those who did not experience these forms of violence. Women were also more likely to report having asthma, irritable bowel syndrome, and diabetes. Findings from the WHO multi-country study on women's health and domestic violence – covering ten countries in the Global North and Global South – confirm that physical and sexual violence against women is widespread. Two sites reported a lifetime prevalence of physical and sexual abuse of less than 25 per cent, seven reported prevalence ranging between 25 per cent and 50 per cent, and six were between 50 per cent and 75 per cent.⁷¹

3.1.2 Sexual abuse

The CSEW 2011/12 reported that around three per cent of women and around 0.3 per cent of men had experienced some form of sexual assault (including attempts) in the last year. The majority of these were for less serious sexual assault, such as indecent exposure, unwanted sexual touching or sexual threats. Serious sexual assault^d can lead to a range of physical and mental injuries. Over half (56%) of victims of serious sexual assault suffered mental or emotional problems, and a further quarter (25%) reported having problems trusting people or having difficulty in other relationships. In four per cent of cases, the victim attempted suicide as a result of the incident, while two per cent of victims of serious sexual assault become pregnant as a result of the incident. Other physical impacts include difficulty sleeping, minor bruises, and scratching. While there is also an increased risk of acquiring a sexually transmitted infection (STI), including HIV.

Research has also been conducted to discover how the coercion leading to serious sexual assault without consent is carried out. In 62 per cent of cases physical force was used, mainly in the form of being held down, and in 27 per cent of cases the woman was drugged, unconscious or incapable of consent (see **section 3.5** for a discussion of the relationship between domestic abuse, illicit drugs and alcohol).⁵¹ The *Sexual Offences Act 2003* and the *Mental Capacity Act 2005* provide the legislative framework in England and Wales under which consent is assessed. Concerns about the sexual abuse of adults with limited mental capacity – such as those with severe intellectual disability – have been repeatedly raised, though a lack of reliable national statistics means that the prevalence of sexual abuse of children or adults who have intellectual disabilities is not known (for a discussion of consent and the *Mental Capacity Act 2005* please see **Chapter 6**).^{72,73} Long-term sexual abuse may increase a woman's risk of urogenital infections and chronic pelvic pain.⁷⁴ As the prevalence for male sexual assault is comparatively low the same analysis is not possible.

d Involving unwanted penetration of the body (vagina, anus or mouth).

Examining the lifetime incidence of sexual assault produces higher figures: according to the CSEW 2011/12, 20 per cent of women and three per cent of men reported having experienced such abuse since the age of 16. Globally between six and 47 per cent of adult women report being sexually assaulted by intimate partners in their lifetime. Based on data extracted from 79 countries and two territories, a 2013 WHO review found that the global lifetime prevalence of physical and/or sexual intimate partner violence among all ever-partnered women was 30 per cent. Experience of violence rose progressively across all age groups among ever-partnered women, peaking in the 40-44 age group. The authors of the WHO report, however, emphasise that there are fewer data points available for the over 49 age group, and that much less is known about patterns of violence among women aged 50 and over.⁵

Forced or coercive sexual intercourse with an HIV-infected partner is one of the routes of transmission of HIV and other STIs to women. The WHO reported in 2004 that half or more of the 40 million individuals infected with HIV in the world are women. The risk of transmission is increased with the degree of trauma inflicted on the victim. Abuse from an intimate partner can also indirectly result in HIV transmission because it reduces the woman's ability to negotiate condom use and the circumstances surrounding sexual intercourse. The abuse – and associated fear of abuse – acts as a barrier to women seeking HIV testing and thus decreases the number of women receiving treatment for the disease.⁷⁵ Watts highlights that, often, women first learn that they are infected following ante-natal testing. Disclosing this information to their partner, or to family and friends, can result in violence, stigma and discrimination, perpetuating the cycle of abuse.⁷⁶

3.1.3 Psychological abuse

Psychological abuse typically involves maintaining coercive control over someone in a non-physical way. It can include controlling behaviour, undermining the victim's confidence and worthiness, and restricting the victim's freedom. The perpetrator may also engage in verbal abuse – in private and public places – designed to 'humiliate, degrade, demean, intimidate, subjugate'.⁷⁷ Threats of physical violence against the victim and/or their loved ones may also be used. Survivors report that the relentless nature of psychological abuse can 'cripple and isolate' them,⁷⁷ yet the impact of this type of abuse, particularly on victims' mental health, tends to be overlooked as it does not present itself as openly as the physical signs of abuse.

The relationship between psychological abuse and mental health problems is bi-directional. It is known that domestic abuse has long-term consequences on the mental health of its victims: the WHO reported in 2013 that abused women are more likely to suffer from depression, anxiety, sleep difficulties, eating problems, emotional distress and suicide attempts.⁷⁸ The psychological impact of continued abuse can result in numbing and habituation, such that successive violent episodes do not have any new psychological effects.⁷⁹ Men and women who have existing mental health problems, 'report a high prevalence and increased odds of domestic violence compared to people without mental disorder, with women more likely to experience abuse than men.'³³ A 2012 systematic review and meta-analysis of studies examining experiences of domestic abuse and mental disorders found the median prevalence of intimate partner violence among women was reported as 45.8 per cent among those with pre-existing depressive disorders, 27.6 per cent among those with pre-existing anxiety disorders, and 61 per cent among those with pre-existing post-traumatic stress disorder (PTSD).³³

Self-harm is an indirect health outcome for victims of domestic abuse. Research published in the Emergency Medical Journal in 2004 showed that women who deliberately self-harm are 75 times more likely to report physical and/or verbal abuse from a partner than women who do not harm themselves. Male victims of domestic abuse are twice as likely to self-harm when compared to men who have not suffered from domestic abuse.⁸⁰

3.1.4 Financial abuse

Financial abuse can take many different forms but all are aimed at limiting and controlling the partner's actions and freedom of choice, and may result in insurmountable levels of debt and other financial problems. These factors may also prevent the victim from leaving the abusive home. A project run by the charity Women's Aid in 2012 on 'Domestic Abuse, Money and Education' recognised that financial abuse could include:

- interfering with the victim's employment, education or training
- controlling access to all household finances (including those of the victim)
- refusing to contribute to shared household expenses
- insisting that the victim takes out loans and credit in her sole name
- direct theft from her
- forcing her to take actions which are dishonest, illegal or against her own sense of right and wrong.⁸¹

Research conducted in 2008 on behalf of the charity Refuge found that 89 per cent of women (n=49) experienced economic abuse as part of domestic abuse. Almost half of the sample^e reported that their abuser had interfered with their education and employment, three-quarters stated that the perpetrator had controlled their access to economic resources, while 18 per cent experienced economic costs generated by the abuser. The latter included women being coerced into getting loans, credit cards, overdrafts, store cards and contract mobile phones in their names which the abuser then used but which they were not allowed to access.⁸² Financial abuse rarely occurs in isolation; the Refuge research noted that it reinforced and overlapped with the other types of control, thereby providing an additional tool through which to perpetrate domestic abuse. The 'economic abuse wheel' attempts to illustrate the constant nature of this type of abuse.

e The sample consisted of users of refuge, floating support and independent domestic violence advocacy services across the geographical areas in which Refuge operates.

Figure 1: The economic abuse wheel



Source: Sharp N (2008) *'What's yours is mine' the different forms of economic abuse and its impact on women and children experiencing domestic violence*. London: Refuge.

Financial abuse is commonly seen in vulnerable groups, particularly where individuals are reliant on someone to handle their finances on their behalf, such as older people or people who cannot read and/or write. Following a period of financial domestic abuse, older people are less likely to recover their financial situation than younger people. Older victims of financial abuse have a three times higher mortality rate than non-victims.⁸³ Financial abuse may involve the loss of a home through deceit, loss of beloved personal assets through theft, or loss of money from improper use of a 'power of attorney'. Loss of money and/or property is likely to result in an adult having fewer resources to take care of their own health, housing and good nutrition.⁸⁴

In the US it has been estimated that financial abuse accounts for half of all types of elder abuse, as other types of abuse – such as psychological abuse, deception and intimidation – are commonly accompanied by financial exploitation.⁸⁵ Elder financial abuse is very difficult to diagnose due to the lack of physical symptomatology and it is thought it remains heavily under-reported. Signs of financial abuse include unusual bank account activity, sudden changes to beneficiaries or advance directive documents, and the worsening of medical conditions due to lack of unfilled

prescriptions.⁸⁶ Despite the devastating effects of financial abuse on older victims, doctors can find it difficult to recognise, diagnose and assist such people. This may be because they are not witnessing the impact, or because they are not trained to recognise the signs.⁸⁵

3.2 The perpetrator

There is no typical perpetrator of domestic abuse. They come from different backgrounds, have had different life experiences and have different reasons for this behaviour. It is a commonly held view that despite their individual motives to abuse, all choose to abuse, and it is not accidental. Mitchell and Gilchrist⁸⁷ provide a contrasting hypothesis that some incidents of domestic abuse can be understood in terms of a panic/anger attack directed at the family member. There are numerous reasons why an individual may choose to abuse someone. Some perpetrators learn to abuse from their childhood years. They may have been the victims of abuse themselves or witnessed one of their parents being abused. A child may grow up believing that abuse is part of the normal way of life and that it is natural for a person to become either the 'in-control' abuser or the 'out-of-control' victim.

The term 'cycle of abuse' can be used to describe the pattern in which a victim of abuse develops into a perpetrator in later life. This explanation is based on social learning theory; it focuses on how aggression, abuse and violence are learned and transferred by individual members of the family to others.^{88,89} The intergenerational transmission of violent interfamilial relationships is not inevitable: a child may grow up appreciating the devastation abuse can cause and be resilient enough to reject such behaviour.⁷⁷ Other studies have shown that a large number of perpetrators were not abused as children and did not come from violent homes.⁹⁰ The *From boys to men* project – a joint venture undertaken by the Universities of Bath, Manchester and Keele – found that, in teenage relationships, the acceptability of domestic abuse among young men was 'highly contingent' upon 'whether or not they had reason enough to feel insecure, aggrieved or 'paranoid': the absence of trust in a relationship was identified as 'fundamental to justifying and explaining abuse'.⁹¹

The desire to control the way an individual acts, feels and thinks is a common motive for abuse of a family member. Psychoanalytic theories of domestic abuse focus on individual internal psychological processes that create a need to be abusive or to accept abusive behaviour.⁸⁹ Perpetrators are sometimes described as lacking empathy and being unable to relate to other people's perspectives and feelings. They may treat their victims as though they are there solely for their convenience and do not deserve their independence. Jealousy can often play a part in such domestic abuse so that if the perpetrator is able to control their partner it will help to reduce their own feelings of jealousy.⁹²

Untreated mental or emotional health problems may, in some cases, result in domestic abuse. Evidence exists to show that the 'rates of violence toward family members by a relative with a psychiatric disorder is between 10 per cent and 40 per cent', which is significantly higher than in the general population.⁹³ Individuals with mental or emotional health problems, however, have an increased vulnerability to being subjected to many forms of abuse, including domestic abuse (see **section 3.1.3**).⁹⁴

A feminist perspective on domestic abuse focuses on patriarchal societies that foster patriarchal family structures in which men are expected to have power over women. Following this theory, unequal power relationships and social attitudes support male power and authority over the

family, ultimately leading to the abuse of women. Merrill proposed a gender-neutral model in 1996⁹⁵ which would apply to abuse perpetrated by either gender, including within straight, gay and lesbian relationships. This model encompasses some of the previously discussed causative factors. Merrill gives three underlying aspects of domestic abuse, the first being that individuals learn how to abuse from their family or friends, and second that they must have the opportunity to abuse. The third is that the perpetrator must choose to abuse. This may reflect a belief that resorting to violence or emotional abuse is the only option when dealing with distorted ideas about gender roles, or the need to control their partner.⁹⁶

- Alcohol and drug abuse are frequently associated with domestic abuse. Please see the final section of this chapter for further discussion.
- For further information about meeting the healthcare needs of domestic abuse perpetrators see **Chapter 6**.

3.3 The cycle of abuse

Domestic abuse does not usually take place continuously, nor is it generally comprised of a single episode. In *The battered woman*, published in 1979,⁹⁷ Walker described abuse between partners as being cyclical and identified three phases that are repeated over time. Each stage lasts a different amount of time, with the total cycle taking from just a few hours to complete, to over a year. The cycle commonly speeds up as time goes on.

Figure 2: The Cycle of Abuse: Diagram illustrating the cyclic nature of domestic abuse



Source: Sex Info at University of California at Santa Barbara
(Available at: <http://www.soc.ucsb.edu/sexinfo/?article=violence&refid=004>)

Stage one

The first stage is known as the tension building stage or 'the calm before the storm'. This is when the tension slowly builds between the perpetrator and the victim. The perpetrator may pick fights, act jealously or possessively, criticise their partner and be agitated and unpredictable. Problems regarding employment, finances, children, and other areas are stressors that increase the tension. The partner will feel like they are walking on eggshells and are likely to try to delay movement to the next stage by trying to keep quiet, please the perpetrator and even attempt to calm them down. The victim will be feeling afraid of the next stage and anxious that it may take place in the near future. Although incidents such as pushing or throwing things may occur in this period, emotional abuse is more commonly seen, and for this reason some victims may choose to purposely trigger the next violent stage to prematurely end the waiting period.

Stage two

Stage two is the violent eruption phase or crisis phase, and it begins with some form of explosive outburst with significant violence. The behaviour of the victim is rarely the trigger for this phase; it is more commonly an external initiator, such as problems at work or money worries. It is a common misconception that violent couples live repeatedly within this stage, as this is normally when help is called for, or the abuse is detected by outsiders. The abuse in this stage is largely physical and occurs as a result of the build up of the uncontrollable tension from stage one. The perpetrator can often cause very serious harm (or even death)^f to the victim, usually in a family environment, and this is when the children are at their highest risk of being impacted, both physically and emotionally. The victim during this stage will experience fear and shock. They will be forced to use self defence, and may try to leave the relationship. It is at this stage that healthcare professionals are most likely to be made aware of the abuse.

Stage three

The final stage is called the honeymoon stage which starts shortly after the violence has ended. The perpetrator will ask for forgiveness and make promises that it will never happen again. The phase will be marked by closeness and affection from the perpetrator as they will be feeling very apologetic and guilty for the hurt they have caused to their loved one. The perpetrator and the victim want to believe that the abuse will never happen again. They may go to counselling and this is likely to bring the couple closer together. The victim of abuse will be forgiving of their partner and have hope for a happier future. They will either try to forget that the abuse ever happened or minimise the extent to which it did. As the victim is witnessing the loving and affectionate side of their partner they may start to blame themselves for the abuse, and if they have previously fled the home they may return.

The honeymoon stage will nearly always come to an end and the cycle will then be repeated. It can be hard for the perpetrators and the victims of domestic abuse to see the cyclic nature of the abuse. This makes it harder for the victim to seek help and leave the relationship. For the perpetrator this will delay the time when they may choose to seek help for themselves.^{98,99,100}

^f Of the homicides reported in 2005/06, 33 per cent of female victims, and 23 per cent of male victims were killed by a partner, ex-partner or lover. (Source: Homicides, Firearm Offences and Intimate Violence 2005/06, Home Office 2007).

3.4 Reasons why adults stay in abusive relationships

It is a commonly held misconception that if domestic abuse is so severe then the victim should choose to leave their abusive partner and if the victim does not leave they must carry some of the blame. Abuse is not the victim's fault and there are emotional and practical reasons why a victim may not walk away from their abusive partner or family member. In the case of elder abuse, the victim may feel entirely powerless to escape. It also should be recognised that what appears to an outsider to be a lack of response to living in an abusive relationship may in fact be a strategic, calculated 'assessment of what it takes [...] to survive in the relationship and to protect [oneself] and any children.'¹⁰¹ Sufferers of domestic abuse live in fear of the next attack and it is a natural response to try to prevent it from happening or, if this is not possible, to reduce the severity of the attack.

Leaving does not necessarily guarantee a victim's safety. If a victim tries to leave but is caught in the process, then the abuse may escalate into something much worse than what it would have originally been. A women's risk of being murdered is greatest immediately after separation,¹⁰¹ when the perpetrator may feel they need to punish their victim for trying to flee the home. This tactic is likely to work because many victims decide that the risk would not be worth taking in the future. Victims who do successfully escape will often find themselves always worrying whether the perpetrator of the abuse will find them. This may be a worse alternative to living with their abusive partner.

The difficulty of breaking free of the 'psychological entrapment' – the cycle of abuse (tension building – violence – honeymoon) previously described – is another reason why victims find it such a struggle to flee from a domestic abuse perpetrator.¹⁰² During the tension building stage the victim will often grasp on to a sense of hope that the next abusive stage will not be reached. This is a time when they will put effort into trying to prevent the abuse from being triggered, distracting them from thinking about leaving. The violent stage is the most obvious time to seek refuge but, due to the often very physical nature of this stage, it can be impossible to get away.

Entrapment may also be reinforced by threats about what will happen to the victim (and/or their loved ones) should they try and leave or disclose the abuse. The defining factor of the honeymoon stage is the manifestation of love and affection, displayed by the perpetrator towards their partner, and the frequent promises to never hurt them again. This can cause the victim to feel renewed love toward their partner and victims often rationalise that they are not really being abused. Victims are motivated to find excuses for the perpetrator and they think of the most recent episode of abuse as a one-off event. A victim will find it very difficult to leave the relationship as they will be unmindful of the reasons for escape.

A victim's response to abuse is often limited by the practical options available to him or her. Being financially dependent on the perpetrator or not having any property which is solely theirs often makes leaving an unthinkable option for a victim. Some victims will not have access to cash or bank accounts and if they left they would find themselves living in far more basic conditions. This problem can be compounded if the victim's immigration status is insecure. If an individual has entered the UK to join their spouse who is a British citizen, or someone present and settled in the UK, they are granted limited leave to remain, initially for a period not exceeding 33 months, which may be extended before being eligible for indefinite leave to remain after five years. Limited leave to remain is subject to the condition that the spouse/fiancé(e) has no recourse to public funds, leaving them unable to access housing or income support.

Recognising that this can leave a victim of domestic abuse financially dependent upon their abuser, with either limited or no options for living safely and independently, the Destitution Domestic Violence (DDV) concession was introduced in April 2012.¹⁸ The DDV concession is aimed at protecting victims of domestic abuse by allowing them to notify the Home Office that they need to access public funds while they make a claim for leave to remain as a victim of domestic abuse. This concession applies to those who entered the UK or were given leave to remain in the UK as a spouse, civil partner, unmarried or same sex partner of a British citizen, or someone present and settled in the UK. Some dependents of those with refugee status would be protected by the DDV concession; however for those who are seeking asylum in the UK, and report domestic violence, there is more limited assistance which includes having their identity protected and being moved to different accommodation.

When children are involved the practicalities become more apparent as the victim often finds that they are not only trying to support themselves but also their child(ren). Research with immigrant and non-immigrant women identified a lack of awareness of services that could help as a barrier to leaving an abusive relationship.¹⁰³ Older people and those with an impairment or disability may be in a situation where their carer is also their abuser – a person that they are fully dependent upon to provide their care needs and for help with mobility and communication. Leaving may be an impractical and highly daunting option. Victims, who are or were in an intimate relationship with the perpetrator, often prolong the time they stay in an abusive relationship because they feel it is in the interest of their child(ren). Some believe it would be more detrimental to the upbringing of their child(ren) if they lived within a single parent family compared with a two parent family, despite the abuse within it. Perpetrators can go to great lengths to stop their victim from leaving and this will often involve threatening to harm the child(ren) or threatening to deny the victim access to them. A victim can also be afraid that following the disclosure of domestic abuse, social services may remove their child(ren) from the family home.

Religious and cultural pressures can also stop victims from leaving. Traditionally the Catholic Church disapproves of divorce. For a victim with those beliefs, choosing to end their marriage may cause them to feel shame and social exclusion. Women from Asian communities are often expected to uphold the family honour and leaving could result in being ostracised by their family and friends. Other external pressures which can influence whether victims of abuse seek help include the worry that if they approach the police they may not be taken seriously and that the abuse will be treated as a 'domestic dispute' which implies that both partners are equally guilty.

92,96,104,105

In 2005 the 'Journal of Family Violence'¹⁰⁶ reported that 'there is a considerable body of evidence demonstrating that survivors of childhood sexual abuse (CSA) are at an increased risk of experiencing subsequent episodes of victimisation'. Individuals with a history of CSA may have difficulty recognising or responding to the threat of relational abuse or negotiating relationship boundaries.¹⁰⁷ Early abuse may play a critical role in the difficulty that many female victims of domestic abuse have in terminating abusive relationships in adulthood.¹⁰⁸ Victims of domestic abuse frequently suffer with low self-esteem, often exacerbated by the abusive relationship. They fear being alone and tolerate the abuse, or believe they do not deserve a better partner, and are torn between a need for love and support and the fear of not having that. These individuals have a higher tendency to excuse their partner's abuse.¹⁰⁹

Abuse within relationships is not easily preventable. Domestic abuse mainly occurs behind closed doors and, for it to stop, the victim must seek help or refuge. Every time a victim forgives the perpetrator of the abuse it reinforces that it is an acceptable behaviour, and it is more likely to be repeated.⁹² It should also be recognised that leaving an abusive relationship is a process that involves periods of denial, self-blame and endurance before the victim comes to recognise the pattern to the abuse and sees it as something from which they need to escape.¹⁰¹

- Please refer to **Appendix 1** for a diagram illustrating the complex relationship and interaction between the causes and consequences of violence and abuse.

3.5 The link between domestic abuse, drugs and alcohol

Gillian's story...

(Age 45)

'I suffered for 11 years at the hands of my controlling husband. To the outside world he was so charming but behind closed doors he was disrespectful and rude – it was like he was two different people.

My husband became violent after being with him for two years, and it became progressively worse, until I was so scared I didn't know what to do or who to turn to. I didn't tell anyone to begin with because I always felt no one would believe me and I was incredibly ashamed. He told me I would be nothing without him and that he would make my life hell if I ever had the courage to leave him. He would taunt me with "who would ever want someone like you?" He insisted that he would never leave me alone if I left.

I began to drink heavily as I could then feel numb and better able to deal with his physical and psychological acts of abuse. I couldn't think straight and nearly lost my business through the stress. I lived only for my daughter. I was exhausted from crying every day and resigned myself to his abuse.

I was frightened to tell anyone, as I knew no one who knew us as a couple would ever believe me and that he would always deny it. I decided to tell my doctor and get something put on record. The doctor was really empathetic and encouraged me to summon up enough strength and courage to contact Women's Aid and get support.

After I left my husband, I still needed support from Women's Aid because I had to make sure that I had people to talk to and discuss any safety issues with. I also had to have continued help from my doctor as I had been drinking heavily as a way of coping with the abuse and knew I had to stop.

I am now living in a flat with my daughter and we feel as if we have our lives back. Without the support from my doctor, I may still be living with my husband.'

Illicit drug use and alcohol consumption, especially at harmful and hazardous⁹ levels, can be a major contributor to the occurrence of domestic abuse, and an outcome of being a victim or witness of abuse. Neither causes domestic abuse; they are proximal reasons.¹¹⁰ The BCS 2010/11 found that 21 per cent of those who had experienced partner abuse in the last year thought that the offender was under the influence of alcohol, while in eight per cent of domestic abuse cases the victim judged their offender to be under the influence of drugs.⁶⁶ The NICS 2007/08 reported that 54 per cent of the worst incidents of domestic abuse took place while the perpetrator was considered to be under the influence of alcohol.³

Victims of domestic abuse have also been found to have increased alcohol consumption compared with non-victims.¹¹⁰ Results from the BCS 2010/11 show that 10 per cent of victims reported that they were under the influence of alcohol, and two per cent were under the influence of illicit drugs, when they experienced domestic violence.¹¹¹ While women may drink alcohol to cope with abuse, the WHO notes that women's consumption of alcohol may be a factor in abuse from their partners.⁵ One theory is that conflict escalates into violence more readily when alcohol has been consumed. In an evidence review, the WHO recognised the following:

- alcohol use can directly affect cognitive and physical function, reducing self-control and leaving individuals less capable of negotiating a non-violent resolution to conflicts within relationships
- excessive drinking can exacerbate financial difficulties, infidelity or childcare problems, resulting in tension building and conflict within a relationship, thus increasing the risk of abuse
- individual and societal beliefs that alcohol causes aggression can encourage violent behaviour after drinking and alcohol consumption can be used as an excuse for violent behaviour
- experiencing violence within a relationship can lead to alcohol consumption as a method of coping or self-medicating
- children who witness domestic abuse are more likely to display harmful drinking patterns later in life.¹¹²

Domestic abuse, characterised by the perpetrator's pre-assault alcohol use, is associated with more serious outcomes, with perpetrator alcohol use being related to approximately 1.5 times the risk of victim injury and medical attention.¹¹³ Other reviews indicate that rates of alcohol abuse and dependence among perpetrators of domestic abuse may be two to seven times higher than in the general population.¹¹⁴ The results of a 2008 study examining the role of illicit drugs in intimate partner violence (IPV) found that drug use (as reported by the perpetrator) was a stronger predictor of IPV than alcohol problems in perpetrators.¹¹⁵ Attempts to combat substance use in perpetrators may have an impact on reducing the severity of the abuse.¹¹³ There is a noticeable dearth of UK-based research on IPV and substance use.^{30,116} Healthcare professionals should be aware that alcohol and drug misuse can be linked with perpetrating and suffering domestic abuse, but it should not be assumed that they coexist in all situations. As suggested by the WHO, it is important to raise public awareness of the links between alcohol consumption and domestic abuse.

- For a more in-depth analysis of alcohol and domestic abuse, please refer to the WHO report 'Intimate partner violence and alcohol'.¹¹²
- For a worldwide perspective on understanding domestic abuse see the WHO report 'Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and nonpartner sexual violence'.⁵

⁹ Harmful use is defined as a pattern of alcohol use that causes damage to health. Hazardous use is defined as a pattern of alcohol use that increases the risk of harmful consequences for the user (World Health Organization, http://www.who.int/substance_abuse/terminology/who_lexicon/en/).

Chapter 4. Specific vulnerable groups

4.1 The impact of domestic abuse on children

Child abuse usually takes place within the immediate family circle; however, it is not within the remit of this report because domestic abuse only involves abuse between adults.^h Nevertheless, it is important to consider the impact of, and harm caused by, children witnessing domestic abuse. According to Meltzer and colleagues, domestic abuse between parents is the most frequently reported form of trauma for children.¹¹⁷ Figures highlighted by the Royal College of Psychiatrists (RCPsych) in 2012 indicate that children are exposed to about three-quarters of abusive incidents occurring within relationships where there is domestic abuse.¹¹⁸ Approximately half the children in such families have themselves been hit or beaten. Figures from a 2011 NSPCC study indicate that 12 per cent of children under the age of 11, 18 per cent of 11-17s and 24 per cent of 18-24s had been exposed to domestic abuse between adults in their homes during childhood. Adult males were the perpetrators in 94 per cent of cases where one parent had physically abused another.¹¹⁹ Older figures, published by the DH in 2002, reported that a minimum of 750,000 children a year witness domestic abuse, while nearly three-quarters of children on the child protection register live in households where domestic abuse occurs, equating to nearly 19,275 children in England in 2002.^{120,121} ChildLine receives almost 2,000 calls a year from children who are experiencing problems with domestic abuse.¹²²

Children can be exposed to domestic abuse in a variety of ways and suffer a broad range of physical and psychological consequences as a result. As Jouriles and colleagues explain, exposure to domestic abuse is not a 'homogenous uni-dimensional phenomenon';¹²³ it is potentially something that disrupts the functioning of a family and the home environment.¹²⁴ Although there is no standardized definition of 'exposure to domestic abuse', most researchers agree that it occurs when children see, hear, are directly involved in, or experience the aftermath of, abuse that takes place between caregivers.¹²⁵ Experiencing the aftermath of domestic abuse could involve seeing a family member being injured or depressed. In nine out of 10 cases of domestic abuse, children are in the same or next room when the abuse is taking place.¹²²

Domestic abuse can also affect a guardian's parenting capacity which can have a negative impact on the child(ren). A parent who is abused may find that their ability to parent, and meet the needs of their child, is restricted or comprised. Cleaver and colleagues stress that 'belittling and insulting a woman in front of her children' undermines her self-respect as well as the authority she needs to parent confidently.¹²⁶ Children may also be abused as part of the abuse of a parent (and vice versa), making it difficult to separate out discrete categories of child abuse and domestic violence.¹²⁴

Edleson reviewed several studies on the impact on children who witness domestic abuse and reported some underlying themes.¹²⁷ A child's behavioural and emotional functioning can be severely influenced by living within a household where domestic abuse is occurring. Children from such environments can exhibit more aggressive and antisocial behaviour (known as 'externalising behaviour problems') as well as fearful and inhibited characteristics ('internalising behaviour problems'). Many children may want to protect the parents from abuse, putting themselves at risk in the process and experiencing feelings of guilt when they are unable to help.¹²⁸ They show signs of anxiety, depression, anger and behavioural difficulties. Estimates of the percentage of children presenting with these types of behavioural problems following exposure to abuse range from 25 to 75 per cent.^{129,130} Hester and colleagues point out that every child is unique and that their reaction will vary according to age, gender, socio-economic status as well as the frequency, nature and length of exposure to domestic abuse.¹³¹

^h It should be noted, however, that the government definition of domestic abuse has been amended to include those who are 16 and 17 years old (see **Chapter 1** and **Section 2.1**).

Exposure may also lead to trauma symptoms in the form of re-experiencing of the events in dreams or flashbacks, with evidence for this finding coming from children scoring higher on post traumatic stress disorder scales.¹²⁵ Younger children may demonstrate their anxiety with physical problems, such as complaining of tummy-aches, wetting the bed, having difficulty sleeping and having temper tantrums. Children who witness abuse may also learn to use it, but this effect has been found to differ between boys and girls. Boys have been shown to express their distress more outwardly with hostility and aggression, whereas girls are commonly found to show evidence of more internalised problems. They may withdraw from other people, become anxious or depressed. Reported physical health problems include difficulties with speech, hearing and development.¹³² Findings from a survey of 148 children (aged under 16) living in refuges in Cardiff showed that almost one-fifth (19%) of the children under five years old had delayed or questionable development. Among the children for whom child health records were available (n=124), 30 per cent had failed to receive all the immunisations that they were due.¹³³

The long-term effects of abuse are also seen in these children. Adults who witnessed domestic abuse as children have been found to experience depression, trauma-related symptoms and low self-esteem.¹³⁴ Analysis of the Lehigh Longitudinal Study – a prospective study of 457 children and families in Pennsylvania established to examine the developmental consequences of family violence and resilience – showed that child abuse, exposure to domestic abuse, and in combination increased a child's risk for internalizing and externalizing outcomes in adolescence.¹³⁵ In addition to these emotional wounds, children who have witnessed abuse are more likely to be either abusers or victims themselves. It is natural for children to learn from their parents and this can lead to a child falling into an abusive adult relationship. It is also the case that children who witness domestic abuse may reject such behaviour and will try not to repeat it.

Neglect is a form of child abuse which can result from domestic abuse. When a parent is suffering abuse they will almost certainly strive to continue to provide love and support for their child(ren) yet this may be extremely difficult in such circumstances. Children living in abusive family environments may be left to look after themselves at an age where hands-on parenting would normally still be occurring.¹²²

It is recognised that educating children about domestic abuse is a key step in the process of curbing domestic abuse. Women's Aid believes that 'the most positive way to reduce and eliminate domestic violence and its effects on children and young people is through a strategy of preventive education work' and that 'all children and young people should have access to domestic violence preventive education programmes'.¹³⁶ Working within schools to build awareness and change attitudes towards domestic abuse is described by the Home Office¹³⁷ as a primary prevention method. An evaluation of three European schools-based domestic abuse prevention education programmes, published in late 2012, found that preventative programmes can secure attitude changes in young people so that they become less accepting of domestic abuse. These types of programmes were found to be most effective when delivered over a number of weeks. It is uncertain whether there is a link between raised awareness and any long-term domestic abuse reduction.¹³⁸

In July 2000 the Home Office awarded £6.3m as part of the £250m Crime Reduction Programme to fund 34 pilot projects that aimed to develop and implement local strategies to reduce domestic abuse, rape and sexual assault. Of these 34 projects, 27 focused on domestic abuse and as a result of three 'education' projects the following have been found:

- children and young people want and value lessons on relationships and on abuse
- following a primary prevention project, pupils had increased awareness of factual information regarding domestic abuse
- training for teachers is important; teachers who do not feel supported are likely to feel under-confident in using the materials and dealing with domestic abuse
- work in schools can make primary and secondary schools pupils think more deeply about domestic abuse.¹³⁷

In line with the recommendations set out by the Home Office in 2001, the BMA supports the implementation of domestic abuse education programmes in all primary and secondary schools, with a specific emphasis on assisting, and raising awareness among, teachers to recognise the signs of domestic abuse. The Government has no plans to make teaching about domestic abuse a statutory requirement. Schools can address the topic of domestic abuse in sex and relationship education as part of a broader programme of Personal, Social, Health and Economic (PSHE) education. When teaching about these issues all schools must have regard to the Secretary of State for Education's Guidance on Sex and Relationship Education.

It is recognised that the Programme Development Group (PDG) responsible for reviewing the evidence upon which the NICE guidance on *Domestic violence and abuse: how social care, health services and those they work with can identify, prevent and reduce domestic violence and abuse* is based 'did not find sufficient evidence to make recommendations on primary prevention programmes.' It is acknowledged in the guidance, however, that this was partly because the PDG only looked at health and social care settings, when most primary interventions are delivered in education settings.^{30,139} The BMA is supportive of further research into the effectiveness of programmes that aim to prevent domestic abuse from occurring.

During her time as Minister of State for Criminal Justice (2003-2007) and Attorney General (2007-2010), Patricia Scotland (now Baroness Scotland), was clear that tackling domestic abuse was necessary to ameliorate its social consequences and its economic impact. Speaking at a Universal Peace Federation conference in 2011, Baroness Scotland told delegates how, in 2003/04, more than three-quarters of a million children were subject to domestic violence, while 89 per cent of women in prison had been sexually abused or suffered some other form of violence before they offended, as was the case with a third of all juvenile offenders. Chairing the Inter-Ministerial Group on Domestic Violence every month for four years, Baroness Scotland brought together representatives from every department including education, health, housing, and criminal justice in order to deliver a multi-faceted response to tackling domestic abuse (see **section 1.2**).

The policies implemented between 2003 and 2010 – including the introduction of specialist domestic violence courts (SDVC) and multi-agency risk assessment conferences (MARACs) – made a significant difference in the way domestic abuse was dealt with in the UK (see **Chapter 8**). The result, according to Baroness Scotland, was a 64 per cent decline in domestic abuse, with every pound spent saving six – amounting to a saving of £7 billion a year. Estimated levels of domestic abuse experienced in 2011/12 were also lower than the level in 2004/05 when the self-completion module was first included in the CSEW, although there has been no statistically significant change in the level of domestic abuse since the 2008/09 survey.

4.2 Pregnant women

It has been estimated by the CEMACH that around 30 per cent of domestic abuse begins during pregnancy.¹⁰ Other studies have identified a more variable incidence rate. In 2005, the WHO's large, multi-national study of women and abuse – based on 24,097 interviews with women from ten countries across the Global North and Global South – reported that the prevalence rate of domestic abuse in pregnancy was between four to 12 per cent. Direct trauma to the abdomen during pregnancy was experienced by 25 to 50 per cent of the sample, while in over 90 per cent of the cases the assailants were the biological father of the unborn child.¹⁴⁰ When focusing only on industrialised countries, the prevalence of domestic abuse during pregnancy is estimated to range from 0.9 per cent to 20.1 per cent, with the majority of studies reporting rates of four to eight per cent.^{141,142,143}

Smaller scale studies have produced prevalence estimates towards the higher end of the range. A survey disseminated to 500 women at an antenatal booking clinic in a north of England hospital found that the prevalence of domestic abuse in the cohort of pregnant women was 17 per cent (n=475).¹⁴⁴ Comparable research undertaken at an antenatal booking clinic in Ireland produced a prevalence rate of 12.9 per cent (n=481).¹⁴⁵ The wide variation between estimates reflects differences in research design and population sampled: few studies include emotional and verbal abuse in their definition of domestic abuse.¹⁴³ An American study found that each year approximately 324,000 pregnant women in the country are abused by their intimate partner, which makes abuse more common for pregnant women than gestational diabetes or preeclampsia – conditions for which pregnant women are routinely screened.¹⁴⁶

The impact of domestic abuse during pregnancy is recognised to be a significant contributory factor to maternal and fetal morbidity and mortality.¹⁴⁷ The CEMACH reported in 2011 that of the 261 women who died from all causes (directly or indirectly related to their pregnancy) between 2006 and 2008, 34 women (13%) had features of domestic abuse. For 11 women, the abuse was fatal.¹⁴⁸ Compared with other victims of domestic abuse, pregnant women are more likely to have multiple sites of injury, including the breasts and pregnant abdomen, implying that the fetus and the woman herself are the focus of the perpetrator's abuse.¹⁴⁹ Fetal trauma, resulting from domestic abuse, can have negative consequences for the mother and baby, though the precise effects will depend on factors such as gestational age and the location and severity of the trauma. Physical domestic abuse is a risk factor for gestational weight gain deficit, low (or very low) birth weight, and pre-term births. A major global review, published by the WHO in 2013, found that women who have experienced partner violence 'have 16 per cent greater odds of having a low-birth-weight baby'.⁵

Women reporting domestic abuse in pregnancy have been found to be at a higher risk for high blood pressure or oedema, vaginal bleeding, severe nausea, vomiting or dehydration, kidney infection or urinary tract infection.¹⁵⁰ The risk of post partum depression also increases: research conducted in Brazil with a sample of 1,045 pregnant women found that 25.8 per cent of the sample had postnatal depression and that this was positively associated with abuse – particularly psychological abuse (OR 2.29, 95% CI).¹⁵¹ Women suffering abuse during pregnancy were twice as likely as unexposed women to experience an antenatal hospitalisation not associated with delivery.¹⁵⁰

The Royal College of Midwives (RCM) has produced guidance for midwives dealing with cases, or suspected cases, of domestic abuse in pregnant women.¹⁵² The RCM advises midwives to look for a number of possible indicators of domestic abuse, which include; a high incidence of miscarriage and termination of pregnancies, stillbirth, preterm labour/prematurity, smoking, alcohol and drug abuse, gynaecological problems, repeated chronic injuries, physical symptoms related to stress or depression, and signs of rape or sexual assault. The RCM states that 'midwives are ideally placed to recognise and detect ongoing domestic abuse and to offer care, support and information to the woman'.¹⁵³

There is a limited amount of evidence to suggest that pregnancy may be a protective factor. A prospective longitudinal cohort study of 7,591 women in Bristol, based on questionnaires administered at 18 weeks of gestation and 8 weeks, 8 months, 21 months and 33 months postpartum, found that fewer women reported domestic abuse victimisation during pregnancy than they did postpartum.¹⁵⁴

- Further information about midwifery, obstetrics, gynaecology and domestic abuse can be found in **Chapter 7**.

4.3 Lesbian, gay, bisexual and transgender community

When domestic abuse is discussed in a healthcare, political or even an informal setting, it is highly likely that its occurrence within same-sex couples will be overlooked. There has been insufficient research on lesbian, gay, bisexual and transgender (LGBT) domestic abuse and the development of a societal and healthcare response to this abuse has lagged behind responses to abuse in heterosexual relationships. Mounting evidence is available which demonstrates that partner abuse is as common and as prevalent among same-sex couples as among heterosexual couples.¹⁵⁵ The *Broken Rainbow annual report 2004/05*¹⁵⁶ – an organisation that provides support for individuals from the LGBT community who are experiencing domestic abuse – estimated that around one in four lesbians, gay men, bisexual and transgender individuals will experience domestic abuse at some point in their lives.

In a UK-wide survey of domestic abuse in same sex relationships (n=746), more than a third of respondents (38.4%) said that they had experienced domestic abuse at some time in a same sex relationship. This included 40.1 per cent of the female and 35.2 per cent of the male respondents. A greater number indicated that they had experienced at least one particular form of abuse during a relationship. This finding suggests that, much like heterosexual victims, same sex couples living with domestic abuse may have difficulty identifying their experiences as abusive. More than three-quarters (77.8%) of the whole sample stated that they had been subjected to emotional abuse (eg being regularly put down) at some time, 40 per cent said they had experienced physical abuse, while 40.5 per cent reported sexual abuse by a partner in their lifetime. While the prevalence of emotional and physical abuse was broadly similar among men and women, gay men and bisexuals reported living through considerably more sexually abusive behaviours than lesbians.¹⁵⁷

In many ways domestic abuse in same-sex couples is the same as in heterosexual couples. The abuse can take many forms (emotional, sexual, physical, financial), occur in a cyclic fashion, and is a way for an individual to maintain control and power over a partner. Under-reporting of abuse is also apparent: societal homophobia, a lack of specialist services dedicated to helping LGBT victims of domestic abuse, and the perception that law enforcement agencies may be homophobic and/or deny that such a crime exists, have all been cited as reasons why abuse is not brought to the attention of the authorities.¹⁵⁸ The case of Tom, a 20 year old gay man who had been living with an abusive partner in Liverpool, highlights some of these concerns (see **Box 3**).

Box 3: Tom's experience of domestic abuse

'After John kicked me and then pushed me down the stairs I decided I'd had enough. Although he apologised after he hit me, I don't want to live like that anymore. I was so scared all the time. The next day I left without telling John and went to stay in London with some friends to escape him. I was worried that he'd track me down and I didn't want to go to the police as I didn't know how they'd react. I didn't think they'd ever have heard of gay domestic violence.'

Source: Broken Rainbow (2010) *Broken Rainbow Annual Report 2009/10*.

Data from Northumbria police indicates that gay and bisexual men accounted for 0.4 per cent of all domestic violence incidents recorded in 2004/05.¹⁵⁹ A survey conducted in 2000 found that of those men in same-sex couples who had lived through abuse from a partner, 18.8 per cent had reported the abuse, while 13.1 per cent of women in same-sex relationship reported the abuse to the police (n=3302).¹⁶⁰

There are some aspects of domestic abuse that are specific to the LGBT community. Lesbians, gay men and bisexuals who have not 'come-out' can be emotionally abused with threats of outing them at work, or to family or friends. The services available to victims of domestic abuse are rarely geared to accommodate the LGBT community. The House of Commons Home Affairs Committee found evidence of only one refuge for gay male victims, based in Somerset.¹⁸ Limited services coupled with the lack of training, sensitivity and expertise of staff in refuge centres on LGBT abuse makes it all the more difficult for sufferers of domestic abuse from the LGBT community to seek help and protection from their abuser. Domestic abuse in same-sex couples is not restricted to just the abuse between the partners or ex-partners. People from the LGBT community may also experience domestic abuse perpetrated by family members on grounds of their sexual orientation.¹⁶¹

There is a clear need to raise awareness of the scale of domestic abuse in the LGBT community. Breaking down the barriers for such individuals to access the services and protection they need, as well as the reporting of the abuse to the police, will not only help get a better understanding of how many individuals are suffering, but it will also reduce the damaging consequences for the victims. With reference to legislation, some progress has been made following the assent of the *Domestic Violence, Crime and Victims Act 2004*,¹⁶ which recognises domestic abuse within same-sex relationships. The introduction of the *Gender Recognition Act 2004*, gave transgender individuals the legal right to live in their acquired gender. This needs to be further developed in female refuges to make trans women feel welcome.

4.4 Minority ethnic groups

Research has shown that the risk of domestic abuse in the UK does not differ significantly by ethnic group.⁶¹ Current research is very limited in that it relates to domestic abuse inflicted on women from ethnic minority communities, by either their partner or family.

Women from BME communities experience the same forms of domestic abuse as those women from all other communities. There are elements that are specific to this group of women, and these must be taken into consideration when designing services which can be effective in helping all sufferers of domestic abuse.¹⁶² There are specialist services for women from BME communities which they may prefer to use.³⁸ Within the Asian community, some women are expected to

uphold the honour of the family by being the 'dutiful wife', and this may mean tolerating domestic abuse rather than leaving the family home. There is evidence to suggest that BME women put up with abuse for a longer period of time and are more reluctant to access services: Southall Black Sisters estimate that it takes BME women an average of 10 years before they leave a violent relationship.¹⁶³ A woman who leaves the perpetrator may make herself vulnerable to being treated as a social outcast by her extended family and wider community, something many would feel is worse than accepting the domestic abuse. In extreme cases, 'honour crimes' can take place, either in the form of assault or killings. These are justified as punishment for bringing shame on the family and transgressing established family and community understandings of 'acceptable behaviour'.^{162,164} Children may also be used as 'pawns' and taken away from their mother after she leaves, or is forced out of a violent situation, on the grounds that this will preserve the child's 'honour'.¹⁶⁵

Forced marriage is another area where domestic abuse occurs. Duress, whether physical or mental, is used for a marriage to take place without the free and valid consent of one or both parties. Some cases of forced marriage may be interlinked with the concerns held for men or women who are at risk of having their permission to remain in the UK cancelled or shortened if they end their marriage. The DDV concession, which applies to those who entered the UK or were given leave to remain in the UK as a spouse, may also apply to them.

Refugees are at risk of domestic abuse and are increasingly likely to suffer in silence because if they have previously lived in oppressive regimes it is probable they will fear seeking help from the police or local government.¹⁶⁴

Racism is a large problem for many women from BME communities: women suffering from domestic abuse can fear that when seeking help they will be subject to racist treatment. Such fears may stem from their own experience, or those of someone close to them. Agencies and professionals may engage reluctantly with BME groups for fear of appearing to be racist.¹⁶⁶ Both would lead to increased under-reporting of domestic abuse in such communities and thus reduce the number of domestic abuse cases which can be stopped or treated.¹⁶⁴ Targeted services for BME groups subject to domestic abuse are limited. Of the 408 local authorities in England, Scotland and Wales, one in 10 had a specialised service for ethnic minority women in 2008. These services are uniquely suited to deal with women facing a very particular set of circumstances, including those fleeing forced marriage or female genital mutilation, or those with insecure immigration status.¹⁶⁷

It is not only individuals from the minority ethnic communities who can be victims of domestic abuse on the basis of cultural, religious or racial differences. People from minority ethnic groups may perpetrate domestic abuse on their family members or partners from the majority community who may have a different skin colour or practise a different religion. The Home Office acknowledges concern about domestic abuse among minority ethnic groups: *Tackling domestic violence: Providing advocacy and support from black and other minority ethnic communities* states that 'being sensitive to, and aware of, the specific issues that affect black and other minority ethnic women should be integrated into the delivery of all support services'.¹⁶²

Migrant domestic workers are a further group of people vulnerable to abuse within the home. Migrant domestic workers are individuals who have entered the UK legally with an employer on a domestic worker visa to work in a private household. These individuals can face physical, psychological and sexual abuse similar to that of domestic abuse victims. While this is acknowledged as an important problem, it falls outside the remit of this report as typically an

employer does not have an intimate or family relationship with the victim. The charity Kalayaan provides advice, advocacy and support services in the UK for migrant domestic workers – further information is available at www.kalayaan.org.uk.

4.5 Older people

There is no standard definition of elder abuse in the UK; the charity Action on Elder Abuse provides the following clear description of it as: 'A single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person'.¹⁶⁸ This definition takes it out of the domestic abuse context as it includes relationships of care, such as one between a healthcare professional and an older person. If the perpetrator of elder abuse is the carer this would only be defined as domestic abuse if the carer is an intimate partner or family member of the victim.

Domestic elder abuse refers to the maltreatment of an older person by someone who has a special relationship with the older person, which occurs in either their home, or in the home of a caregiver. It has been estimated that roughly two-thirds of all elder abuse perpetrators are family members.¹⁶⁹ *The national study on abuse and neglect among older people* reported that 51 per cent of mistreatment in the previous year (2005) involved a partner/spouse, 49 per cent another family member, 13 per cent a care worker, and five per cent a close friend (respondents could mention more than one person).¹⁷¹ The reasons behind elder abuse, the forms that elder abuse can take, and the resulting consequences overlap significantly between domestic and institutional elder abuse.

The WHO has predicted that by the year 2025, the global population of those aged 60 years and above will more than double from 542m in 1995 to around 1.2bn.¹⁷⁰ Elder abuse is a growing problem that should be taken seriously, although there is a limited amount of research published on its prevalence. *The UK national study of abuse and neglect among older people* marked the first dedicated analysis of its kind in the UK. Based on face-to-face interviews with 2,111 people aged 66 and above in 2006, the study reported that 2.6 per cent of this group reported mistreatment and neglect by family, friends and care workers, equating to about 227,000 individuals. When this definition was widened to include neighbours and acquaintances the figure rose to four per cent. Neglect was the most common form of mistreatment (1.1%) followed by financial abuse (0.7%) – findings that challenge the still common perception of abuse as physical violence.^{57,171} These figures were thought by the research team to be under-estimates of the scale of abuse due to the 'conservative definitions used to measure mistreatment, and the absence of people in the survey with severe dementia or living in residential care.'¹⁷¹ The latter points are important since empirical studies and clinical accounts indicate that a shared living situation and having dementia are major risk factors for elder abuse.¹⁷²

The WHO report on *Violence and health* divides elder abuse into a number of categories.¹⁷³

1. **Physical abuse** – this involves the use of physical force, with acts such as hitting, slapping, pushing, kicking or burning. It also includes the misuse of medication, physical restraints and force-feeding.
2. **Sexual abuse** – this is when sexual contact is made with an older person without their consent. This includes rape, unwanted touching, coerced nudity and sexually explicit photography.

3. **Psychological abuse** – this involves the infliction of anguish, pain or distress through verbal or non-verbal acts. It includes emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, harassment, verbal abuse, and isolation from family, friends, services or supportive networks.
4. **Financial or material abuse** – this is the illegal or improper use of an older person's money, property or assets. This includes fraud, exploitation, forging of signatures, stealing, and the pressurising or deceiving of an elder to sign important documentation, such as a Will or contract.
5. **Neglect and abandonment** – neglect occurs when the person trusted to care for an older person ignores the medical or physical care needs of that person, fails to provide access to appropriate health, social care or educational services, and the refusal or failure to provide the necessities of life (such as food, water, clothing, personal hygiene, personal safety). Abandonment is defined as the desertion of an older person. Research has found that neglect is the most common form of elder abuse (55% of reported cases in the USA in 1996)¹⁷⁴ compared with the other four types.

Defining an elder abuse perpetrator is as challenging as describing the defining characteristics of a perpetrator of any other type of abuse. Studies have discovered some common causal factors, which vary depending on the relationship the perpetrator has with the older person. The domestic abuse may have simply continued from a younger age, where habitually one member of a couple had always exerted power and control over the other. Now with one or both members being older, this is classed as elder abuse. Primarily in the case of adult children, the abuser is commonly dependent on their victim for either financial support or housing. Data from the *UK national study on abuse and neglect among older people* indicate that 53 per cent of perpetrators were living in the respondent's household at the time of the abuse – this included 25 per cent of financial abuse perpetrators and 65 per cent of interpersonal abuse perpetrators.¹⁷¹ Strained family relationships may worsen when a family member becomes stressed as an older person may gradually become more dependent on their care giving. Cultural and socio-economic factors, such as the depiction of older people as frail, weak and dependent, the restructuring of the basic support networks for older people and the migration of young couples to other areas can also have an impact on the likelihood of elder abuse.^{169,175}

4.6 Disabled people

In defining disability, the BMA's 2007 report, *Disability equality in the medical profession*, emphasised the importance of doctors understanding the social model of disability.¹⁷⁶ Thinking about disability using the social model enables a broader understanding of the ways in which disabled people – people with physical, sensory, and/or intellectual disabilities – can be discriminated against. The social model recognises that an individual is disabled by society through attitudinal, environmental and organisational barriers and not as an inevitable result of their impairment or medical condition.

The results of the 2011/12 CSEW indicate that women and men with a long-term illness or disability were more likely to be victims of any domestic abuse in the last year (12.8% and 7.3% respectively), compared with those without a long-term illness or disability (4.6% and 6.1%). Drawing on the findings of the 2009/10 BCS, researchers at UCL and King's College, London estimated that the odds of being a victim of violence in the past year were two-fold higher for

those with physical disability and three-fold higher for those with mental illness-related disability, when compared to those without disability. The proportion of violence that could be attributed to the independent effect of disability in the general population was estimated to fall within the region of 5.7 to 9.3 per cent, at a cost of £1.51 billion.¹¹

Disabled individuals can experience the same forms of domestic abuse as non-disabled individuals but may be more vulnerable. Certain forms of abuse may be specifically related to their disability. They include the abuser withholding care or undertaking it neglectfully or abusively, removing mobility or sensory devices that are needed for independence, withholding access to medicines, claiming state benefits on behalf of the disabled individual making it easier for them to control the disabled person's finances, and using an impairment to taunt or degrade the individual.³⁸ Research undertaken by the Equality and Human Rights Commission confirmed that the visibility of the impairment was an 'exacerbating risk factor' for experiencing abuse. The report cites the example of an interviewee with intellectual difficulties and a visual impairment who had stones thrown at him on the street by a group of children who called him 'blind man'. Other characteristics that are unrelated to the impairment, such as a person's ethnicity or age, may further compound the violence experienced by disabled people.¹⁷⁷ People with a disability are likely to experience abuse over a longer period of time and can suffer more severe injuries as a result of the violence. They may have to rely on family members for their care and this puts them at risk of being abused by a person with whom they place so much responsibility and trust.¹⁷⁸ This would also apply in the 'family style' group living discussed earlier in the report.

If a person has a mobility impairment, it may be more difficult for them to get out of the way of the perpetrator at the time of an attack, or to seek permanent refuge. If they require specialised transport to leave the home, which often will be arranged or provided by a carer, they are effectively trapped. Having a communication impairment would mean that accessing helplines and making appointments might be very difficult. A further barrier preventing disabled people from escaping their abuser is that they may be socially isolated from friends and family either due to their impairment or due to the control of their carer. This makes reporting domestic abuse extremely difficult as they have no one to turn to and often no opportunity to see health or social care professionals without the carer being present.³⁸ Individuals with an intellectual disability are vulnerable to domestic abuse as they may have impaired speech or are too cognitively impaired to report domestic abuse, or to realise that a crime has been committed.

Research on domestic abuse services, conducted on behalf of Women's Aid, found that 85 out of 3615 women resident in refuge accommodation in England on 2 November 2006 were recorded as disabled. On the same day in 2006, 125 disabled women were using non-refuge based services. While 38 per cent of the refuges surveyed (n=133) offered some form of specialist services for disabled women, the majority were defined as 'structural services', such as the provision of ramps and handrails. Other respondents to the survey recognised that they were not meeting the 'complex needs' of disabled women.¹⁷⁹

Disabled people may also perpetrate abuse against a family member and this must therefore be taken into consideration.

‘There are two areas in which domestic abuse and learning disability need to be considered. The first is the child with the learning disability living in an environment where domestic abuse happens. The second is where the adult with a learning disability lives with a partner or in a group home where domestic abuse happens – either as the victim or the victim-perpetrator of such abuse.

Where the parents have not been supported to deal with the emotional consequences of having a child with a disability there can be a failure to bond in a secure way and the relationship between the birth parents can suffer as well as the relationship with the child. The extra dependency needs of a child with a disability, when added to other environmental problems, such as difficult living conditions, can make such a family more vulnerable to depression or anger. Watching violence in the home is even more frightening for a child with a disability who often knows their birth and existence are seen as negative.

The vulnerable child who has been exposed to domestic abuse is also at risk of identifying with the oppressor and repeating such behaviour at a later stage. Group homes for adults with learning disabilities who have experienced domestic and or sexual abuse need support to avoid repetition in the adult stage of childhood experiences.’

Quote from Dr Valerie Sinason, President of the Institute of Psychotherapy and Disability

Chapter 5. Detection of domestic abuse in healthcare practice

The 2013 BMA President's Seminars highlighted the role of healthcare professionals in the detection of domestic abuse. The NHS has a vital role to play in dealing with domestic abuse and its short- and long-term consequences. As stated in the 2010 *Alberti report*, the Health Service 'has a clear duty to help and, as far as possible, heal the victims of violence and contribute to multi-agency efforts to increase the safety of women and children in our society.'²⁹ This chapter will explore why victims of domestic abuse often go undetected in healthcare settings and provide advice on how identification may be improved.

5.1 Behaviour and attitudes of healthcare professionals to domestic abuse

The healthcare profession presents barriers to the reporting of domestic abuse and these fall into two main categories: 1) the doctor's attitude and 2) the healthcare setting within which they work, both of which can reduce the number of domestic abuse cases reported.

A small-scale study (n=28) of Australian doctors, published in 2004, found that a doctor's management of victims and perpetrators was influenced by their gender, perceptions and attitudes.¹⁸⁰ Doctors in the study were uncertain what to look for and lacked confidence in knowing what to do next if they identified domestic abuse. Adopting a purely clinical focus, and not investigating the context in which physical injuries or mental health problems arose, led to doctors feeling frustrated when patients were non-compliant with their advice, or did not return for follow-up appointments. Some doctors admitted occasional reluctance to acknowledge the problem, even when they had grounds for suspicion. Reactions to their victimised patients ranged from understanding, close identification, and distress, to frustration with their inability to engender change.

Similar findings were reported by a UK-based study. When asked what they found hard about dealing with survivors of domestic abuse, staff at South Birmingham Primary Care Trust reported the following:

- 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
- feeling frustrated with victims of domestic violence, because of likely recurring needs.²⁹

A more recent survey, conducted in 2012 with 272 GPs from Bristol and Hackney, measured primary care clinicians' levels of knowledge, attitudes towards, and clinical skills in domestic abuse. Just over one-quarter (29%) of GPs reported feeling prepared to ask appropriate questions about domestic abuse, or to make referrals for the women (24%). While GPs expressed a positive attitude towards engaging with women experiencing abuse, the survey found that over half (51%) asked all patients presenting with symptoms or signs of abuse about domestic abuse. Barriers to inquiry included the clinicians' lack of time and/or experience, the stigma attached to patient disclosure, and the lack of effective post-disclosure interventions available. The majority of clinicians (80%) either did not know what resources were available to help respond to patients experiencing domestic abuse, or knew that such resources were not accessible.^{181,182}

Questions have also been raised about whether doctors have a responsibility to inquire about domestic abuse. A study – undertaken in south London with mental health service users and professionals – produced mixed responses about whether community mental health teams should be addressing domestic abuse. One respondent – a team manager – thought that the holistic approach offered by the community mental health team would result in the signs of abuse being identified and discussed. Some psychologists and psychiatrists, however, did not see it as part of their remit to focus on domestic abuse:

‘I suppose my first response is should we be addressing this? [...] so many things are coming under the role of psychiatry to sort out when actually they are not mental health problems. [I] suppose I struggle a bit with us taking on things that aren't mental health problems...perhaps we should be directing people elsewhere.’¹⁸³

As discussed in this report (and particularly in this chapter), the BMA position is that doctors have a role in identifying domestic abuse, but no one speciality (such as psychiatry) is particularly responsible.

Consultations with healthcare professionals may be one of the few occasions when the victim is unsupervised. By being aware of the warning signs, clinicians may be able to encourage the victim to disclose abuse and discuss their situation.¹⁸ Some care settings may not be appropriately structured to allow the privacy and time needed to explore a victim's problems with domestic abuse. There is also evidence that there is a lack of training among healthcare professionals on how to deal with domestic abuse (see later section within this chapter for more detail), leaving them unsure about what to look for and what to do if abuse is disclosed. As a result of poor (or no) training, doctors can revert to their natural instincts and this may be to prioritise the preservation of the couple, or avoid intervening in an intimate relationship and thus ignore the abuse.¹⁸⁰ Research has shown that doctors who have received training are much more likely to ask patients about domestic abuse. With training, 35 per cent ‘almost always’ ask, and without training only 13 per cent ‘almost always’ ask. Doctors who ask more regularly about domestic abuse are more likely to have patients who disclosed the abuse.¹⁸⁴ The Home Office reports that healthcare professionals find ‘post-it’ notes containing the phone number for the local domestic violence support agency particularly helpful in prompting them to remember to ask.¹⁸⁵

Despite some doctors' concerns about identifying cases of domestic abuse, nearly all primary care doctors believe it is their responsibility to identify, support and consider referring victims of domestic abuse.¹⁸⁶ A study completed in the USA in 2003 found that doctors who came across cases of domestic abuse were most likely to treat the emotional complaint (82%), document the abuse in the medical record (79%), and treat the physical complaint (67%).¹⁸⁴ Another study in the USA found a doctor's response to encounters with suspected victims of domestic abuse includes discussing their observations with the patient (80%), giving the patient information about community resources (80%), making a note in the patient's chart (76%), facilitating safety arrangements (65%), and encouraging the patient to report to the police (63%).¹⁸⁷

5.2 Patients' views of doctors

Research into how victims of domestic abuse view healthcare professionals, and their responses to the abuse, have produced contradictory findings. It has been reported that women see the health sector as an appropriate site for intervention against domestic abuse, and that they expect the health service to take an interest in understanding and acting on womens' experiences of abuse.¹⁸⁸ This finding does not correlate with the results from the 2010/11 SCJS which found that 19 per cent of female victims of domestic abuse, and 42 per cent of male victims, had told no-one about the incident, apart from the survey in question. Victims of domestic abuse were most likely to have

told their friends, relatives or neighbours. Of those who did seek medical help for domestic abuse, the service most frequently used by women was the GP (65%), followed by the Accident and Emergency (A&E) department (35%).⁵⁰ Women experiencing intimate partner violence seek care from emergency departments approximately three times more often than non-abused women.¹⁸⁹ Research carried out by Women's Aid in 2005 found that 19 per cent of female victims of domestic abuse approached a doctor for help.¹⁹⁰

Research with female victims found that they were unsure as to whether domestic abuse was a valid matter to discuss in a medical consultation. Women perceived healthcare providers as disinterested in social problems and were concerned that the clinician would reframe their situation as a medical problem.¹⁹¹ The same meta-analysis identified a lack of privacy and a (perceived) lack of confidentiality as further barriers to disclosing domestic abuse. Focus groups with women in south Birmingham who were survivors of domestic abuse also reported the following as obstacles to receiving the help they felt they needed:

- 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
- not understanding violence issues for lesbian and transgender women
- healthcare staff listening to accompanying abusive partners or family members instead of to the woman herself.

A dominant theme from interviews with mental health service users about disclosing domestic abuse centred on their fears about the potential consequences. These included fears about not being believed; that disclosure will lead to the disruption of family life and their children being taken away; the fear of retaliation from their partner; and fears about the consequences for their immigration status if the police/boarder agency became involved. Not recognising the behaviours as abusive – either by denying the abuse, its seriousness, or that it may be a health concern – together with feelings of self-blame, embarrassment and shame, added to the victims' disinclination to discuss domestic abuse.¹⁸³

The outcome of a disclosure of domestic abuse to a healthcare professional is dependent on many factors such as whether the healthcare professional has been trained to deal with domestic abuse, their attitude towards the abuse, the services available for them to refer patients to, and the time available to discuss the problem further. Healthcare professionals also have the difficult task of determining how best to approach the issue of domestic abuse with their patients. A report examining the role of the NHS in responding to violence against women asked service users and survivors what would have helped them overcome some of the barriers that they faced. Seven key points were raised:

- 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
- more effective publicity in health services about the availability of women’s support services and helplines.²⁹

An additional component of effective inquiry, consistently raised in the literature, is the need for domestic abuse to be approached in a sensitive, supportive, and non-judgemental manner by the healthcare professional; a point considered in more detail in the following section.^{183,191}

5.3 Enquiring about domestic abuse

Medical providers are well placed to identify and intervene on behalf of patients who are experiencing domestic abuse. Despite female victims concerns about whether domestic abuse was a valid matter to discuss in a medical consultation, there is evidence that women have positive expectations of healthcare professionals should they disclose abuse. Feder and colleagues found that women wanted the healthcare professional to display an understanding of the complexity of domestic abuse and valued their confirmation that the violence they had experienced was unacceptable and undeserved.¹⁹¹ The signs and symptoms of abuse are often easily concealed from the doctor or nurse, and the victim may not choose to broach the subject. Routine enquiry about domestic abuse, commonly known as ‘screening’,ⁱ may increase the rates of identification.

- For further information on the opinion of patients and healthcare professionals on routine enquiry for domestic abuse please refer to **Appendix 2**.

The Home Office report *Tackling domestic violence: the role of health professionals*¹⁸⁵ explains that there are two methods of enquiry which can be used to identify domestic abuse in the primary care setting. ‘Routine enquiry’ refers to asking all women who are using the service direct questions about their experiences, if any, of domestic abuse regardless of whether there are any signs of abuse, or whether abuse is suspected. ‘Selective enquiry’ involves asking women directly about their experiences, if any, of domestic abuse where there are concerns or suspicions, including visible signs/symptoms. The report states that all healthcare professionals should practise selective enquiry and routine enquiry should be considered in a number of different settings, including maternity services where the risk of domestic abuse is far greater than average.

Routine enquiry has several theoretical advantages over selective enquiry, though it needs to be implemented flexibly and safely to take account local factors, including the availability of private space and the staff based in the setting. It ensures all women are provided with basic information about domestic abuse, including the existence of specialist services that can provide support, and with clear messages that it is unacceptable and can present in many different forms. It should help to reduce the stigma associated with abuse, and gives victims a message that they are not alone in their experience.

i Screening is a technical public health and clinical term; it is a process of identifying apparently healthy people in a population who may be at increased risk of a disease or condition. It is recognised that while screening may be commonly used with regard to enquiring about domestic abuse, its application in this context is not accurate, particularly since domestic abuse is a complex social phenomenon and not a disease.

Routine enquiry may also create an important opportunity for early intervention, rather than reactive crisis management.^j Most surveys of women in healthcare settings indicate that the majority agree with, and are supportive of, screening or routine enquiry about domestic abuse. A review by Feder and colleagues found that:

'[W]omen who were not yet ready to disclose abuse still found screening beneficial as it helped to remove the stigma attached to partner violence, raised awareness of partner violence, gave them a sense of validation and let them know there is somewhere they can go if they need help when they are ready to disclose'.¹²

The American Medical Association guidelines on domestic abuse advise that doctors should 'routinely enquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care'.¹⁹² The American College of Obstetricians and Gynaecologists also recommends that doctors routinely enquire about intimate partner violence with all patients, regardless of whether or not they are pregnant.¹⁹³

Screening women for domestic abuse in healthcare settings is a controversial issue. There is no official regulation that doctors in the UK must routinely question all patients for domestic abuse and the effectiveness of 'screening', or universal routine enquiry, has been called into question. A 2013 Cochrane review of the evidence for screening women for intimate partner violence in care settings found that while screening doubled the likelihood that abused women were identified, it did not increase the numbers referred for specialist help, nor did it reduce the level of violence experienced by women, or improve their health and wellbeing at any time point from three to 18 months after the screening.¹⁹⁴ Concerns have been raised about the potential harm – or adverse effects – of screening including 'reprisal violence, psychological distress, family disruption, and risk of a child being removed from a mother's care following child protective services involvement'.¹⁹⁵ Though the Cochrane review found no evidence of harm, this finding is based on one trial; further research on the harms, or otherwise, of screening is required.¹⁹⁴

^j Since it is mainly women who experience domestic abuse, routine enquiry is generally discussed in the context of asking women patients only.

Sarah's story...

(Age 27)

'The violence started pretty much straight away; he drank far too much and was drunk a lot of the time. I had grown up in a violent home, and had always said that if a man ever hit me, I'd hit straight back. The first time he hit me, I slapped him and it turned out to be the worst thing I could have done – he punched me repeatedly until he had to be dragged off me by two others who lived in the flat upstairs.

After that it became a regular occurrence; I didn't dare call the police for fear of what he might do afterwards. He was psychologically abusive and would tell me that if I ever left him he'd find me, wherever I was and kill me. I became pregnant and by that stage the abuse was mostly psychological but on one occasion, I wanted to go out but he wouldn't let me – he stood in my way, smashed a bottle against the wall and held the broken bottle to my seven months pregnant stomach.

I left on several occasions, but always went back because I was scared of what he'd do when he found me. My health visitor used to see me upset but I never told her what was happening, as I was too scared that I would lose my baby. She was a really good listener and I felt that she was the only person I could confide in, so eventually I dropped some hints to test the water. She was supportive without being interfering and because of this I made the decision to tell her. She was fantastic and told me about the Freephone 24 Hour National Domestic Violence Helpline, who I called and who put me in contact with local Women's Aid refuge. I moved out with my son and into a refuge outside of the local area, so that my ex couldn't find me. It has taken some time to get over the psychological effects of the abuse, but I am rebuilding my life and am now studying for a Sociology degree at university. My son is doing well at school and we are looking forward to a happy future.'

The guidelines in the UK are far less supportive than those in the USA of introducing a blanket rule to routinely enquire about domestic abuse in all patients. The DH states that routine and sensitive enquiry in antenatal care about domestic abuse should be included as a part of taking a social history.¹⁹⁶ This is endorsed by the Royal College of Obstetricians and Gynaecologists, and routine enquiry in maternal health through midwives has been rolled out in the UK (see **section 7.3** for further discussion).¹⁹⁷ The Royal College of Psychiatrists also recommends that, due to the association between domestic abuse and poor mental health, enquiry about domestic abuse in the past and present should be included as part of the clinical assessment of all patients and families.¹⁹⁸ The College of Emergency Medicine maintains that while there is 'insufficient evidence to advocate screening all women for domestic abuse [...] clinicians should be prepared to ask simple direct questions, if there is any clinical suspicion'.¹⁹⁹ The DH report explains the importance of adopting routine enquiry about domestic abuse in conjunction with appropriate protocols, training and support for the staff involved. Routine enquiry should not be treated as a one-off episode: a victim of abuse may need to hear the questions several times before gaining the confidence to disclose the information, and it is important to ask at different stages of a woman's pregnancy. The DH does not recommend that routine enquiry should be carried out on all patients outside antenatal care; instead it states that 'the extension of routine questioning to other health settings [also] requires further development and research validation prior to wholesale introduction'.²⁰⁰

This latter point was reiterated by the Taskforce on the Health Aspects of Violence Against Women and Children – Domestic Violence Sub-group in 2010. After considering routine enquiry in some depth, the sub-group reported that '[T]here 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 sub-group were also concerned that the implementation of routine enquiry is 'patchy when it becomes policy' and that the majority of clinicians do not support it. 'Safe enquiry', where there is a low threshold for asking about domestic abuse, combined with referral to appropriate services, is instead advocated by the subgroup.²⁹ Despite the absence of DH support for routine screening, there is evidence to suggest that some NHS Trusts, do have protocols in place – notably in emergency departments, or urgent care centres.²⁰¹

The NICE guidelines on domestic violence and abuse recommend that:

'[H]ealth and social care managers and professionals should ensure front line staff are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse. The enquiry should be made in private on a one-to-one basis in an environment where the person feels safe, and in a kind, sensitive manner.'³⁰

There are, however, other approaches to 'screening' for domestic abuse. A trial conducted in emergency departments, family practices, and women's health clinics in Ontario, Canada randomised women to one of three screening approaches: a face-to-face interview with a healthcare provider (doctor or nurse), a written, self-completed questionnaire, and computer-based self-completed questionnaire. The trial found that women preferred the self-completed approach over face to face questioning, though self-completion was not found to increase the identification of prevalence.²⁰² The UK National Screening Committee is responsible for reviewing screening policies every three years and making recommendations to ministers in the four UK countries about whether or not a screening programme for a certain condition should be implemented. At present, a systematic population screening programme is not recommended for domestic abuse, though a review of this policy began in May 2013; at the time of writing the conclusions of this review had not yet been disclosed. In 2009, an analysis of how far screening women for domestic (partner) violence in different healthcare settings met the National Screening Committee's criteria for a screening programme concluded that there was 'insufficient evidence to implement a screening programme for partner violence against women either in health services generally or in specific clinical settings'.¹²

- For further information and guidance on asking about domestic abuse refer to the NICE guidance *Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively*.³⁰ Older publications include *Responding to domestic abuse: a handbook for health professionals* (2005)²⁵ published by the DH and *Responding to domestic abuse: Guidelines for healthcare workers in NHS Scotland* (2003)²⁰³ published by NHS Scotland.

5.4 The need for education and training

Despite the lack of a consensus around enquiring about domestic abuse in healthcare settings, the importance of training healthcare professionals to be 'open' to the disclosure of domestic abuse and 'responding appropriately' is widely accepted.¹² Findings from non-randomised trials conducted in the USA^k have shown that training healthcare providers leads to an increase in ability to identify and help partner abuse victims, as well as other attitudes and values thought to be important to aid healthcare providers to identify and help such victims.²⁰⁴

In the UK, encouraging findings about the benefits of training are gradually emerging. Feder and colleagues undertook a randomised control trial to examine how training sessions – delivered to the clinical team at 24 GP practices – could improve the team's identification, support, and referral of domestic abuse victims to specialist agencies. Working in partnership with specialist domestic abuse agencies, the training was combined with a simple referral pathway to domestic abuse advocacy, and with ongoing support to IRIS (Identification and Referral to Improve Safety) practices. One year after the second training session, the 24 intervention practices recorded 223 referrals of patients to a domestic violence advocacy group while the 24 control practices recorded 12 referrals.²⁰⁵ Whether the increase in women referred translates into better (health) outcomes and improved quality of life for those women is unknown. An economic analysis of the trial showed that this type of intervention was cost-effective based on NICE/quality-adjusted life-year criteria.²⁰⁶

Information on the extent of training received by doctors on domestic abuse is limited and mainly consists of guidelines rather than accounts of what happens in practice. Within the General Medical Council's (GMC) recommendations for undergraduate medical education it states that medical students should be able to '[I]dentify the signs that suggest children or other vulnerable people may be suffering from abuse or neglect and know what action to take to safeguard their welfare.'²⁰⁷ No direct reference is made to domestic abuse or domestic violence.

Since 2010, the importance of recognising potential victims of abuse has been added to the Foundation Programme (FP) curriculum in postgraduate education and training: by the end of the programme all trainees must be able to demonstrate an awareness of the potential for physical, psychological and sexual abuse of patients, and manage such cases in a similar way to safeguarding children and vulnerable adults. More specifically, the trainee must have the ability:

'to identify, refer and participate in both the medical assessment and care planning in cases where the interests of a child, vulnerable adult, including those with learning difficulties or a potential victim of abuse, need safeguarding.'

The curriculum also states that a trainee must be capable of dealing with ethical and legal situations, and ensure patient privacy when discussing sensitive issues.²⁰⁸

Different Medical Royal Colleges produce their own independent guidelines on training professionals. The Royal College of General Practitioners (RCGP) incorporates domestic abuse into the curriculum for the training of GPs in relation to the healthcare of women. The RCGP curriculum states that a GP should be familiar with local support services, referral services, networks, and groups for women (eg family planning, breast cancer nurses, domestic abuse resources), as well as recognise the prevalence of domestic abuse and question sensitively where this may be a concern.²⁰⁹

k The majority of studies focus on the USA as it is here that guidelines for dealing with domestic abuse in a healthcare setting are more extensive.

In 2012, the RCGP also launched new guidance, in conjunction with the domestic abuse charity Co-ordinated Action Against Domestic Abuse (CAADA), to help GP practices respond to domestic abuse safely, quicker and more effectively.²¹⁰ *Responding to domestic abuse: Guidance for general practices* features key principles to help GPs and healthcare staff respond quickly and effectively to patients who disclose domestic abuse. These include:

- the practice manager should build strong partnerships with local domestic abuse services and ensure domestic abuse training for the practice team
- the practice should establish a domestic abuse care pathway, so that the team understands the correct process for identifying abuse, responding to disclosure, risk assessment, referral and information sharing
- direct referral to a domestic abuse service for further assessment of any patient disclosing abuse to a clinician should take place. Some practices may develop an internal referral route to a practice nurse or other health professional with additional domestic abuse training who will conduct the specialist assessment
- domestic abuse should also be addressed by the local strategic lead for the clinical commissioning group.

The guidance also features resources to help the practice team, including a process map for responding to domestic abuse and a services directory.²¹¹

Box 4: RCGP e-learning course on violence against women.

Royal College of General Practitioners – Violence against Women E-Learning course

A key aspect of the VAWG action plan taken forward by the Department of Health includes work to improve awareness and training of professionals such as the development of an e-learning toolkit by the Royal College of General Practitioners (RCGP) on violence against women and children. The e-learning tool enables GPs to identify and respond to victims more effectively.

Since it launched in September 2011, the RCGP Violence against Women and Children e-learning course has been accessed by approximately 650 primary health care professionals. The course includes a pre and post-course assessment designed to measure learners' knowledge and attitudes before and after completing the course. The average score on the pre course assessment is 70.6%; the average on the post course assessment is 78.1% demonstrating a 7.5% increase. Users have the opportunity to rate the lessons out of 5 and the current average rating is 4.1, making it one of the most highly regarded courses on the e-learning platform.

Some of the free text comments made by users include:

"This is really useful as am now more aware of domestic violence. Very thorough."

"Very informative, giving me some confidence in how one should start asking somebody about violence."

"Think I have not been detailed enough and probing enough for years and feel a better degree of enablement to be helpful in such circumstances."

"Excellent and informative. Easy to read but loads of information."

In addition, the course has been widely promoted including through a well-attended domestic violence workshop at the RCGP annual conference, an article in the RCGP News and through the various College websites and Chair's blog.

Source: HM Government (2012) *Call to end violence against women and girls. Taking action: The next chapter.*

The BMJ and EDV Global Foundation are also currently developing an e-learning module on domestic abuse for use by all health professionals that will be offered worldwide. This is due to be launched in 2014.

The presence of domestic abuse training in the curriculum for undergraduate medical students does not necessarily equate to all junior doctors becoming competent at dealing with such a complex problem. In 2010, the Taskforce on the Health Aspects of Violence Against Women and Children, Domestic Violence Sub-group found that NHS staff frequently lacked the knowledge, skills and understanding of domestic abuse to the extent that they could not respond supportively, even at a very basic level. Part of the problem, according to the sub-group, was that the '[P]rovision of domestic violence training for NHS employees is patchy and poorly integrated into pre-registration or undergraduate clinical training'.²⁹ A survey conducted in 2008 by Women's Aid, on behalf of the House of Commons Home Affairs Committee, found that 60 per cent of respondents said NHS Trusts were training health professionals on domestic abuse. The training, however, was confined to selected health professionals; while health visitors were trained in 96 per cent of cases, and midwives in 87 per cent of cases, a much lower number (55%) of A&E staff had received training on domestic abuse.¹⁸

Medical school curricula are not always closely followed. A study in the USA found that while 86 per cent of USA medical school deans report teaching about domestic abuse, only 57 per cent of medical students report learning about it.²¹² Final-year residents from across the USA were surveyed about their perceived preparedness to counsel on preventative and psychosocial subjects. The results showed that less than half of respondents felt well prepared to counsel patients about domestic abuse²¹³ (see **Appendix 3** and **4** for practical information on detecting domestic abuse during a consultation and the actions required following a disclosure of abuse).

All healthcare professionals and staff working in healthcare settings should receive training on enquiring about domestic abuse. The Home Office stated in *Tackling domestic violence: The role of health professionals*¹⁸⁵ that 'given the importance of domestic violence as a factor impacting on health, training about enquiry should be part of pre-registration curricula and post-registration on-the-job training for *all* health professionals. Basic awareness training is also useful for administrative staff with patient contact, eg GP receptionists, A&E receptionists'. It has been recommended by the Home Office that training of healthcare professionals in preparation for enquiry about domestic abuse should include the following key aspects:

- at least one day in length
- explain the nature and extent of health problems caused by domestic abuse
- include information about how to ask direct questions about a victim's experience without compromising their safety
- training on how to respond when domestic abuse is disclosed
- information on the local availability of services for victims
- coverage of safety planning for those experiencing abuse
- information about the safe documentation of domestic abuse.¹⁸⁵

Equipping NHS staff with the skills to identify, treat and refer women and child victims of violence appropriately, was a key recommendation to emerge from the independent Taskforce on the Health Aspects of Violence against Women and Children. In response to this recommendation, the DH set out its plans in late 2010 to develop a training 'matrix' in domestic abuse, which will

describe learning outcomes, map existing training courses, and outline training pathways for different professional groups. At the time of writing, the training matrix had not been published. It is essential that this type of resource is developed for NHS staff and that it includes tools for communicating with those who find words difficult, such as using pictures or another easy to understand format (see, for example, 'Books Beyond Words').

Domestic abuse training

It's like taking care of someone's bad knee and not taking any notice of the fact that they weigh 25 stone and don't do any exercise. If you ignore it, you can't manage your patient effectively. I felt (domestic violence) was a huge undiagnosed problem. I felt uncomfortable about what to do, so it was a good opportunity to go and find out. I've got this lady who is a victim of abuse, but it is emotional and financial; it used to be physical, but not anymore. She's got arthritis, depression, a multitude of various things. I think this has a big impact on her health. And because we both know, we can talk about it; we don't pretend that I can make her better. She has been offered help, and she's refused, she copes the way she can. It makes it a lot more effective, and I don't beat myself up that I can't get her better. At least I know I have been able to offer the help. It's a missing piece in the picture. I think it is a bigger piece than she thinks it is; she thinks the physical abuse was the worst but I think the emotional and financial abuse is holding her back. But we can keep talking about it until she decides to deal with it in a more formal way. That is going to take time.

General Practitioner

5.5 The role of the primary healthcare team

Identification of domestic abuse falls largely to the primary health care team (PHCT), and this involves a broader range of professionals than GPs. Practice nurses are heavily involved with well-women care¹ and are often responsible for completing new patient screening appointments. Nurses are in an ideal position to offer advice and support if domestic abuse is suspected or disclosed. Midwives come in direct and regular contact with pregnant women, whose incidence of domestic abuse is higher than average, and they are able to provide an enabling environment for the disclosure of domestic abuse during pregnancy. Midwives can make referrals and provide ongoing support. Health visitors may identify domestic abuse through their contacts with families with young children.

Management and support staff in a GP's surgery are also PHCT members who may be able to play a part in identifying domestic abuse. They are well placed to convey the point that domestic abuse is wrong by displaying posters and educational leaflets containing this message. Reading information about domestic abuse is likely to be one of the first steps that a victim takes in acknowledging that what they are experiencing is not acceptable. Information must be publicly available for everyone to read, such as in the waiting room; this not only educates the victims and the perpetrators, but it also works to change public perceptions of domestic abuse. Information about seeking help, including helpline phone numbers, should always be displayed in private areas, such as on the back of toilet doors.

¹ Many GP surgeries offer a 'well woman' clinic, where patients may be seen by a female doctor or practice nurse. The well woman clinic will often provide advice on general health, gynaecological problems, family planning, cervical smears etc. Some local hospitals also run well woman clinics. To use these, you do not need a referral from a GP and an appointment isn't always needed

This will enable a victim to take a note of the information without anyone else knowing. It is important that all information sources, whether verbal or written, are available in languages other than English so as to dissolve the language barrier which may prevent women from ethnic minorities from disclosing domestic abuse.

NHS leaders and managers are also responsible for planning and commissioning services for victims and survivors of domestic abuse.

It would be extremely valuable for all members of the PHCT to remember the national 24-hour freephone domestic abuse helpline number (0808 2000 247) and to pass this to their patients.

The PHCT is an entity which is continually evolving. As explained by the RCGP a PHCT 'refers to groups of professionals delivering health services in the community at 'primary' or first points of contact with the health service'.²¹⁴ Since the 1990s there has been an expansion of the PHCT to include a number of different professions working in primary care, and an emphasis on the different professions working together as a team. A PHCT consists of GPs, practice nurses, community nurses, health visitors, midwives, practice managers and administrative staff, as well as allied health professionals who include for example physiotherapists, occupational therapists, speech and language therapists, chiropodists/podiatrists, and dieticians. A further group of healthcare professionals that provide primary care are those working for GP out-of-hours^m care services. This group is particularly important since studies have indicated that violence peaks on weekends and bank holidays.^{36,215}

It is critical that there is a joined-up approach to dealing with domestic abuse across the whole PHCT. Since the publication of the first edition of this report, the structure of the NHS in England, including primary care, has changed following the *Health and Social Care Act 2012*. Previously, primary care trusts (PCTs) commissioned most NHS services and controlled around 80 per cent of the NHS budget. On April 1 2013, PCTs were abolished and replaced with clinical commissioning groups (CCGs). These have taken on many of the functions of PCTs as well as some functions previously undertaken by the DH. They are now responsible for developing and implementing improvements for victims of domestic abuse as part of their commissioning plans, based on local need. These will agree priorities with their local partners and these will be reflected in joint health and wellbeing strategies, based on joint strategic need assessments.

Domestic abuse is also a public health issue. *The public health outcomes framework 2013-2016*, published by the DH, sets out the desired outcomes for public health and how these will be measured.²¹⁶ Domestic abuse is one of 19 indicators that will be used to assess whether improvements are being made in the wider factors that affect health, wellbeing, and health inequalities. Public health guidance on how social care, health services and those they work with can identify, prevent and reduce domestic violence has also been published by NICE. Since April 2013, local authorities have become responsible for commissioning the majority of public health services for people in their area. Prior to this date local authorities already had the responsibility for tackling domestic abuse.

^m The period from 6:30pm until 8:00am on weekdays, and all weekends, bank holidays and public holidays.

Under the *Crime and Disorder Act 1998*, for example, local authorities have a statutory responsibility to work with other agencies to reduce crime and disorder in their local area. With domestic abuse accounting for almost a fifth of all recorded violent crime, it should be included within local crime reduction strategies and action plans.

To fulfil their new public health remit, close working is needed by local authorities with CCGs, NHS England, Public Health England and other agencies to ensure that integrated care pathways are provided for victims. In the case of sexual assault (some of which will be domestic in nature), new commissioning arrangements have already been agreed in England; these are outlined in **Table 2** below.

Table 2: New arrangements for commissioning sexual assault services.

Service	Current/Transitional Commissioner	Commissioning Responsibility from 2012/2013	Approximate Resources 2012/2013
Sexual Assault Services	Individual Police Forces	Collaborative commissioning between NHSCB police forces and LAs	Estimate for all Police Forces: £10.1m
	PCTs	Collaborative commissioning between NHSCB police forces and LAs	Estimate from contributing PCTs: £7.9m
	Local Authorities (from 11 upper tier LAs only so underestimated)	Collaborative commissioning between NHSCB police forces and LAs	Estimate from contributing LAs: £1.1m
	Home Office	Funding local commissioners for independent sexual violence advisers (ISVAs)	£1.6m (Until 2014/15)
	Ministry of Justice	Direct funding and commissioning local rape support services and commissioning new ones in areas with gaps in the service	£3m until 2014/14 (Coalition commitment)

Source: NHS England (2013) *Securing excellence in commissioning sexual assault services for people who experience sexual violence*.

As explained by the DH, victims of domestic abuse use health services frequently and require wide-ranging medical services. They are likely to be admitted to hospital more often than non-abused victims and are issued more prescriptions.²⁵ It is therefore critical that a PHCT/CCG has a mechanism in place to help identify patients who repeatedly seek medical treatment, and additionally those who frequently miss appointments, as both behaviours are symptomatic of domestic abuse. The former also applies to secondary care, for example, identifying patients who repeatedly present to Emergency Departments with physical injuries. A study in 2004 compared the healthcare utilisation in family practice of abused women (not solely domestic abuse) to that of the average female population. It was reported that abused women had almost double the consultation rate together with a sevenfold prescription rate of pain medication in the youngest and middle age categories, and threefold in the oldest age group.²¹⁷ Identifying 'repeat visitors' will enable more cases of domestic abuse to be unearthed, thus increasing the number of victims who are referred to agencies, that can subsequently reduce the chances of further harm.

- Refer to **Appendix 3** and **4** for detailed guidance on detecting and responding to cases of domestic abuse.

Chapter 6. Ethical considerations for healthcare professionals dealing with domestic abuseⁿ

6.1 Confidentiality and information sharing

Respect for confidentiality is an essential requirement for the preservation of trust between patients and healthcare professionals. In addition to the traditional ethical obligation of medical confidentiality, there is also a strong public interest in maintaining confidentiality so that individuals will feel confident in sharing private information relevant to their health and wellbeing. An increase in public awareness of confidentiality may result in improved reporting rates of crimes such as domestic abuse, which in turn raises the number of people treated. In the case of victims of domestic abuse, confidentiality is essential in enabling them to disclose their experiences as their physical safety may be dependent on confidentiality being maintained.

The right to confidentiality is not absolute: information can be disclosed when a patient consents to its disclosure. Confidentiality may also be countered when the rights of a third party to be protected from harm are jeopardised in a serious way. When rights such as these collide, a balance must be struck between the importance of maintaining confidentiality and the harms that could be avoided if confidentiality was breached. Where there are reasons to believe that children are at risk of significant harm as a result of domestic abuse, protection should normally take precedence over confidentiality. All healthcare professionals must therefore understand and be honest with patients about the limits to confidentiality.²⁵ The GMC guidance *Confidentiality* (2009) sets out the principles of confidentiality and respect for patients' privacy that doctors are expected to understand and follow.

6.1.1 Consent to information sharing

Care is increasingly provided by multidisciplinary teams and, following a disclosure of domestic abuse, a healthcare professional may wish to discuss the matter with members of their team. The healthcare professional may also feel it is appropriate to report it to other agencies such as the police or social services. Multi-agency risk assessment conferences (MARACs) are monthly meetings held between a range of statutory and voluntary agencies – such as the police, victim support agencies, probation, social services, housing, and health services – with the aim of providing a coordinated response for high-risk victims of domestic abuse and their children (those at risk of murder or serious harm – see **section 1.2**). All medical members of a team receiving information in order to provide support or care for a patient are bound by a legal duty of confidence.²¹⁸ The BMA's guidance on this matter starts from the basic position that adults who retain capacity under the terms of the *Mental Capacity Act 2005* are usually in the best position to understand how to promote their own interests and ordinarily, confidential patient information should not be disclosed without the consent of the patient. Provided that a healthcare professional gains consent from the patient then information may be disclosed to third parties. Consent can be defined as freely given, informed agreement. It is generally advisable that evidence of the patient's consent to disclosure to third parties is kept on the patient's file.

The UK Council of Caldicott Guardians has also published *Practical guidance on the application of Caldicott guardian principles to domestic violence and MARACs*.²¹⁹ To be implemented correctly, the MARAC process must comply with all the Caldicott principles set out in **Box 5**.

ⁿ The BMA Medical Ethics Committee (MEC) has published widely on the issues considered in this chapter; much of what follows draws on guidance produced by the MEC for doctors in England and Wales: "Vulnerable adults and the disclosure of confidential information".

Box 5: Caldicott principles and MARACs

1. **Formally justify the purpose** – It can be justified both in terms of individuals best interest and the interests of society.
2. **Identifiable information only when absolutely necessary** – It will normally be necessary to use identifiable rather than anonymised information.
3. **Only the minimum required should be used** – Use proportional disclosure based on risk.
4. **Need to know access** – MARAC 'needs to know' even if some individual agencies do not. Confidentiality is maintained by representatives personally signing a specific confidentiality agreement.
5. **All must understand their responsibilities** – A statement is read out at start of each MARAC reminding participants of their ethical, legal and cultural responsibilities. Caldicott Guardians as gatekeepers to the individual's information should ensure that their organisation is effectively engaged with the MARAC process.
6. **Comply with and understand the law** – Caldicott Guardians should understand and authorise MARAC information sharing.

Source: UK Council of Caldicott Guardians (2012) *"Striking the Balance": Practical guidance on the application of Caldicott guardian principles to domestic violence and MARACs (multi agency risk assessment conferences).*

Patients have the right to object to information they provide in confidence being disclosed to a third party in a form that identifies them, even if this is to someone who might provide essential healthcare. Where patients are competent to make such a choice, and the consequences of that choice have been fully explained, the wishes of the patient should be respected. It is particularly important in the context of domestic abuse that the patient is involved in all stages of the decision-making process and that they retain as much control as possible over disclosures of information. They may feel threatened by the thought of others knowing about their situation and may be concerned that the disclosure of what has occurred may lead to further maltreatment. There are no easy solutions; healthcare professionals must consider whether other members of the household are also at risk, and whether continued or more severe abuse could result in permanent damage. The patient may need time to come to a firm decision about disclosure. As part of the consent-seeking process, where a vulnerable adult is making a decision that is seriously at odds with an objective assessment of his or her interests, healthcare professionals should sensitively explore the reasons behind the decision (see **section 6.1.4**). This could include exploration of the possibility of confidential referrals to groups or organisations that offer support to vulnerable adults. Any refusal to disclose should not result in the patient being abandoned by services; continuing care and support should be offered.

6.1.2 Disclosures in the public interest

When treating a patient who has disclosed domestic abuse, it is the responsibility of a healthcare professional to emphasise that although information given to them by the patient is confidential, there are limits to this confidentiality. In the absence of patient consent any decision as to whether identifiable information is to be shared with third parties must be made on a case-by-case basis and must be justifiable in the 'public interest'. Traditionally disclosures in the 'public interest' are made where disclosure is essential to prevent a serious and imminent threat to public health, national security, the life of an individual or a third party (eg children in the home who may be at risk of significant harm) or to prevent or detect serious crime. The GMC in its guidance *Confidentiality* (2009) states:

'There can also be a public interest in disclosing information: to protect individuals or society from risks of serious harm, such as serious communicable diseases or serious crime; or to enable medical research, education or other secondary uses of information that will benefit society overtime. Personal information may, therefore, be disclosed in the public interest, without patients' consent, and in exceptional cases where patients have withheld consent, if the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential. You must weigh the harms that are likely to arise from non-disclosure of information against the possible harm, both to the patient and to the overall trust between doctors and patients, arising from the release of that information.'²²⁰

The GMC has also produced supplementary guidance about confidentiality and reporting gunshot and knife wounds.²²¹

The Nursing and Midwifery Council's *Standards of conduct, performance and ethics for nurses and midwives* states that nurses or midwives should protect all confidential information, but that they must disclose information if they believe someone may be at risk of harm, in line with the law of the country in which they are practising.²²²

6.1.3 Balancing benefits and harms

The decision to disclose is based partly on a balancing of several moral imperatives, including the risk and likelihood of harm if no disclosure is made, the risk and likelihood of harm if a third party disclosure is made and the need to maintain the trust of the patient. There is no broad consensus of how harm to people should be evaluated or from whose perspective it should be judged. For the victim who suffers harm, it may be perceived in very different terms than by the decision maker outside the situation who is trying to weigh it up. The BMA's advice is that, where feasible, healthcare professionals should try to envisage the seriousness of the potential harm from the viewpoint of the person likely to suffer it. While a refusal to disclose information by a competent adult can be overridden in order to protect a third party, such as a child or vulnerable adult, who may be in the household, it becomes more difficult where an adult refuses to disclose information in order to protect him or herself.

In some circumstances health professionals may seek to disclose information on the basis of the public interest in order to protect competent adults where they have a reasonable belief that the individual will be the victim of serious crime such as violent assault. Here a difficult balance will need to be found between respecting a patient's decision-making rights and an assessment of the likelihood of a serious crime being prevented by disclosure. The healthcare professional should ensure that the patient will not be put at increased risk following disclosure. Ultimately, the decision as to whether to disclose information about abuse to a third party rests with the healthcare professional responsible for the patient's care. Discussion of the case on an anonymised basis with colleagues or with other agencies, including medical defence bodies, the BMA and GMC, may assist. Disclosure in these circumstances is likely to be exceptional: BMA guidance on this matter states that 'there should be strong evidence of a clear and imminent risk of a serious crime likely to result in serious harm to the individual, and the disclosure of information is likely to prevent it.'

This is an area where there are no right or wrong arguments, just difficult judgements in difficult, individual cases. Although the guidance might suggest that you should do all you can to bring the perpetrators of domestic abuse to book, I still believe it has to be up to the individual clinician in the individual case to make the best decision they can in the light of the facts that they know.

Hamish Meldrum
Former Chair of Council, BMA

Knowledge or belief of abuse and neglect of a child or vulnerable adult is an exceptional circumstance which will usually justify a healthcare professional making a disclosure in the 'public interest' to an appropriate person or agency. If the healthcare professional has reason to believe that children or a vulnerable person are at risk, then protection should take precedence over confidentiality. There is a complex balance to be struck: there may be cases where, although protection is the ultimate aim, confidentiality needs to be maintained initially (when it is safe to do so) to enable the child to trust the doctor and be supported by the doctor through any disclosure.

It is essential that healthcare professionals are aware of the risk factors and carefully weigh up evidence obtained from a victim concerning the alleged abuse of a child. It should not be assumed, that simply because an abusive relationship exists between two adults in the household that any children are subject to abuse. Research has found that children are negatively impacted from witnessing abuse and this should be taken into consideration. Following the publication of Lord Laming's report, *The protection of children in England: A progress report*, in March 2009, the Government updated *Working together to safeguard children* in 2010 and again in 2013. This a 400 page document setting out detailed, statutory guidance for organisations that are responsible for commissioning or providing services to children, young people, and adults who are parents/ carers; and organisations that have a particular responsibility for safeguarding and promoting the welfare of children and young people. It states that all healthcare professionals working with children and families should 'be alert to the potential need for early help for a child who [...] is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health, domestic violence'.²²³ Local areas are identified as playing a crucial role, particularly in the provision of 'effective early help services'. Further guidance, produced by the Home Office, stresses that local authority children's services and domestic abuse services should 'develop protocols for joined-up working' and identify 'appropriate referral pathways'.²²⁴

The GMC also updated its own guidance in 2012, *Protecting children and young people: The responsibilities of all doctors* makes it clear that that every doctor has a responsibility to take appropriate action on even minor concerns when it comes to safeguarding children. The guidance states that: 'Taking action will be justified, even if it turns out that the child or young person is not at risk of or suffering abuse or neglect, as long as the concerns are honestly held and reasonable, and the doctor takes action through appropriate channels.'²²⁵ The GMC guidance complements the BMA's toolkit on this topic (see below). The Association explains that:

'no two cases are identical, and the needs of children and families vary from case to case. Decisions about how best to respond when there are concerns about harm to a child necessarily involve a degree of risk – at the extreme, of leaving a child for too long in a dangerous situation, or of removing a child unnecessarily from its family. In each case, these

risks need to be weighed and advice may need to be taken from other professionals and local agencies' such as the Local Safeguarding Children Boards.²²⁶

6.1.4 Adults who lack the capacity to consent or disclose information

Where adults lack the capacity to make a decision about whether or not to disclose information relating to harm or abuse, decisions need to be made on their behalf. Decisions can either be made by an attorney acting under a health and welfare lasting power of attorney, or, in the absence of an attorney, relevant health professionals can make a decision based upon an assessment of the individual's 'best interests.' Exceptionally decisions can be made by the court or by a court-appointed deputy. Attorneys are under a legal obligation to act in the best interests of the individual who appointed them. Where attorneys appear to be making decisions that are clearly not in the best interests of the individual, and the problems cannot be resolved locally, the decision can be referred to the Court of Protection.

Decisions taken on behalf of an incapacitated adult involve making as objective an assessment as possible of what would be in the individual's overall best interests taking into consideration all relevant factors. Any 'best interests' assessment will ordinarily involve discussion with those close to the individual. In relation to domestic abuse, however, care has to be taken to ensure that anyone consulted who is close to the individual is in fact acting in his or her interests. Although the past and present wishes of an incapacitated adult need to be taken into account when making a best interests assessment, they are not necessarily determinative. The decision needs to be made on the basis of the individual's current circumstances and needs, including, where necessary and appropriate, referral to appropriate authorities. The BMA has produced a *Mental Capacity Act tool kit*, a *Consent tool kit*, and a *Confidentiality and disclosure of health information tool kit* that can assist in such situations. All three are available online:

- British Medical Association (2009) *Consent tool kit (fifth edition)*. <http://bma.org.uk/practical-support-at-work/ethics/consent-tool-kit>.
- British Medical Association (2008) *Mental Capacity Act tool kit*. <http://bma.org.uk/practical-support-at-work/ethics/mental-capacity-tool-kit>.
- British Medical Association (2009) *Confidentiality and disclosure of health information tool kit (second edition)*. <http://bma.org.uk/practical-support-at-work/ethics/confidentiality-tool-kit>.

In summary, patients have the right to expect that information about them will be held in confidence. Prior consent to information sharing should be obtained and a competent patient has the right to object to information being shared with third parties. Under certain circumstances, a healthcare professional may breach the confidentiality of their patient if there is a risk of serious harm or death to the patient or if neglect, or abuse, of a child or vulnerable adult is known or suspected. If a decision is made to disclose then this must be to a reputable agency and only directly relevant information should be provided.

For further information about confidentiality and guidance on how this can be adhered to please refer to the BMA publication *Medical Ethics Today*.²²⁷

6.2 If the perpetrator is registered with the same doctor

It is not uncommon for the perpetrator to be registered with the same GP as the domestic abuse victim. It is stated in the GMC's *Duties of a doctor* that a doctor must 'Respect patients' right to confidentiality' and this would mean that following a disclosure of domestic abuse from a patient the doctor would be breaching confidentiality, and potentially increasing the risk of further abuse, by initiating a discussion about the abuse with the perpetrator. It is unlikely that the victim who has divulged information about their abuse will wish the matter to be raised with the perpetrator: fear of retaliation from a partner is known to be a common reason for victims not revealing a history of domestic abuse.²²⁸ Many GPs would feel uncomfortable about engaging in a difficult and potentially confrontational situation with the perpetrator. The practice environment can be helpful in conveying the message that domestic abuse is not tolerated through the display of written materials, such as posters. The perpetrator may be in need of medical care in the same way as any other patient and the GP has a duty to ensure that the appropriate medical care is provided.

In some circumstances, the fear of violence from the perpetrator towards members of the PHCT may be justified and some attempt should be made to assess the risk to staff and ensure that they are protected from such an individual. Removal of the alleged perpetrator from the doctor's list without good evidence that the patient represents a real threat to staff at the surgery, or to other patients, should be strongly discouraged. The BMA General Practitioners Committee (GPC) vigorously defends the rights of both practices and patients to terminate a relationship that is not working. Practices must provide the patient with a reason for their removal and normally a warning should have been given by the practice in the last year (unless this is impractical under the circumstances). The GPC states that violence or threatening behaviour by the patient is a valid case for the removal of a patient as GPs have a right to protect themselves, their staff and any other individuals on their premises.²²⁹ This is also reflected in section 13.11 of the *Standard general medical services contract*.²³⁰

The RCGP provides the following guidance for GPs on considering whether they can continue to care for the perpetrator of domestic abuse (and child abuse) as well as the victims:

'GPs may feel unable to provide support to both sides equitably, especially to the perpetrator. Each situation should be considered independently. A GP needs to make an explicit decision about whether to continue to care for both parties. If it is difficult to continue to care for the perpetrator, this needs to be conveyed clearly and in a way that does not increase the danger to anyone, including the GP. However, a GP is ethically obliged to ensure that the perpetrator receives ongoing care and should refer on to another doctor.'²³¹

6.3 Meeting the healthcare needs of domestic abuse perpetrators

While the safety of a domestic abuse victim and their children is of primary importance in all cases of domestic abuse, healthcare professionals also have a duty to meet the healthcare needs of their patients who are perpetrators of abuse. Minimal research has been conducted on the service provision available to perpetrators of domestic abuse, and published research is of variable quality. A study completed in 2006 found that when perpetrators were prepared to find help they would most frequently access their GP. When consulting their GP, however, few perpetrators were found to identify domestic abuse as 'the problem', instead it was more common to present a case for requiring psychological care.^{232,233}

When discussing the subject of domestic abuse with a perpetrator, a GP needs to have some empathy with the perpetrator's situation and confidence that benefit can come from initiating discussion of the topic. It is the role of a healthcare professional to understand, but not excuse, the actions of the perpetrator, and to provide effective management of the situation.²³³ There is a disappointing lack of guidance available for healthcare professionals on the management of domestic abuse perpetrators. The DH produced a comprehensive handbook titled *Responding to domestic abuse: A handbook for health professionals* in 2005,²⁵ yet this contains no details on how a doctor should manage a patient who discloses that they are a perpetrator of domestic abuse. NHS Barking and Dagenham have produced a short guide for healthcare professionals on 'working with perpetrators'. It features details of how to respond to a disclosure and where to refer (see **Table 3**).²³⁴

Table 3: 'Do's and don'ts' when responding to domestic abuse perpetrators

Do:	Don't:
Acknowledge that their disclosure statement is an important first step towards finding a way out of domestic abuse.	Assume that accessing help for drug or alcohol difficulties will stop someone's violence/abuse. They may need to get help for their substance abuse alongside help for their abusive behaviour.
Affirm any accountability shown by them. Their behaviour is a choice and they can choose to stop.	Assume that anger management, individual or couples counselling are appropriate. They are potentially dangerous where there is domestic violence.
Be respectful and empathetic but do not collude. Domestic violence is unacceptable and many behaviours are against the law.	Assume that medication will fix the violence.
Give the patient the RESPECT phoneline number and make sure they understand that this is a confidential information and advice line for people worried about their abusive behaviour.	

Source: NHS Barking and Dagenham (2008) *Domestic violence. Working with perpetrators – A guide for Healthcare Professionals*.

Perpetrators of domestic abuse are most likely to present to a healthcare professional in times of crisis, for example, when their partner may have threatened to leave or deny access to their children. Other situations which may alert doctors to the possibility of domestic abuse include drug and alcohol related problems or stress related illness.²³³ It is the responsibility of a GP to direct patients who disclose that they are perpetrating domestic abuse to appropriate specialist support services. The organisation RESPECT is available to assist healthcare professionals (as well as domestic abuse perpetrators, their (ex) partners, friends and family and all frontline workers) who come into contact with perpetrators in their work. RESPECT is the UK association for domestic

abuse perpetrator programmes and associated support services. Through its phoneline doctors can learn about the perpetrator programmes available in their local area, receive advice about working with perpetrators, and receive information about how perpetrator programmes work, what is involved, what is best practice and how they are different from anger management courses.²³⁵ This information can then be relayed to the patient, with the aim of encouraging them to seek further help themselves.

The Men's Advice Line & Enquiries (MALE) explains that perpetrator programmes are designed to help a perpetrator change their behaviour and develop respectful, non-abusive relationships. Most perpetrator programmes work with men, but occasionally also with women. They are usually small groups of eight to 15 men who have been violent or abusive in a current or previous relationship. Programmes will differ in length and content, some will take men who self-refer, whereas others will only take men who are mandated to attend by the courts. They support perpetrators to address what is underpinning their abusive behaviour while holding them accountable for their violence. No programme can guarantee that the perpetrator will change. Research into the effectiveness of perpetrator programmes has found that most perpetrators who complete a programme do stop their violence for a period, although some replace their physical violence with heightened verbal or psychological violence.²³³ A joint University of Bristol and Home Office study in 2006 found that half of the sample (n=178) were involved in at least one further incident within the three-year follow up period. One in five of these re-offended against a different partner.²³⁶ Perpetrators who have voluntarily attended programmes are more likely to stop their physical violence than those referred by the courts.²³⁷ The Probation Service, however, has reported long waiting lists and difficulties getting perpetrators on to programmes.²³⁸

Chapter 7. Management of domestic abuse within healthcare specialties

Dealing with domestic abuse is not the sole responsibility of primary care teams. Given that victims of domestic abuse present in numerous different healthcare settings, such as a hospital's emergency department, an obstetrician appointment, or a midwifery home visit, it is a multidisciplinary concern.

Staff working in all areas of the health service who are likely to encounter domestic abuse should be trained and educated about domestic abuse, including:

- information on the risks and warning signs
- the health consequences
- ways of dealing with disclosure
- what specialist services exist to help.

There are common elements across all medical specialties in the way victims of abuse should be dealt with, yet some key differences also exist. Healthcare professionals who encounter cases of domestic abuse comprise a number of the components of the multi-agency approach to tackling the crime. It is crucial that, in addition to meeting the specific medical needs of their patients, they must take a consistent approach to the referral of patients to specialist domestic abuse services. Most regions have Domestic Abuse Forums^o (DAFs), which are collections of representatives from interested bodies. Their aim is to coordinate agency responses to domestic abuse. These fora may be a starting point in helping to identify which voluntary body may be most appropriate. It is the responsibility of the acute Trust or CCG to establish a clear referral pathway to a domestic abuse service. Some professional organisations, such as the College of Emergency Medicine,²³⁹ have addressed the fact that each healthcare setting has specific aspects to their approach to domestic abuse, and have produced guidelines for their members on how to identify and manage victims of domestic abuse.

This chapter outlines five main areas outside of primary care which commonly treat victims of domestic abuse.

7.1 The emergency department

It is estimated that one in four women and one in five men have experienced domestic abuse by a partner since the age of 16.⁵¹ These prevalence figures are highly relevant to emergency medicine: Boyle and Todd found that 1.2 per cent of emergency department visits in the UK are due to domestic abuse.²⁴⁰ To put this in context, an emergency department with 55,000 patients of all ages attending during one year would see 500 adult patients suffering due to domestic abuse.¹⁹⁰ Similar research was undertaken at an emergency department in Lausanne, Switzerland but a greater prevalence figure was reached: 25 per cent of the total sample (n=1602) stated that partner violence was the reason for the current consultation.²⁴¹ It is realistic to assume that the incidence rates derived from these types of interview-based surveys are underestimated since they are invariably hampered by the reluctance of victims to disclose information.⁸⁰ An alternative approach was adopted in a study conducted in Kansas City, Missouri. Female domestic abuse homicide cases over a five year period were identified with the assistance of Kansas City Police Department. Medical records from 12 hospitals were subsequently searched to determine how many homicide victims visited the emergency department within the two years preceding

^o More commonly referred to as domestic violence forums.

their homicide. The study found that 44 per cent of the victims presented to the emergency department with over 90 per cent of this group presenting with injuries on at least one occasion.²⁴² These figures emphasise the importance of domestic abuse awareness in emergency medicine.

As outlined in **Chapter 5**, the DH does not support routine screening for domestic abuse (with the exception of antenatal services), although there is evidence to suggest that some NHS Trusts have put protocols in place, particularly in emergency departments. College of Emergency Medicine (CEM) has produced 'guidelines for the recognition and management of domestic violence in emergency departments' that support a selective approach to enquiry. The guidelines state that clinicians should be prepared to ask simple, direct questions about abuse if it is suspected and that all emergency department staff should have training in domestic abuse to enable them to undertake selective screening.²⁴³ Inquiry about domestic abuse by healthcare staff is acceptable to most women. A study - conducted across three general practice surgeries, one antenatal clinic and one emergency department in Cambridge – reported that 92 per cent (n=1452) found routine enquiry by healthcare staff acceptable.²⁴⁴ This gives an indication that the CEM approach of questioning *only* when domestic abuse is suspected would also be acceptable to patients.

While routine enquiry for domestic abuse is not recommended in emergency departments, it is still important that emergency doctors know how to create the opportunity for a patient to disclose domestic abuse so that self-reported victims can be offered help. Methods of providing an enabling environment include consultations taking place in a private room, and patients being seen without the presence of a family member.^p Emergency departments must also convey what domestic abuse is, that it is wrong, and that help is available. This can be done by displaying posters and providing information leaflets in places where they can be discreetly picked up. It has been found that leaflets placed in the women's toilets disappear very quickly.⁸⁰ There are barriers to healthcare professionals identifying cases of domestic abuse in emergency departments. These include:

- the erroneous assumption that domestic abuse occurs exclusively to women which may lead to healthcare professionals not considering men as possible victims
- the attitudes of healthcare professionals who may feel apprehensive in asking patients about domestic abuse for fear of offending them or putting their patient at greater risk
- time constraints posing a large problem for providing each patient with the length of consultation they may require
- a lack of private rooms for treating patients.⁸⁰

Training for healthcare professionals who work within emergency medicine needs to be implemented on a national scale. This should include details about the prevalence of domestic abuse, the risk factors associated with it, the signs and symptoms which can be commonly presented by the victims, how to enquire about domestic abuse, and how to deal with a disclosure.

Management of domestic abuse within an emergency department is likely to be challenging for its staff as the working environment can be highly pressured. This could prevent a healthcare professional from being able to spend the necessary time with a patient to provide the calm, non-judgemental and supportive treatment that they require. There should be a multidisciplinary

p This can be particularly difficult if the patient does not speak English and in such circumstances an interpreter is vital.

response to domestic abuse. It is the responsibility of all emergency healthcare professionals to know how to provide an immediate response, followed by methods of referring patients to the appropriate specialist services. It is increasingly regarded as good practice to have a representative from the emergency department attending the local MARAC.

A number of emergency departments have gone further and employed IDVAs. IDVAs based at the emergency department of the Bristol Royal Infirmary provide support for male and female victims including crisis intervention, risk assessment and advocacy.²⁴⁵ Early findings from the Themis project, run by CAADA, indicate that IDVAs working in the hospital setting are typically identifying victims who are younger, are experiencing a higher severity of physical and/or sexual abuse, are more likely to be pregnant, and who present with complex needs than victims accessing help from IDVAs elsewhere.²⁴⁶

Emergency departments can also play an important role in violence prevention and reduction through sharing anonymised data with the police and community safety partnerships (CSP). An evaluation of the effectiveness of an information sharing partnership between health services, police, and local government in Cardiff found that this intervention led to a significant reduction in admissions for violent injury: rates fell from seven to five a month per 100 000 population compared with an increase from five to eight in comparison cities. The intervention was also associated with an increase in police recording of minor assaults: rates increased from 15 to 20 a month per 100 000 population in Cardiff compared with a decrease from 42 to 33 in comparison cities.²⁴⁷ Evidence compiled in 2012 by the Centre for Public Innovation – in a report commissioned by the DH and Home Office – found that 36 per cent of A&E/CSP partnerships were sharing information to a standard that has been recommended by the CEM in their *Guideline for information sharing to reduce community violence*.²⁴⁸

Example of good practice...
A&E and community violence prevention.

Research from Cardiff demonstrates that hospital A&E departments have the potential to contribute to the management of community violence particularly intimate partner violence. Depersonalised A&E intelligence is pivotal in directing assault reduction initiatives in collaboration with the police and local authority partners. Evidence from the Cardiff model indicates a reduction in A&E alcohol-related violence activity by as much as 30 per cent, as a result of targeted policing to licensed premises that generate assaults and an identification of victims of violence coming through A&E. The model is being implemented in 22 of the 34 A&Es across the South East and is cementing a closer working relationship between the NHS and Crime and Disorder Reduction Partnerships.

Early indications suggest that victims of intimate partner violence are becoming more visible as these types of assaults are catalogued. As a result A&E staff are developing roles to respond to this by establishing nurse liaison posts or follow-up individual victims with a range of specialist interventions. Additionally, post-code data can be used to target residential districts with high rates of intimate partner violence for increased health visitor coverage, to aide support for mothers and reduce risk to children. Some A&Es are starting to introduce brief interventions for alcohol – referring individuals picked up by this work; evidence has found that reducing alcohol consumption of perpetrators of domestic violence on its own can reduce further episodes of violence.

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Following a disclosure of domestic abuse in an emergency department, the CEM advises that a healthcare professional should enquire about the extent and severity of the abuse in a non-judgemental manner and that an assessment should be made of the victim's immediate safety. When there are concerns about the welfare of children, this should lead to the prompt activation of local child safeguarding procedures. Contact with the police and voluntary agencies should be offered from the emergency department as it may be safer for the victim to contact agencies for help from the hospital than from their home (though in most instances, the individual must consent to disclosure first – see **Chapter 6**). Patients should be provided with written information about local voluntary agencies, which they can then opt to use in the future.²⁴³

A healthcare professional's first priority with a patient who has suffered from domestic abuse is to treat the physical injuries. It is crucial that these are meticulously recorded and photographs taken if appropriate. It must be explained to victims that domestic abuse is unacceptable and against the law. While police contact must be offered, the healthcare professional must not influence the patient to make any decisions about to whom they disclose the information. A study into the relationship between domestic abuse disclosed in an emergency department and that disclosed to the police found that refusal of police contact is common. This study also estimated that less than one per cent of domestic abuse cases that present to A&E departments ultimately lead to a conviction.²⁴⁹

Healthcare professionals within an emergency department may refer patients to another healthcare speciality for further treatment of their injuries. It is therefore important that healthcare professionals outside emergency departments are knowledgeable about the various forms of domestic abuse and how it may present to them in their practices.

7.2 Obstetrics and gynaecology

Physical violence is the second leading cause of trauma during pregnancy after motor vehicle accidents.²⁵⁰ The exact prevalence of domestic abuse victims who are pregnant remains unknown as it is highly dependent on the screening methods used and the population studied. The risks of domestic abuse are known to be particularly acute in pregnancy, as the health and safety of two potential victims are placed in jeopardy. It is estimated that a third of all domestic abuse starts or escalates during pregnancy though, as outlined in **Chapter 4**, there is a degree of variation across estimates.²⁵¹

Obstetricians are the key healthcare professionals in contact with women with, or at high risk of, complications during pregnancy, and are in an opportune position to identify victims of domestic abuse. Domestic abuse is associated with numerous negative health outcomes for the mother and child, including miscarriage; still or premature birth; low birth weight; fetal brain injury and fractures; and fetal death, due to falls or blows to the abdominal region. Women reporting domestic abuse in the USA, prior to or during pregnancy, were also found to be at a high risk for vaginal bleeding, severe nausea, high blood pressure or oedema, vomiting or dehydration, kidney infection or urinary tract infection, as well as hospital visits related to such morbidity.²⁵²

Domestic abuse can exert indirect effects on the developing fetus. Martin and colleagues found that women reporting domestic abuse in the USA prior to pregnancy evidenced a greater number of substance disorder symptoms when compared with non-victims. After becoming pregnant, 'the links between women's experiences of intimate partner violence and their use of substances became stronger, with the women who experienced each type of partner violence being more likely to use alcohol and illicit drugs.'²⁵³ Additional indirect harm can result from women being prevented from receiving proper antenatal or postpartum medical care by their abusive partners. Irregular or late attendance for antenatal appointments may also be the result of low self esteem and depression following abuse.

To encourage the disclosure of sensitive information, all pregnant women should have at least one consultation with the lead healthcare professional during the pregnancy which is not attended by the partner or any family member. A set of confidential notes should be kept separate from those held by the patient. This recommendation is supported by the CEMACH report *Saving mothers' lives: Reviewing maternal deaths to make motherhood safer 2006-08*.¹⁴⁸ Attending an antenatal appointment alone may be particularly difficult for non-English speaking women for whom their partner, or family member, is their translator. While a translator may be provided by the hospital, or by their Link worker, midwives report that this did not always help:

'I doubt very much they're going to open up to a question like that that's had to be translated to a third party and you know I'm more than aware that it may well be there's a higher risk in women who can't speak English or don't know how to access services, so I always feel very uncomfortable with that really.'²⁵⁴

When treating an expectant mother, CEMACH also recommends that the healthcare professional should 'adopt a non-judgemental and supportive response to women who have experienced physical, psychological or sexual abuse and must be able to give basic information to women about where to get help. They should provide continuing support, whatever decision the woman makes concerning her future'.¹⁰

Domestic abuse includes sexual assault by an intimate partner or family member. Such acts increase a woman's risk of contracting STIs, and raise the possibility that conception may occur as a result of rape. Victims of domestic abuse are significantly more likely to describe their pregnancy as unplanned and unwanted than women without such experience.^{255,256} Infections such as Chlamydia – which is one of the most commonly transmitted STIs in the UK – can have serious implications for men and women, but the consequences are notably more serious for reproduction in females. Paavanen and Eggert-Kruse²⁵⁷ reported that Chlamydia is the most important preventable cause of infertility and adverse pregnancy outcome. The adverse pregnancy outcomes which may result from the transmission of Chlamydia include ectopic pregnancy, premature rupture of membranes, preterm birth, low birth weight and still born.²⁵⁷ Gynaecologists are likely to encounter women suffering from STIs, and therefore due to the association between STIs and domestic abuse gynaecologists are in an important position to identify cases of domestic abuse.

Gynaecologists and obstetricians must be well-informed in order to raise their awareness of domestic abuse. It is critical that these healthcare professionals understand the possible implications of domestic abuse on women, whether pregnant or not, as this should help to increase the chance of identification. The 2011 CEMACH report recommends that enquiries about domestic abuse should be routinely included when taking a social history during the antenatal period and that it must be accompanied by the development of local strategies for referral to a local multidisciplinary support network to whom the woman can be referred if necessary.¹⁴⁸ Obstetricians and gynaecologists must be aware of the role of social services and child protection matters and work in liaison with all necessary support services.

The Royal College of Obstetricians and Gynaecologists (RCOG) published guidance in 1997 stating that teaching about domestic abuse should be an integral part of training for obstetricians and gynaecologists, and their ability to address this delicate subject should be evaluated in examinations. It also recommended that obstetricians should routinely ask patients about domestic abuse by introducing questions about the subject during the course of all obstetric and gynaecological consultations.²⁵⁸ Domestic abuse now appears in the RCOG core curriculum for specialty trainees in modules on antenatal care, and sexual and reproductive health, recognising the need to provide more comprehensive care to domestic abuse victims. The RCOG introduced an advanced training skills module in 2011 to enable clinical leadership in the provision of domestic violence and forensic services.²⁵⁹ The International Federation of Gynaecology and Obstetrics (FIGO) has also recognised its role in tackling domestic abuse.²⁶⁰

No evidence exists on whether or not RCOG guidelines are being followed and hence whether routine enquiry has been implemented in obstetrics and gynaecological healthcare settings. Similarly little is known about the effectiveness of routine enquiry in identifying cases of domestic abuse during pregnancy. Evidence from primary healthcare indicates that direct questioning increases the likelihood of disclosure; on this basis screening pregnant women during obstetrics and gynaecological consultations should have a positive impact. The effectiveness of routine enquiry may extend beyond identifying abuse among pregnant women. Findings from an

evaluation of the Bristol Pregnancy and Domestic Violence Programme (BPDVP) indicated that the introduction of routine enquiry 'led to the realisation that a number of child protection cases may have previously gone unnoticed'.²⁵⁴ This is an area of research which must be developed.

7.3 Midwifery

The Royal College of Midwives (RCM) strongly supports the importance of midwives in tackling domestic abuse. The RCM states that every midwife has a responsibility to provide each woman in their care with support, information and referral appropriate to her needs. The RCM supports routine enquiry into domestic abuse throughout pregnancy and the postnatal period, which is accompanied by measures including a systematic and structured framework for referral and support for women who disclose domestic abuse. The RCM states that same-sex, independent interpreters and advocates must be used for non-English speaking women, rather than family members, and that education and training programmes on domestic abuse are essential for all midwives. The RCM proposes that domestic abuse is best challenged by a multidisciplinary approach, in which professionals work in partnership with local service providers, police, voluntary sector and the woman herself. The RCM addresses its responsibility in the protection of midwives by recommending that 'employers of midwives should have procedures and facilities in place to support midwives who may themselves be in abusive relationships'.²⁶¹

The RCM has also produced a comprehensive guidance paper on domestic abuse which provides midwives with information about the scale of the problem as well as working practice guidelines.¹⁵³ It highlights that the midwife is ideally placed to recognise and detect ongoing domestic abuse and to offer care, support and information to the woman. In summary, the RCM states that a midwife's role and responsibility following routine enquiry and a disclosure of domestic abuse is 'to provide the appropriate response, believing the woman, showing her that someone cares, not judging her, respecting her reasons and decisions to stay or leave the relationship, offering her support, providing her with helpful information, referring her to appropriate agencies, or any other action that may be required'.¹⁵³

In 2004, the DH funded a study in Bristol exploring the impact of equipping midwives to enquire routinely about domestic abuse during the antenatal period.²⁶² A year later, in response to the evidence provided by the study, the government recommended that all trusts should be working towards routine enquiry in maternity services.²⁵ A five year follow up study of the Bristol programme found that midwives attitudes in relation to their role in domestic abuse had changed significantly: all of those surveyed now reported that enquiry was a fundamental part of their role. Through the support of mandatory training, the skills, knowledge and confidence associated with antenatal enquiry for domestic abuse – developed through the 2004 programme – had been maintained. Barriers to routine enquiry persisted: they included the continued presence of a partner, the lack of appropriate interpretation services for non-English speaking clients, and the lack of privacy in some clinical areas.²⁵⁴

7.4 Psychiatry

The relationship between mental ill-health and domestic abuse is well documented. A 2013 review of the different types of domestic abuse experienced by men and women receiving psychiatric treatment reported that in women, the prevalence of lifetime partner violence was 30 per cent in inpatient settings and 33 per cent in outpatients. In men, the prevalence of lifetime partner violence was 18 per cent across all settings.²⁶³ While people who are suffering from mental health

problems may be more vulnerable to domestic abuse, there is also research to suggest that domestic abuse can increase the risk of mental illness, and that continued abuse may lead to more persistent mental-ill health.

- See **Chapter 2** for further information about psychological abuse.

Psychiatrists are in a key position to not only treat the mental health disorders caused as a result of domestic abuse, but also to spot the warning signs in patients which may indicate that they are a victim of domestic abuse.

The RCPsych states that psychiatrists must:

- be aware of the nature and prevalence of domestic abuse
- understand the dynamics of domestic abuse and how it affects the safety and autonomy of abused patients
- be able to ask sensitively about domestic abuse
- be able to provide information about a range of interventions
- be able to carry out a risk assessment and be aware of the factors associated with risk of increased violence, homicide and suicide
- be aware of and prepared to collaborate with community organisations and other professionals working in the area of domestic abuse, including child protection services
- have some understanding of civil and criminal law related to domestic abuse, and of police, social services and community help available to victims of domestic abuse.¹⁹⁸

Following disclosure, victims of domestic abuse may suffer stigmatisation and social isolation, and are likely to fear diagnosis of a mental health problem as this may lead to further discrimination. This barrier to disclosure must be taken into consideration by psychiatrists when treating patients, and it is crucial that patients are believed if they do disclose abuse. The RCPsych recommends that screening by interview should be introduced as part of a sensitive clinical enquiry as the safest and most effective method. It is suggested that the following opening question can be asked as part of a general psychiatric assessment; 'Has there ever been violence in your relationships?' The benefit of asking this question is that it enables a psychiatrist to ask a patient about being a victim or perpetrator of domestic abuse without falling into preconceived notions of who is abusive to whom. Understanding the psychology of the perpetrator and the victim is critical for effective treatment and additionally psychiatrists must be aware of the potential impact of domestic abuse on children's mental health.

There is no single way of managing domestic abuse cases. The psychiatrist must support the victim through a process of empowerment so that they feel capable of seeking further help and putting an end to the cycle of abuse. There are few guidelines aimed specifically at psychiatrists providing help to identify and manage domestic abuse cases. Recognising this gap, the College published an edited book in 2013, *Domestic violence and mental health*, which gives practical guidance on how mental health professionals can identify and respond to domestic abuse experienced by their patients. The RCPsych's core curriculum for undergraduate psychiatry, published in 2011, now specifies that all trainee doctors should be taught about the link between domestic abuse and mental health problems.

The charity Women's Aid has suggested numerous guidelines for mental health services which include the need to develop specific domestic abuse policies, together with appropriate protocols and guidelines for responding to domestic abuse victims.²⁶⁴ Raising awareness of domestic abuse, including its prevalence, manifestation and available support services for victims, is paramount in improving the service provided by mental healthcare professionals.

7.5 Nursing and health visiting

Nurses are in a strong position to identify domestic abuse as they work in an array of different healthcare settings; from an emergency department dealing with acute injuries caused by a violent domestic abuse incident, to schools where a nurse may identify children who are impacted upon by domestic abuse. Nurses may often be the first people, outside of the family, to discover that domestic abuse is occurring.

In the book *Family violence in primary care*²⁶⁵ the role of the community nurse in the prevention, detection and management of elder abuse is highlighted. **Section 4.5** highlighted some of the difficulties of identifying elder abuse. Sensitive inquiry, and creating an environment in which older people feel able to discuss what is happening to them, can enable elder abuse to be disclosed to nurses and other health professionals. These principles can also be applied to other types of domestic abuse. Community nurses, including district nurses, health visitors and community psychiatric nurses, are ideally placed to deal with cases of domestic abuse mainly due to their ongoing relationship with their patient. The nurse is usually welcomed into the home and so has the opportunity to see the interactions between other family members.

Practice nurses working within GP surgeries are largely involved with well-women care and are often in a position to see a female patient without the presence of a family member or partner. The resulting private consultation may enable the patient to feel able to discuss domestic abuse with the nurse. School nurses must be aware of the impact domestic abuse can have on children. As well as the possible physical injuries, there may be a psychological impact. School nurses should be vigilant for changes in the behaviour of a child as witnessing domestic abuse can cause children to display aggressive and antisocial behaviour, or become fearful and inhibited. The Nurse-Family Partnership (known as the 'Family Nurse Partnership Programme' in England) has been repeatedly shown to be one of the most effective programmes in improving parental disciplinary practices, reducing abusive behaviour, and improving family wellbeing.²⁶⁶ The programme is designed for vulnerable, young, first-time mothers. Through offering intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until the age of two years, the programme helps young parents to build supportive relationships, adopt healthier lifestyles for themselves and their babies, and provide good quality care (see BMA Board of Science report, *Growing up in the UK*, published May 2013).

Despite the clear role for the nursing profession in the detection, treatment and prevention of domestic abuse there is a lack of existing protocols and guidelines. A survey published in the *Nursing Times* in 2002 found that not all nursing and midwifery tutors included domestic abuse in their curricula. The report concluded that 'the inclusion of domestic violence in the nursing and midwifery curricula should become an institutional priority and should not be left to the motivation of the individual tutor'.²⁶⁷ In the IRIS programme (see **section 5.4**) the training sessions on the identification, support, and referral of domestic abuse victims were delivered to the entire clinical team, so that nurses were trained alongside GPs. The Royal College of Nursing (RCN)²⁶⁸ advocates that due to the seriousness of domestic abuse, it must be acknowledged through education

and local policies that endorse protection of victims of domestic abuse. The RCN recommends that every nurse adopt an empowering and supportive approach to patients using a structured framework. The RCN guidance (2000) heavily emphasises the importance of nurses operating a collaborative approach to dealing with domestic abuse, such as working with a local DAF.²⁶⁸

Domestic abuse training

I think [the training] gave me insight into why people don't leave, because I think your initial reaction when somebody tells you is "leave" and if they don't leave then it is their fault. But things aren't that simple. It's taught me a little about how to support people if they decide to stay in that situation because you can't just wash your hands of them. You need to provide on-going support and advise them how to stay safe while in that situation.

Health visitor

Chapter 8. Adopting a multi-agency approach

8.1 The need for a multi-agency approach

This report has focused on the role of healthcare professionals in tackling domestic abuse. It is an issue requiring different types of interventions and does not fall neatly under the jurisdiction of a single agency or government department. By working closely with other central government departments, regional government and local partnerships, the Home Office helped to catalyse the development of a more effective, multi-agency response to domestic abuse, as initially set out in the consultation paper 'Safety and justice'. This culminated in the biggest overhaul of UK legislation on domestic abuse for 30 years with the assent of the *Domestic Violence, Crime & Victims Act 2004*.¹⁶ The Act was introduced to increase the protection, support and rights of victims and witnesses. It also gives the police and other agencies the tools to get to the heart of domestic abuse crimes. Under the Act, the breach of a non-molestation order (made under Part IV of the Family Law Act 1996) was made a criminal offence carrying a maximum penalty of five years (Section 1, implemented July 2007). Access to non-molestation and occupation orders was extended to include same-sex couples as well as to couples that, while not living together, have or have had 'an intimate relationship of significant duration' (Section 3, implemented December 2005).

Following the publication of the 2003 strategy, and the assent of the 2004 Act, the foundations of a more coordinated approach to tackling domestic abuse were initially laid through the establishment of an Inter-Ministerial Group on Domestic Violence. The Group included representatives from Northern Ireland and Wales, as well as Ministers from key departments, including Constitutional Affairs, the Solicitor General, Health, Education, and Work and Pensions. Working together, the Group led the implementation of the strategy with a particular focus on education and awareness raising, early identification and intervention, improving reporting and conviction rates, safe accommodation choices for victims, and building relationships between the civil, criminal and family law courts. Each year the Group was required to publish a delivery or an action plan to highlight how key deliverables were being achieved. Following the change in government in 2010, the Inter-Ministerial Group on Domestic Violence was replaced by a Violence Against Women and Girls (VAWG) Inter-ministerial Group. Chaired by the Home Secretary, the VAWG Group meets quarterly to monitor progress against the 2011 *Ending violence against women and girls action plan*.²⁰ April 2011 also saw Section 9 of the 2004 Act come into force. This sets out the provisions for statutory, multi-agency, domestic homicide reviews aimed at learning lessons from deaths arising from domestic abuse.

In addition to the legislative changes outlined above, the past decade has witnessed a number of non-legislative reforms aimed at tackling domestic abuse through more collaborative, multi-agency working. Specialist domestic violence courts (SDVCs) were introduced in 2005, with 127 in operation by 2012 in England and Wales. They aim to make the system more 'user friendly' by bringing together police, prosecutors, court staff, and the probation service to identify and track domestic abuse cases. The partners also work with specialist support services for victims to ensure that witnesses, who may feel vulnerable and intimidated, are supported throughout the process. All those involved, from the magistrates to the court ushers, are specially trained in domestic abuse issues. Feedback on the effectiveness of SDVCs has been positive, particularly in relation to increasing the number of successful prosecutions: in 2005, 59 per cent of overall domestic violence cases recorded by the CPS led to convictions. By 2007/08 this figure had risen to 71 per cent of cases tried in SDVCs.¹⁸ At the time of writing, a SDVC was being piloted in Derry, Northern Ireland while Scotland had one SDVC in Glasgow, with similar courts due to be set up across the country.²⁶⁹

Another non-legislative shift saw the introduction of MARACs in 2006/07, initially in those areas with an established SDVC. These are monthly meetings held between a range of statutory and voluntary agencies (such as the police, victim support agencies, probation, social services, housing and health services) with the aim of providing a coordinated response for high-risk victims (those at risk of murder or serious harm) of domestic abuse and their children. The meetings help to ensure that all the agencies involved are communicating regularly about the case, that they are sharing information, and that safety plans are in place in order to lower the risks to the victim (and any children).

Over 250 MARACs are operating across England, Wales and Northern Ireland managing over 50,000 cases a year.²⁷⁰ They exist in some parts of Scotland, notably North Lanarkshire, while other areas – such as Perth and Kinross – are piloting the scheme.²⁷¹ In September 2013, Scotland also appointed their first specialist procurator fiscal for domestic abuse with the power to change prosecution policy. Domestic abuse cases throughout Scotland will now be co-ordinated by the newly-created national prosecutor, appointed to improve the way such crimes are tackled. Funding for MARACs comes directly from the Home Office, and is budgeted for until March 2015. The new Police and Crime Commissioners took over commissioning services for victims at a local level in 2013.

The Home Office, in association with non-governmental organisations, also fund IDVA who can represent victims at MARACs. These are trained specialists providing independent advocacy and support to high-risk victims. As well as being the victim's primary point of contact, helping them to navigate the support services available, IDVAs are responsible for assisting with the implementation of their safety plans. This may involve obtaining civil injunctions to protect the individuals affected, improving home security, support with mental health problems or alerting schools to the risks that the children face. *Safety in numbers*, the first large scale, multi-site evaluation of IDVA services across England and Wales produced promising results. Almost 80 per cent of victims said that they felt safer after support from an IDVA, with 57 per cent experiencing a complete or near cessation in the abuse they were suffering following around three to four months of contact with an IDVA.²⁷² The BMA acknowledges the importance of domestic abuse advocates, and considers they are well placed to work within hospitals (see **section 7.1**).

An additional, multi-agency resource, available to victims of domestic abuse are Domestic Abuse Forums (DAFs).²⁰³ Over 200 DAFs are now in operation following their initial establishment in the 1980s. They bring together statutory and voluntary sector agencies to share information and to coordinate activities in response to domestic abuse. Participating agencies include local authority departments, the police, probation, health services, refuges, women's support and outreach projects, community projects and the voluntary sector. It is known that while the police and refuges are frequently the most heavily involved, the health service is at the opposite end of the spectrum.²⁷³ The reasons why healthcare professionals have been relatively absent from DAFs remain unclear. The DH speculate that it is due to the additional burden of work they generate and the implications for confidentiality of becoming involved in discussions with other agencies.²⁰⁰ There is no standard model for how DAFs should operate as by their nature they must respond to local needs and conditions. The Home Office²⁷⁴ describes five main areas of work for a DAF.

1. Coordinating and facilitating the development of local agency responses and services.
2. Improving the practice of agencies, and their service delivery, for example through training.

3. Supporting projects to assist domestic abuse survivors, and setting up new ones.
4. Awareness-raising among the general public.
5. Preventative measures such as perpetrators' programmes and work in schools.

Healthcare professionals working with, or supporting the work of, a DAF can be extremely beneficial to the service they are able to provide to patients. A DAF may address referral systems between A&E departments and refuges, produce material to improve local liaison (such as the development of local resource directories), develop and implement good practice guidelines, provide training in domestic abuse awareness, produce written materials on domestic abuse to raise public awareness and run educational and preventative programmes within schools.²⁰⁰ Organisations including the RCN, RCM and RCOG endorse the importance of healthcare professionals adopting a team-orientated approach to domestic abuse by utilising the work of DAFs.^{153,268,275}

With the exception of DAFs, it is apparent that many of the new services available following the legislative and non-legislative reforms – such as MARACs, SDVCs, and IDVAs^q – are in the statutory sector: they respond to incidents reported to the criminal justice system. Research conducted on behalf of the Equality and Human Rights Commission (EHRC) found that, of the new services that opened in 2008, 60 per cent were in the statutory sector.¹⁶⁷ While these developments are to be commended, it should also be recognised that the majority of those experiencing abuse do not report it to the police. Statutory provision can only tackle a small part of the problem. By way of contrast, levels of provision in the community and voluntary sector have remained static, and in some instances have declined (for further details see **Chapter 9**).

Across all sectors, there continues to be a significant level of unstructured investment, as well as overlapping and duplicated use of resources. This can make services very difficult to access for victims (who commonly give up trying to get help), as well as for perpetrators of domestic abuse who are trying to change their behaviour. In building on the improvements outlined, there needs to be a shift from a reactive crisis management approach, to proactive detection of the early signs of domestic abuse.

- Please refer to **Appendix 5** for a diagram illustrating a possible preventative framework for violence and abuse.

q It is recognised that IDVAs are normally provided through NGOs, though they have been able to bid for central government funding to support IDVAs and other domestic abuse services, like MARACs.

Chapter 9. Other services involved in domestic abuse

Healthcare professionals can play a large part in tackling domestic abuse but they are by no means alone in so doing: organisations working outside of the health service may identify new cases of domestic abuse and may either assist these individuals directly, or may recommend another, more appropriate, support facility. This chapter explains the key services which exist outside of the health service to help individuals affected by domestic abuse.

- For a comprehensive list of support services please see **Chapter 11**.

9.1 Voluntary and community services

The voluntary and community sector is a major provider of specialist services to victims and perpetrators of domestic abuse. Organisations vary in size and by the types of services they are able to offer. Women's Aid is an example of an organisation which operates on a national scale and supports a network of over 300 services for women and children suffering from domestic abuse, including a 24-hour helpline, refuge accommodation, outreach services and support groups. Women's Aid also produces *The UK gold book*, a directory for refuge and domestic abuse services. It features comprehensive listings for over 500 domestic and sexual violence services across the UK, detailing the type of services and facilities provided, and referral procedures. The charity Refuge is another national organisation providing a suite of services, from a network of refuges and child support workers, to outreach services and independent domestic abuse advocacy. Help and support for male victims of domestic abuse is provided by the ManKind Initiative. As well as running a helpline, ManKind delivers specialist training and gives presentations to statutory agencies and other organisations on how they can support male victims within their communities.²⁷⁶

Smaller organisations tend to offer a narrower range of services: the National Centre for Domestic Violence (NCDV), for example, specialises in providing free legal support to victims of domestic abuse, usually by helping them to obtain non-molestation and other orders (injunctions) that can protect them from further abuse. Seeking the services or advice of organisations like Women's Aid can enable a healthcare provider to learn about other, less well known services which are available for victims in their local area, like the Freedom Project. This is run by the charity Dogs Trust across London, Hertfordshire and Yorkshire to foster dogs for people fleeing a violent household.²⁷⁷

Emergency accommodation for victims of domestic abuse can mean the difference between life and death. If a victim feels they have nowhere to go they may be more likely to remain living with the perpetrator for a longer period of time. Staying in a refuge can provide victims fleeing domestic abuse with a degree of safety and support that would otherwise not be available to them. A refuge is a safe house where individuals who are experiencing domestic abuse can stay free from abuse. Refuge addresses (and sometimes telephone numbers) are confidential; there are nearly 400 across the UK, though they are unevenly spread across the country.²⁷⁸ Refuges are consistently rated more positively by domestic abuse victims than any other agencies in terms of the services they provide. Refuges were found to be helpful in terms of the actual assistance provided and the attitudes of the staff, and additionally victims of domestic abuse value the opportunity to share their experiences and feelings with other victims.²⁷⁹ A survey by Women's Aid found that in 2009/10 there were 263 refuge organisations in England operating an estimated 690 residential properties for women and children affected by domestic abuse. It has been calculated that these properties provided 17,615 women and 17,785 children with temporary accommodation across England in this period.⁵⁶ The number of refuges for men remains unknown but the helplines for male domestic abuse victims such as MALE will be able to provide advice on housing options for men. MALE states that despite the helplines for men there is a vast lack of a wide network of specialist services that exist specifically for men and are staffed by trained workers.²⁸⁰

William's story...

William is a retired prison warden. Now divorced, he was a victim of domestic abuse, with the perpetrator being his wife.

The abuse was physical and mental and lasted for a number of years. Often he would go to work with a badly bruised face and gave the excuse that he 'walked into a door' or 'tripped over the children's' toys.

During his marriage, he suffered a number of physical injuries including: black eyes, cuts to his face and neck, as well as broken fingers. On one occasion a carving knife was thrown at him during an evening meal. Their children witnessed many of these incidents.

William retired on health grounds. His children are now grown up and have nothing to do with their mother. As he was much larger than his wife, the police initially believed him to be the perpetrator, in particular as this is what his wife had claimed.

Social workers thought his wife to be a tender, caring mother and said it was a happy home because there were pictures on the walls. The attacks were unprovoked and indiscriminate. William later discovered that his wife's parents had a similar history – where her father was abused by her mother.

There are refuges operating around the country which are in existence to meet the needs of domestic abuse victims from specific ethnic minorities. These include the Jewish Women's Aid²⁸¹ which runs the only secure refuge where Kashrut, Shabbat and festivals are fully observed, and Ashiana,²⁸² an Asian women's refuge, located in South Yorkshire.

The organisation Broken Rainbow, the first LGBT organisation dedicated to confronting and eliminating domestic abuse within and against the LGBT community, has reported a shortage of refuge services for LGBT people. Although LGBT women can stay in women's refuges, they are traditionally focused on the needs of heterosexual women. For gay, bisexual and transgender men there are almost no emergency refuge services.²⁸³

Helplines are a vitally important service provided by voluntary and community organisations for domestic abuse victims. The National Domestic Violence Helpline is a 24-hour free phone number for the whole of the UK, run in partnership between Women's Aid and Refuge. The helpline is available for women and children victims of domestic abuse, as well as friends, family and professionals seeking to support women and children who are experiencing or have experienced domestic abuse. Women's Aid in Northern Ireland, Scotland and Wales operate separate helpline numbers which can be accessed for the same purposes. For male victims of domestic abuse, the organisation MALE provides a range of services aimed primarily at men experiencing abuse from their partner. This includes a helpline for male victims as well as their family, friends and professionals wishing to support such victims. Despite the existence of other, more specialised, helplines, it would be acceptable for a healthcare professional to direct a patient towards these two key national helplines for women and men as these would provide further signposting to other more specific sources of support.

Voluntary and community organisations can also provide advocacy and outreach responses to domestic abuse. Outreach services support victims of domestic abuse in their homes and communities, providing accessible points of contact and information. Advocates provide individuals suffering from domestic abuse with support, information and advice. They recognise that individuals may come from positions of fear and isolation and require the skills of an advocate to negotiate housing, legal support and benefit entitlement. The Southall Black Sisters is an example of a not-for-profit organisation providing specialist advice, information, casework, advocacy, counselling and self-help support services in several community languages for Asian and African-Caribbean women.²⁸⁴

Despite the invaluable support provided by voluntary and community services, they are facing an uncertain future. Levels of provision in the voluntary sector have tended to remain static or, in some instances, diminish.⁵⁹ Between 2008/09 and 2009/10, Women's Aid estimates that there was a 23 per cent reduction in the total number of refuge houses, with 320 women (approximately 9% of those seeking refuge) turned away by Women's Aid on a typical day in 2011 due to lack of space. Data from IMKAAN – an organisation running services for women from Black, Asian and Minority Ethnic groups – reported in 2010 that two of their six specialist refuges had closed and that two others had suffered from cuts to local authority funding.²⁸⁵ Rather than closing services completely, some organisations have responded by cutting back on the breadth of provision on offer. RESPECT, the organisation that works with perpetrators of domestic abuse, reported that between 2010 and 2011, budget cuts meant that they reduced the number of clients they worked with by 78 per cent.²⁸⁶ Accounts from service providers and users also indicate that staff at local specialist support services were not always available on evenings, weekends and bank holidays; periods when abuse can peak.²⁸⁷

9.2 Local authorities

Housing, social work and perpetrator programmes are three key services which local authorities provide for individuals suffering from domestic abuse in their area.

An individual may be considered homeless if they live in accommodation where it is probable that living there will lead to abuse from someone else who lives there or used to live there. A local authority's housing department is obliged to provide advice about finding somewhere else to live, and depending on the individual situation the domestic abuse victim may be entitled to emergency accommodation. Under the *Homelessness Act 2002*, in England and Wales individuals who 'are vulnerable because they have fled their home because of violence' are in the 'priority need' category which places stronger duties on a housing authority to secure accommodation for them and their household.²⁸⁸ The *Homeless etc (Scotland) Act 2003* places people deemed vulnerable as a result of domestic abuse in the 'priority need' group for local authority accommodation.²⁸⁹ The Government report *Sustainable communities: settled homes; changing lives* (2005) states that between 1997 and 2004 more than 146,000 homeless households were rehoused by local authorities because of domestic abuse. A report in 2005 from the Office of the Deputy Prime Minister pledges to increase the number of refuge places, and improve their quality, and will support new approaches to domestic abuse and homelessness, including 'Sanctuary'^r schemes that provide extra security to help the victims of domestic abuse to stay in their own homes, where it is safe for them and they choose to do so.²⁹⁰ In 2008-09, local authorities reported that there were 3,820 cases where people were able to remain in their existing home due to sanctuary scheme measures.²⁸⁷

r A Sanctuary scheme provides professionally installed security measures to allow those experiencing domestic violence to remain in their own accommodation where it is safe for them to do so, where it is their choice and where the perpetrator no longer lives within the accommodation. (Source: Department for Communities and Local Government (2006) *Options for Setting up a Sanctuary Scheme*. London: Department for Communities and Local Government).

When giving evidence to the House of Commons Home Affairs Committee, domestic abuse and homelessness charities identified significant problems with the current test for 'priority need' for victims of domestic abuse. Due to the hidden and often secretive nature of the abuse, victims can find it hard to show evidence that it has taken place. This can result in them being superseded by others in the priority list for social housing, leaving these victims with the stark choice of remaining with their abuser or becoming homeless.¹⁸

By definition, social care services look after the health and welfare of the population.²⁹¹ Social workers often work with people whose behaviour presents risks to either themselves or others and in such situations social workers may have to take action in order to safeguard the welfare of a vulnerable person. Social workers may be presented with cases of domestic abuse either via direct contact from an affected individual, or the case may be referred to them from another professional, such as a GP or police officer. Following disclosure of domestic abuse, a GP may refer the case to social services with the consent of the patient. Social services primarily become involved in cases of domestic abuse when children are at risk. It is good practice, and beneficial to the doctor-patient relationship, that if a healthcare professional is obliged to refer the case to social services when consent has not been given, that the patient is informed beforehand. Healthcare professionals must be mindful of the fear embedded in many individuals that social services will automatically remove children from homes where there is domestic abuse.²⁹² This is not the sole intention of social services, and the report *Supporting parents, safeguarding children* (2006) outlines the approach of social services to reduce the number of children taken into care due to domestic abuse. The report states that 'the challenge for health and social services lies in ensuring that children whose parents are finding it difficult to care for them (i) get enough help and support to assure their safety and wellbeing, and (ii) receive help early enough to minimise the risk of children becoming looked after' (see also *Working together to safeguard children* (2013)).²⁹³

As part of a local authority's domestic abuse prevention strategy they may provide programmes for perpetrators of domestic abuse. Such programmes are designed to help change the behaviour of the perpetrator and enable them to develop respectful, non-abusive relationships. All programmes should be compatible with the 'Statements of principles and minimum standards of practice', issued by RESPECT, the UK-wide membership association for domestic abuse perpetrator programmes and associated support services. Most perpetrator programmes work with men and according to Women's Aid 'there are currently no perpetrator programmes and associated services being run in the UK for same-sex domestic violence or for female perpetrators'.²⁹⁴ Some programmes take men who self-refer, others take men who are mandated to attend by the courts as part of a probation order, or as a recommendation from the family courts. A perpetrator of domestic abuse can call the RESPECT phoneline for further information about the perpetrator programmes available in their local area that take self-referrals.²⁹⁵

- For further information on perpetrator programmes see **Chapter 6**.

For detailed information on the Home Office achievements and future plans in tackling domestic abuse please see the *Call to end violence against women and girls: Taking action – the next chapter*, (2012).²⁷⁰

9.3 Legal agencies

Healthcare professionals have an important relationship with the legal profession, since prosecutors striving to gain protection for domestic abuse victims may rely heavily on a doctor's medical records. Morris (2003) explains that doctors may be asked by solicitors for medical reports and these must be written promptly and must contain all the facts. Doctors must record what they saw, observed and heard. Doctors may worry about making definite statements because they fear they are being asked to make a judgement. They, however, need only record the facts as it is the responsibility of the court to pass judgement.²⁹⁶

- Information about the police and legal profession's involvement with domestic abuse can be found in **Appendix 6**.

9.4 Employers

It is estimated that domestic abuse currently costs UK businesses over £1.9 billion a year, while in any one year, more than 20 per cent of employed women take time off work because of domestic abuse. Their behaviour – such as being repeatedly late for work – can also be misinterpreted. Disciplinary action may follow, with an estimated two per cent losing their jobs as a direct result of the abuse. Such abuse may also be prevalent in the workplace; 75 per cent of victims, for example, can receive abusive calls, emails or texts during the working day. In April 2013, the EHRC published new guidance to help employers support staff who are experiencing domestic abuse. The guidance outlines how employers should respond if an employee is affected by domestic abuse and is designed to enable employers to develop a domestic abuse workplace policy. Having a domestic abuse workplace policy can help to demonstrate that domestic abuse is not tolerated within or outside the workplace and displays a commitment to providing support for staff.²⁹⁷

In June 2013, the DH together, with the Corporate Alliance Against Domestic Violence (CAADV),^s launched a Public Health Responsibility Deal pledge for any organisation wanting to help and support staff facing domestic abuse to sign. The Pledge states that:

'We will treat people within our organisation with respect and dignity. We will do everything we can to prevent stalking, violence or abuse either in the workplace or that has an effect on people in the workplace, whether from a colleague, family member or anyone else. This will include having guidance in place which is suitable to the size of our organisation. The guidance will ensure that an appropriate, safe and sensitive response can be implemented and our employees supported when they raise such an issue.'²⁹⁸

^s CAADV brings together a number of companies to work collectively to raise awareness of the impact of domestic violence in the workplace and provide policies, procedures and training for member firms and their employees.

Chapter 10. Conclusions and recommendations

Conclusions

Domestic abuse is a significant social concern and has a number of health consequences. This report illustrates that victims tend to under-report domestic abuse and that healthcare professionals largely do not identify those who have experienced it. In order to respond effectively, healthcare professionals should be trained to recognise and manage domestic abuse. Until recently, healthcare professionals have not fully considered the challenges which domestic abuse raise. There is a need for the medical profession to take a more proactive stance including taking a multi-agency approach.

The government's strategic approach to tackling domestic abuse in England was set out in the consultation paper *Safety and justice*, and this approach has led to the *Domestic Violence, Crime & Victims Act 2004*, the most comprehensive piece of legislation on domestic abuse in over 30 years.¹⁶ With the introduction of the UK Government's action plan to *End violence against women and girls* there is an operational framework in place for a multi-agency approach to tackling the problem.¹⁹ Preventing domestic abuse will only be achievable if all services dealing with affected individuals prioritise the concern and work to achieve the goals laid out in the government plan.

As the major professional organisation representing doctors in the UK, the BMA, through this report, aims to lead the way in encouraging all health professionals in all disciplines, to raise awareness of the problem of domestic abuse and to develop strategies to identify and reduce the substantial impact upon the health and welfare of adults and children. The following recommendations build on those outlined in the BMA's 2007 version of this report and reflect the 2014 NICE guidance set out in *Domestic violence and abuse: How health services, social care and the organisations they work with can respond effectively*.³⁰

Recommendations

Healthcare professionals

- Addressing domestic abuse in the healthcare setting is a priority. In order to achieve this, all healthcare professionals should:
 - receive training on domestic abuse
 - take a consistent approach to the referral of patients to specialist domestic abuse services and ensure clear referral pathways have been implemented
 - ensure that they ask patients appropriate questions in a kind, sensitive manner in a private space in which the person feels safe in order to encourage disclosure of abusive experiences
 - ensure people who may be experiencing domestic abuse can be seen on their own in a place where they cannot be overheard (a person may have multiple abusers and friends or family members may be colluding in the abuse). Friends or family members should not be used as interpreters
 - give the clear message that domestic abuse is unacceptable and not the victim's fault, and that there are specialist support services which can provide information, advice and support
 - display information in waiting areas, in healthcare settings, such as GP practices, highlighting the support available for people experiencing domestic abuse. This should include support for disabled and older people
 - recognise that men, and people in same-sex relationships, can also be victims of domestic abuse and should therefore be questioned if domestic abuse is suspected
 - establish clear policies and procedures for staff who have been affected by domestic violence and abuse. Ensure staff have the opportunity to address issues relating to their own personal experiences, as well as those that may arise after contact with patients or service users

- have clear protocols in place for sharing information that are secure and will not put anyone at risk
- recognise when children and young people are affected by domestic abuse, develop an understanding of their risks and needs, and ensure staff know how to refer children and young people to child protection services
- provide all those currently (or recently) affected by domestic violence and abuse with advocacy and advice services tailored to their level of risk and specific needs
- provide people who experience domestic violence and abuse and have a mental health condition with evidence-based treatment for that condition.
- GP practices and other agencies, such as outpatient clinics, should include training on, and a referral pathway for, domestic violence and abuse.
- Pre-qualifying training and continuing professional development for health and social care professionals should include domestic violence and abuse.

Commissioners

- Those with responsibilities for commissioning domestic abuse services should:
 - plan services based on an assessment of need and service mapping
 - establish an integrated commissioning strategy that meets the health and social care needs of those who experience domestic violence and abuse (including young people) addresses the perpetrator's behaviour and health needs, and meets the needs of all local communities
 - ensure there are integrated care pathways for identifying, referring (either externally or internally) and providing interventions, including psychological, to support people who experience or perpetrate domestic abuse.

The UK governments

- The UK governments should:
 - raise general awareness of domestic abuse, including for example its prevalence, manifestation and available support services for victims
 - ensure strategies to address domestic abuse are explicitly highlighted in their public health strategies
 - develop a more structured and statutory basis for addressing domestic abuse at the local level in a similar manner to the policies in existence for child protection
 - recognise that men are also victims of domestic abuse and this needs to be taken into consideration when developing policy to address this concern
 - work to identify and combat the barriers to reporting incidents of domestic abuse. This should help identify the true prevalence of domestic abuse.
- The rights afforded to transgender individuals by the *Gender Recognition Act 2004* should be proactively implemented, for example, refuges must be more accessible to transgender individuals.
- Further work is required in order to:
 - ensure that information about support services is readily available in healthcare settings such as GP surgeries, ED units and maternity departments
 - raise awareness of the scale of domestic abuse in the LGBT community
 - break down the barriers for such individuals to access the services and protection they need
 - empower victims to report the abuse to the police.

- Domestic abuse education programmes should be implemented in all primary and secondary schools, with a specific emphasis on assisting, and raising awareness among, teachers to recognise the signs of domestic abuse.

Research

- There already exists a good research base on domestic abuse, in particular with regard to female victims. Further research is needed on:
 - prevalence of elder abuse
 - domestic abuse within ethnic minority groups
 - the experience of disabled men who are victims of domestic abuse
 - pregnant victims of domestic abuse
 - the implementation and effect of the RCOG guidelines on the routine enquiry of female patients in obstetrics and gynaecological healthcare settings
 - the number of refuges which exist for male victims
 - the effectiveness of programmes that aim to prevent the occurrence of domestic abuse
 - the effectiveness of interventions after disclosure of abuse to healthcare professionals
 - system level changes in healthcare settings that improve the response of healthcare professionals to survivors of domestic abuse
 - prevalence and experiences of gay male victims of domestic abuse
 - prevalence and experience of transgender victims of domestic abuse
 - effective treatment and interventions for perpetrators of domestic abuse.

Chapter 11. Examples of useful contacts

Please note that all external links are provided for your convenience: the inclusion of any link does not imply the BMA's endorsement of the website, its operator or its content. The BMA is not responsible for the content of any external website.

National Domestic Abuse Helpline: 0808 2000 247

Freephone 24-hour helpline run in partnership between Women's Aid and Refuge.

For women

Women's Aid

www.womensaid.org.uk

Women's Aid is the national domestic violence charity that helps thousands of women and children every year.

Scottish Women's Aid

www.scottishwomensaid.co.uk

Helpline: 0800 027 1234

Welsh Women's Aid

www.welshwomensaid.org

Helpline: 0808 8010 800

Women's Aid Federation Northern Ireland

www.womensaidni.org

Helpline: 0800 917 1414

Refuge

www.refuge.org.uk

Refuge offers a range of services which increase women's choices and gives them access to professional support whatever their situation.

For men

Men's Advice Line

www.mensadvice.org.uk

The Men's Advice Line helpline (0808 801 0327) provides a range of services aimed primarily at men experiencing domestic abuse from their partner. They also provide a range of services to professionals from the statutory and voluntary sector.

Men's Aid

www.mensaid.com

Provide free practical advice and support to men who have been abused. Men's Aid operates a helpline from 8am to 8pm, 7 days a week on 087 1223 9986.

Survivors UK

www.survivorsuk.org

The UK's only charity dedicated to helping the survivors of male rape and sexual abuse. Survivors UK operate a National Helpline on 0845 122 1201 (opens Mondays, Tuesdays and Thursdays 7pm to 10pm).

Men's Health Forum

www.menshealthforum.org.uk

Provide an independent and authoritative voice for male health.

Specific groups

Action on elder abuse

www.elderabuse.org.uk

A UK charity working to protect, and prevent the abuse of, vulnerable older adults.

Broken rainbow

www.brokenrainbow.org.uk

Support for LGBT people experiencing domestic violence. LGBT people staff a helpline on 0300 999 5428 (Monday and Thursday 10am to 8pm; Tuesday and Wednesday 10am to 5pm).

Chinese Information and Advice Centre

www.ciac.co.uk

A UK charity offering free legal advice and support to disadvantaged Chinese people living in the UK. Women's Support Project is dedicated to helping Chinese women and families who are struggling or in distress.

Dogs Trust, Freedom Project

<http://www.dogstrust.org.uk/az/ff/freedomproject/#.UTR926LwkQc>

The Freedom Project is a free foster care service for dogs belonging to women fleeing from domestic abuse. The service is run in the Greater London and Yorkshire areas.

Jewish Women's Aid

www.jwa.org.uk

Jewish Women's Aid is a registered national charity run by Jewish women for Jewish women and their children who have experienced or are experiencing domestic abuse. Jewish Women's Aid operates a helpline on 0808 801 0500.

Powerhouse

www.thepowerhouse.org.uk

A safe house for women with learning disabilities, set up by the Beverley Lewis House.

Refugee Council

www.refugeecouncil.org.uk

Provide support and help to refugees and asylum seekers and make information and advice available to them directly.

Relate

www.relate.org.uk

Relate is the UK's largest provider of relationship counselling and sex therapy. Relate offers a wide range of services for couples, families and individuals, supporting them through all stages of their relationships. Services available in England, Wales and Northern Ireland. **Couple Counselling Scotland** (www.couplecounselling.org) offers similar services in Scotland.

Southall Black Sisters

www.southallblacksisters.org.uk

Southall Black Sisters is a not-for-profit organisation established to meet the needs of black (Asian and African-Caribbean) women. It provides information, advice, advocacy, practical help, counselling and support to women and children experiencing domestic and sexual violence (including forced marriage and honour crimes).

UK Disability Forum

www.edfwomen.org.uk/abuse.htm

The Women's Committee is working to raise awareness of abuse against all disabled women.

For children

The Hideout

www.thehideout.org.uk

Women's Aid website for children and young people providing information about domestic abuse that is easy to read and understand.

ChildLine

www.childline.org.uk

ChildLine is the free helpline for children and young people in the UK. Children and young people can call on 0800 1111 to talk about any problem, including domestic abuse.

Legal advice

National Centre for Domestic Violence

www.ncdv.co.uk

Charity specialising in helping victims of domestic violence obtain non-molestation and other orders (injunctions) from court to protect them from further abuse. Their service is completely free and available 24 hours a day, 7 days a week, 365 days a year.

Northern Ireland Legal Services Commission

www.nilsc.org.uk

Provide publicly funded legal services to help people who are eligible for legal aid to protect their rights in civil matters.

Other

Co-ordinated Action Against Domestic Abuse (CAADA)

www.caada.org.uk

CAADA provides practical help to support professionals and organisations working with domestic abuse victims.

Respect

www.respect.uk.net

Respect is the UK membership association for domestic abuse perpetrator programmes and associated support services. The Respect Phonenumber 0808 802 4040 offers information and advice to domestic abuse perpetrators, their (ex)partners, friends and family and to frontline workers who come into contact with perpetrators in their work.

Samaritans

www.samaritans.org.uk

Samaritans is available 24 hours a day on 08457 90 90 90 to provide confidential emotional support for people who are experiencing feelings of distress or despair.

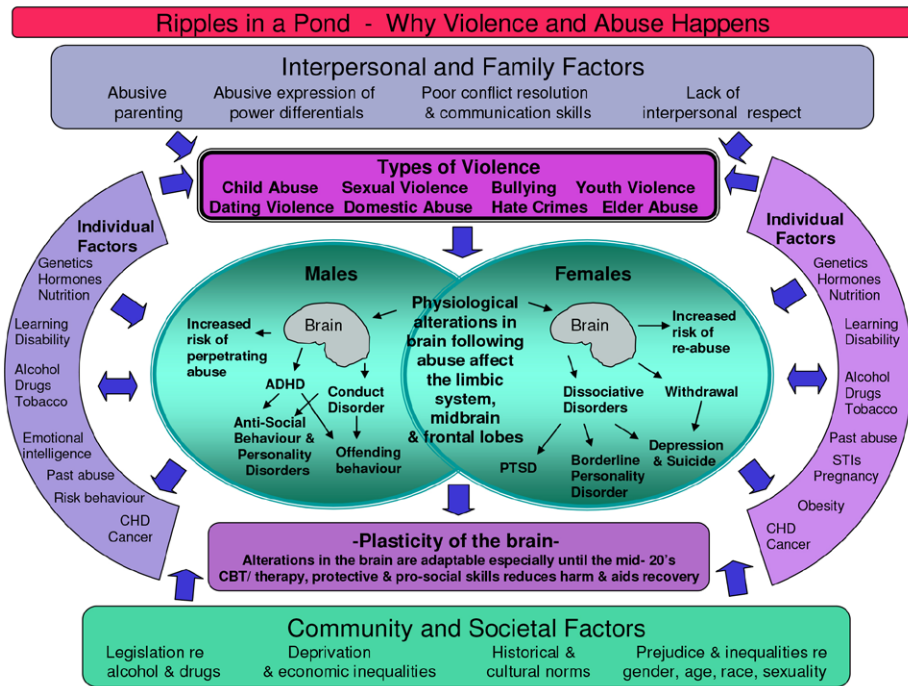
Victim Support

www.victimsupport.org

Victim Support is the national charity which helps people affected by crime. They provide free and confidential support to help victims deal with their experience, whether or not they report the crime. Their helpline number is 0845 30 30 900.

Appendix 1

An illustration of the complex relationship and interaction between the causes and consequences of violence and abuse



As quoted by the South East Regional Public Health Group (2006), 'the risk and impact of violence and abuse tend to be expressed differently according to gender norms as illustrated in the central circles. However, exceptions to the norm exist as gender is expressed on a continuum'.

Diagram provided by South East Regional Public Health Group, Information Series 1, *Preventing violence and abuse: Creating safe and respectful lives* (2006).

Appendix 2

Patient and healthcare professional opinion on routine enquiry for domestic abuse

While there are a limited number of studies examining the acceptability of routine enquiry in the UK, the findings of systematic reviews give a good indication of the perceived views of women and doctors on this topic. Combining data from 14 qualitative and 19 quantitative studies, a 2009 systematic review of domestic abuse screening programmes found that the proportion of survey respondents who found screening by healthcare professionals acceptable ranged from 35 per cent to 99 per cent. Variation in attitudes between countries was apparent: in UK-based studies, 20 per cent of respondents did not support screening in a general practice context and 40 per cent thought that women should rarely or never be asked about partner violence in an A&E department.¹² The acceptability of being asked was not significantly different between women who were, and those who were not, experiencing domestic abuse at the time of questioning.⁶⁸ The main finding from the systematic review was that the majority of survey respondents and informants did find enquiry acceptable even if it made them uncomfortable.¹²

Similar results were produced following a survey of female psychiatric patients (n=71) in Wandsworth, south west London. When questioned about the acceptability of their psychiatrist or key worker asking about their experience of domestic abuse, 82 per cent regarded such questions as 'entirely acceptable', with 10 per cent objecting and the same proportion 'unsure'.²⁹⁹ A higher percentage of pregnant women found this type of questioning acceptable: an evaluation of the Bristol Pregnancy Domestic Violence Programme found that 94 per cent of women (n=236) felt comfortable with a midwife asking about domestic abuse, with 96 per cent also reporting that they felt it was entirely appropriate for a midwife to ask the question. Research conducted in Wales following the implementation of the 'domestic abuse antenatal care pathway' reported that all the participants that were interviewed (n=12) said they were not offended to be asked about domestic abuse, and each felt it was the role of the midwife to ask.³⁰⁰

Doctors and nurses have been found to be less enthusiastic about routine enquiry for domestic abuse in all patients, in comparison with the patients themselves. The 2009 systematic review of screening programmes identified a wider variation in the acceptability of domestic abuse screening among healthcare professionals (ranging from 15 per cent to 95 per cent acceptability) than was apparent among patients; many surveys showed that a majority of clinicians did not find it acceptable.¹² An examination of the knowledge, attitudes, and clinical practice of UK primary healthcare clinicians (doctors and nurses) in London and Bristol found that 71 per cent reported feeling unprepared to ask appropriate questions about domestic abuse (n=463). A related, qualitative study focusing on the perceptions and experiences of 11 GPs and six nurses from the London and Bristol practices reported that all the informants felt that they had a role in addressing domestic abuse as a health care professional.¹⁸² The rationale behind why healthcare professionals are predominantly against routine enquiry is described in more detail in **Chapter 5** of this report, and includes lack of education in or experience of routine enquiry, time constraints, fear of offending or endangering patients, and lack of effective interventions. A healthcare professional may also worry that as a result of their intervention a violent perpetrator may act in a threatening or violent manner towards members of the healthcare team. Further research is required on the exact advantages and disadvantages of routine enquiry before any thought can be given to making the procedure compulsory for doctors.

Appendix 3

Detecting domestic abuse during consultation with healthcare professionals

The debate about routine screening for domestic abuse has somewhat overshadowed the less controversial issue of the need for healthcare professionals to receive training in being open to the disclosure of domestic abuse and signalling to patients that it is a legitimate health care issue that can be discussed. It is crucial that a doctor or other healthcare professional ask appropriate questions and in a gentle and non-threatening manner in order to encourage the disclosure of a patient's abusive experiences. The safety of the victim is of the utmost importance and it is vital that before any form of enquiry begins the healthcare professional assesses whether their intervention will leave the victim in either greater safety or danger. Before asking any questions a healthcare professional must also consider the following aspects of good practice:

1. Treat people with respect and dignity at all times. If the patient is being abused they are likely to feel ashamed, humiliated and frightened, and hence even the slightest hint that a healthcare professional is sceptical about their story could stop them disclosing the information.
2. Respect confidentiality and privacy. It is important to acknowledge the possible dangers associated with breaching these. The consultation must take place in a private room where confidentiality can be guaranteed and the patient must be assured that unless there are exceptional circumstances, the information they provide will be fully confidential.
3. See the victim alone. The presence of a partner or relative may prevent the patient from being honest about the domestic abuse they are suffering. The only exception to this is when you have a professional interpreter present.
4. Consider the need for an interpreter. This service may be necessary to provide an interpreter for a different language or an advocate for an individual with a learning disability. The interpreter must be a professional and independent of the doctor and the patient.^{25,200}
5. Think of your conversation as the start of a process, rather than a one-off event. The patient should not be pushed into disclosing abuse but should be given the time and space to have a conversation. If the patient does not want to discuss it during the appointment, let them know that you are there to talk if and when they are ready.

It would be a mistake for a healthcare professional to focus only on the treating of a patient's injuries or distress, without asking about their causes, as this would provide only limited help to a victim of domestic abuse. Enquiring about domestic abuse is a challenging task as the victim will often be feeling extremely daunted by the situation. The DH and the RCGP, in conjunction with the charity CAADA, have produced guidance on how healthcare professionals and GPs, respectively, should deal with domestic abuse in a healthcare setting.^{200,210} The DH advises that to help put a victim at ease, asking some indirect 'lead-in' questions would be beneficial. These include such questions as:

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

Healthcare professionals should not be afraid to ask direct questions as these are more likely to result in a disclosure of the abuse being suffered by a patient. Many of the direct questions focus on evidence of physical assault and injury, but many victims of domestic abuse will not display such symptoms at the time of the consultation.²⁰⁰ This therefore means that certain questions may not always be necessary or appropriate, and as such the healthcare professional must assess each individual patient separately. The following questions have been suggested by the RCGP as examples of what a GP could ask their patient.

- I noticed you had a number of bruises. Could you tell me how they happened? Did someone hit you?
- You seem frightened by your partner. Have they ever hurt you?
- You mention your partner loses their temper with the children. Do they ever lose their temper with you? What happens if they do?
- Have you ever been in a relationship where you have ever been hit, punched, kicked or hurt in any way? Are you in such a relationship now?
- Does your partner sometimes try to put you down or control your actions?
- Sometimes, when others are over-protective and as jealous as you describe, they react strongly and use physical force. Is this happening in your situation?
- Your partner seems very concerned and anxious. That can mean they feel guilt. Were they responsible for your injuries?³⁰¹

The above questions largely refer to a patient's partner, but this can be adapted to for example a family member or carer, depending on the suspected perpetrator. If a GP is unsure of who is abusing the patient then it would be best practice to ask questions about a broader range of individuals, such as from the family, community, their carers, and their partner.

Each and every time a healthcare professional enquires about domestic abuse with a patient they must emphasise that the discussion will be confidential. Fear is often one of the reasons why a victim may remain in an abusive relationship and not feel able to tell anyone about their suffering. Such reassurance could make the difference as to whether or not a patient chooses to disclose information. As reported by the RCGP, 'the concept of confidentiality may be unfamiliar to many first generation immigrants and the protection it offers will need to be carefully explained and emphasised'.³⁰¹ There are, however, limits to confidentiality which must be explained to the patient, such as if there is reason to suspect children are at risk, safeguarding and protection should always take precedence over confidentiality.²⁵

The WHO issued new clinical and policy guidelines on 'the health sector response to partner and sexual violence against women' in 2013.³⁰²

GUIDELINES FOR HEALTH SECTOR RESPONSE →

WHO's new clinical and policy guidelines on the health sector response to partner and sexual violence against women emphasize the urgent need to integrate these issues into clinical training for health care providers. WHO has identified the key elements of a health sector response to violence against women which have informed the following recommendations:



Women-centred care:

Health-care providers should, at a minimum, offer first-line support when women disclose violence (empathetic listening, non-judgmental attitude, privacy, confidentiality, link to other services).



Training of health-care providers on intimate partner violence and sexual violence:

Training at pre-qualification level in first-line support for women who have experienced intimate partner violence and sexual assault should be given to healthcare providers.



Identification and care for survivors of intimate partner violence:

Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence, in order to improve diagnosis/identification and subsequent care.



Health-care policy and provision:

Care for women experiencing intimate partner violence and sexual assault should, as much as possible, be integrated into existing health services rather than as a stand-alone service.



Clinical care for survivors of sexual violence:

Offer comprehensive care including first-line support, emergency contraception, STI and HIV prophylaxis by any perpetrator and take a complete history, recording events to determine what interventions are appropriate.



Mandatory reporting of intimate partner violence:

Mandatory reporting to the police by the health-care provider is not recommended. Health-care providers should offer to report the incident if the woman chooses.

HEALTH-CARE WORKER INTERVENTION →

Violence against women is a global public health problem of epidemic proportion, requiring urgent action. Health-care providers are in a unique position to address the health and psychosocial needs of women who have experienced violence, provided certain minimum requirements are met:



- ✓ Health-care providers are trained
- ✓ Standard operating procedures are in place
- ✓ Consultation takes place in a private setting
- ✓ Confidentiality is guaranteed
- ✓ A referral system is in place to ensure that women can access related services
- ✓ Health-care settings are equipped to provide a comprehensive response, addressing both physical and mental consequences
- ✓ Health-care providers gather forensic evidence when needed

All statistics can be found in the report entitled Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence, by the World Health Organization, the London School of Hygiene & Tropical Medicine, and the South African Medical Research Council, found here: <http://www.who.int/reproductivehealth/publications/violence/en/index.html>

Appendix 4

Actions required following a disclosure

If a patient reveals that they are being abused by a person close to them then it is important that the healthcare professional feels confident in responding to this. The patient must feel that they can trust the healthcare professional to help them stop the abuse. As explained by the DH, the role of a healthcare professional is to provide support and information to help the patient make a decision about what to do next, encourage them to have a safety plan and to help assess the risk to the patient and if applicable, their children. One key message to convey to all healthcare professionals is that in cases when a patient is being abused by their partner, they must not advise them to leave. This can put the victim at an increased risk of injury or murder, and hence leaving immediately may not be the best option.²⁵

Combining the suggestions by Heath in 1992,³⁰³ the DH in 2000²⁰⁰ and 2005²⁵ and the BMA's original report on domestic abuse in 1998, the following six-staged approach is recommended for healthcare professionals, following the disclosure of domestic abuse. The stages are respect and validation, assessment and treatment, record keeping, information giving, information sharing and follow-up and support.

1. Respect and validation

A healthcare professional's first response to a victim of domestic abuse is of great importance as it may be significant in determining whether a victim chooses to disclose further information and seek further help, or whether they feel that they cannot trust the healthcare professional and hence choose to face the situation alone. The victim may have been suffering domestic abuse for a long period of time before gaining the courage to confide in a healthcare professional, and therefore they must be treated with an empathetic, supportive and non-judgemental response. Affirm that the patient has made an important step by discussing the abuse. It is imperative that the healthcare professional reassures the victim that they believe them, that the abuse is not their fault, and that they have a right to safety. Confidentiality must also be further emphasised at this stage.^{25,200}

2. Assessment and treatment

Patients who disclose domestic abuse during an appointment with a healthcare professional may present with physical injuries which require an immediate response. It is not the job of a healthcare professional to give advice to the domestic abuse victim about what action should be taken. The professional is, however, expected to ask the patient if they would like to be referred to specialist services for further treatment and/or support. If the patient is unwilling/unable to engage with other services at this time, the healthcare practitioner can provide signposting and information about local services. It is also important that the safety of the victim is assessed and a safety plan prepared. This may be as simple as asking the patient if it is safe for them (and any dependents) to return home. The safety plan does not need to be written, but it must be talked through with the patient so that they are aware of what it entails. There are specialist organisations and charities listed in **chapter 11** that can help a victim devise a safety plan. The victim of domestic abuse is the only person who can reliably predict the risks they are susceptible to, and thus it is the job of the healthcare professional to prompt the victim to think about the following points.

- History of abuse to both the victim and children.
- Has the domestic abuse increased in severity?
- What does the abuse entail? Including both the physical and emotional aspects.
- Victims' current fear of the situation and thoughts about the immediate danger.

- Self-harm or suicide threats/attempts by the victim.
- Attempts to get help over the last year.
- Availability of support from family and friends, and whether any alternative accommodation is available if necessary.

With the information gathered during an assessment of the victim's safety, a safety plan must be produced covering the following key topics.

- Places to avoid when the abuse starts.
- Those a victim can turn to for help or inform that they are in danger.
- Places to hide important phone numbers, such as help-line numbers.
- How to keep the children safe when the abuse starts.
- Teaching the children to find safety or get help.
- Keeping important personal documents in a safe place so that they can be easily found if the victim needs to leave suddenly.
- Letting someone in authority know about the abuse so that it can be recorded (important, for example, in immigration cases).
- Packing an emergency bag and hiding it in a safe place for use if the victim needs to leave in an emergency.
- Plans for who to call and where to go in the case of an emergency (eg domestic abuse refuge).
- Contact details for professionals who can offer advice or support for when the abusive relationship is over.
- If the victim has left the perpetrator then they must know how to keep their location a secret and make plans to teach their children about the importance of keeping this a secret.

If there are children in the household who are thought to be in danger, then local safeguarding guidelines must be followed. This may include contacting social services, ideally with the victim's consent. The DH document *Responding to domestic abuse: A handbook for healthcare professionals* (2005)²⁵ gives clear advice on what to do in such situations. *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children* (2013)²²³ should also be consulted.

A healthcare professional must also consider their own safety and that of their colleagues. If there is an immediate risk, for example if the perpetrator is behaving aggressively in the reception area, then the police should be called. A healthcare professional should never take on the responsibility for dealing with a high-risk situation.^{25,200}

3. Record keeping

Keeping accurate documentation of successive consultations with a patient who has disclosed domestic abuse, or who it is thought may do so in the future, is crucial. A healthcare professional's record of the domestic abuse may be required as evidence in several scenarios, such as during the prosecution of a perpetrator, if the victim was obtaining protection through an injunction or court order, in cases where the victim is at risk of deportation due to immigration laws, for housing provision applications and to assess the possible risks to children. Healthcare professionals do not need permission to record the disclosure of domestic abuse or their findings from an examination, and this must be explained to the patient.

The DH lists 12 key information facts that a healthcare professional should document when dealing with a case of domestic abuse. They are as follows:

1. date of birth
2. ethnicity
3. response to screening questions
4. relationship to perpetrator
5. if female, whether they are pregnant
6. whether there are any children in the household
7. nature of abuse, and if physical – the type of injuries
8. brief description of all forms of domestic abuse experienced
9. whether this is the first episode, and if not, what frequency over what period
10. safety assessment
11. indication of information provided on local sources of help
12. indication of any action taken, eg referral to specialist service.

Each primary care organisation should have its own guidelines on recording domestic abuse information. It is advised by the DH that a healthcare professional should use the patient's words rather than their own, document injuries in as much detail as possible and record whether the victim's explanation for it are consistent. Taking photographs of physical injuries will convey the severity of them more effectively than a verbal description. Drawings or body maps to show the injuries are an additional method of record keeping. Notes on domestic abuse should be kept separately from the main patient record: they should never be written in hand-held notes, such as maternity notes. Keeping domestic abuse notes separately can have adverse effects as it may mean that the abuse is not put in context with a patient's overall wellbeing. With the introduction of computerised records, it may be easier to attach the domestic abuse notes to a patient's main notes, however, care must be taken that none of this information is visible on the opening screen.^{25,200,301} The record should only be accessible to those who are directly involved in the patient's care.

4. Information giving

As stated earlier, it is not the job of a healthcare professional to give advice to a victim of domestic abuse about what action they should take. Ill-informed advice could have serious consequences for all those involved.²⁰⁰

A healthcare professional must provide the victim with information about where they can go for help and how to contact local services. The DH states that 'patients who experience domestic abuse don't have a set list of options'.²⁵ These will depend on matters such as their personal circumstances, the immediate risk they face, whether children are involved, and the available services in their area and what capacity these have at that time. Victims should be provided with information about seeking advice from helplines, getting support from domestic abuse agencies, contacting the police, getting legal advice about obtaining a restraining order, taking additional safety measures, and seeking emergency refuge accommodation. It is acceptable for a doctor to offer help to the victim in making contact with other agencies.³⁰¹

5. Information sharing

The legalities of confidentiality and information sharing for a healthcare professional are complex. The DH, GMC and Home Office have all published guidance for healthcare professionals about sharing information, and these are further explained in chapter six of this report.^{25,200,304} Each trust or health authority should have information sharing policies to help inform healthcare professionals, and these should be followed. Overall, as stated by the Home Office in its paper *Safety and justice* (2003) 'information which attracts a duty of confidence may only be shared if the individual consents, if there is a legal obligation to share the information, or if the public interest in sharing the information overrides the need to keep it confidential'.

6. Follow up and support

Due to the nature of primary care, and especially with the work of GPs, a patient is likely to have repeat consultations with the same healthcare professional over time. It is the role of a healthcare professional to provide continuing support every time they see a patient who has once disclosed that they are suffering from domestic abuse. This will allow a healthcare professional to monitor the patient for signs of further, or increased, domestic abuse. During follow-up appointments a healthcare professional should revisit the initial safety plan to check whether it needs updating, and also to support the victim in following the plan and utilising the available specialist services.²⁰⁰

A further element of support, as described by the DH,²⁰⁰ is meeting the needs of healthcare professionals working with domestic abuse cases. In England, the local health authority should address the best way to support staff dealing with this area of healthcare. Additionally, the working environment should be accommodating so that staff would feel comfortable disclosing their own experiences of domestic abuse.

Appendix 5

A diagram illustrating a preventative framework for violence and abuse

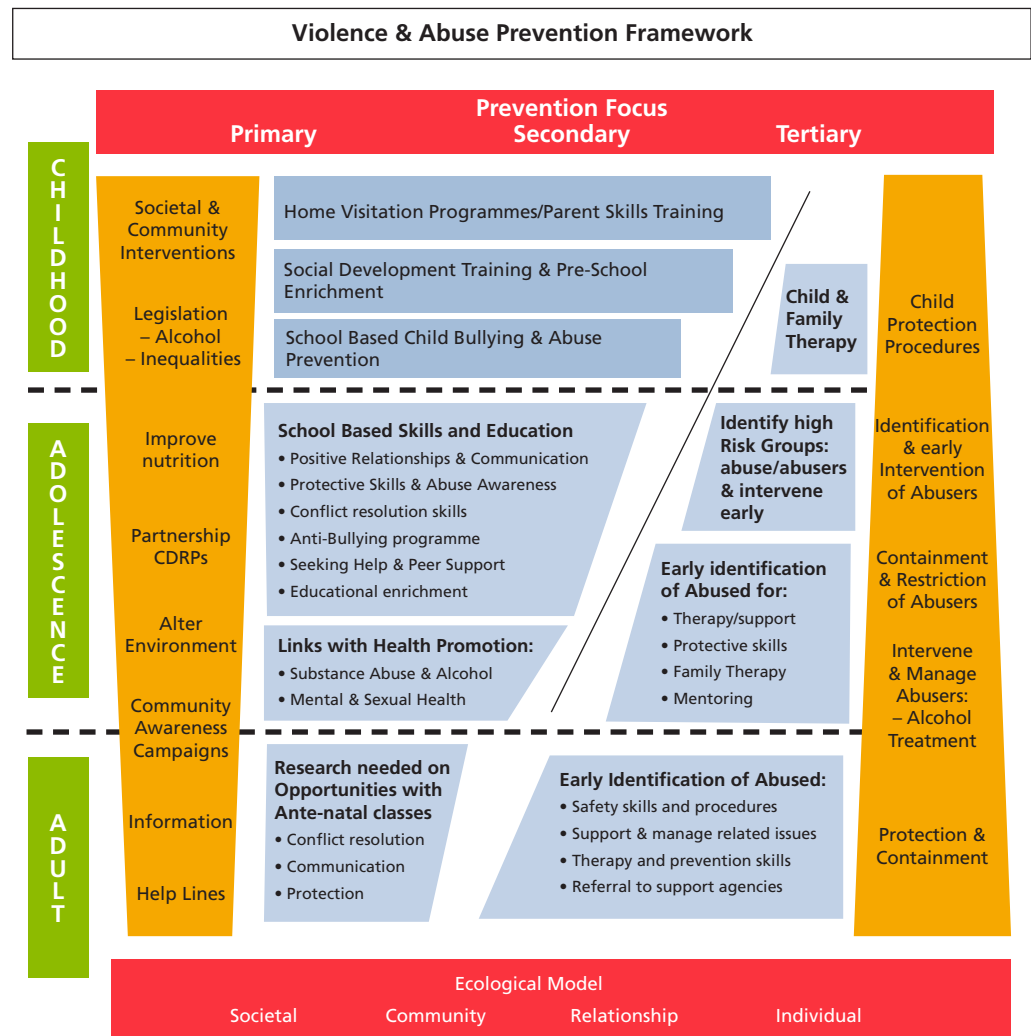


Diagram provided by South East Regional Public Health Group, Information Series 1, *Preventing violence and abuse: Creating safe and respectful lives* (2006).

Appendix 6

The police and legal profession's involvement with domestic abuse

The police

The police are a key, 24-hour agency for people experiencing domestic abuse and may be a victim's first port of call in an emergency. The police's first priority in domestic abuse cases is to ensure the safety of the victim (and their dependents) and protect them from further harm. By arresting known or current offenders, police can increase the safety of the victim and send strong messages that their actions are taken seriously and will not be tolerated.³⁰⁵ Most local forces have a specialist division – either a Community Safety Unit or a Domestic Violence Unit – specifically to deal with such cases.²⁰³ The police officers working in these units will have received training in handling cases of abuse.

As part of the National Delivery Plan for Domestic Violence the government has funded several Domestic Violence Enforcement Campaigns (DVECs) which were directed solely at improving police performance in relation to evidence gathering and enforcement and, through such efforts, to increase the number of offenders brought to justice. The conclusions drawn from the completed DVECs include that:

- all call handlers within control rooms and call centres should receive training to ensure they increase the level of detail recorded to ensure the best possible investigation
- police forces should consider deploying a dedicated domestic abuse response vehicle with domestic abuse officers
- police officers should undertake enquiries to ensure that outstanding offenders not present at crime scenes are arrested at the earliest opportunity and cases are subject to dynamic and robust, accountable management by frontline services.³⁰⁵

The Association of Chief Police Officers provides robust guidance for police officers in *Guidance on Investigating domestic abuse* (2008).³⁰⁶ These guidelines aim to provide the police service with clear information about the policing of domestic abuse by providing operational, tactical and strategic advice. The police service acknowledges the importance of multi-agency working and the guidance highlights that a police officer is responsible for informing victims of the local availability of refuges, victim support, outreach services and places of safety.

With the often violent nature of domestic abuse incidents a victim may feel no option but to involve the police through fear for their own safety. If the police are called, the victim's main motive is more likely to be to stop the abuse, rather than to prosecute the perpetrator. In an emergency anyone experiencing abuse should dial 999 and ask for 'police'. When the police are notified of an incident of domestic abuse the victim should expect them to:

- respond quickly to their call
- talk to them separately from the violent person
- arrest the perpetrator where there is sufficient evidence
- arrest the perpetrator if they have broken the terms of a court order with power of arrest or bail conditions
- arrange for medical treatment for the victim if necessary

- keep records of all incidents of domestic abuse against the victim
- help you to access other agencies
- arrange transport to a safe place if they want this.³⁰⁷

All officers whether on the telephone or at the scene of the crime must be equipped to handle initial contact with victims of domestic abuse in a professional and sympathetic manner.²⁰³

Legal profession

A solicitor can help a victim of domestic abuse understand their legal options for gaining protection against the perpetrator of the abuse. Victims of domestic abuse should be advised to approach solicitors specialised in this subject, and organisations such as Women's Aid and MALE can help recommend relevant solicitors. Victims of domestic abuse may not pursue their legal rights to protection due to the high costs often involved. Individuals on income support or family credit could be eligible for Legal Aid which covers the costs of taking the matter to court. Healthcare professionals must be aware of the service which solicitors can provide and advise patients accordingly. Once a victim has made the initial contact with the legal profession, they will have all the options explained to them about how they can put a stop to the crime they are falling victim to.²⁰³

Appendix 7

BMA President's Seminar Series Attlee Room, House of Lords, 15 January 2013

The role of health professionals in identifying and responding to domestic abuse, including child and elder abuse

Speakers

- Chaired by **Professor Sheila the Baroness Hollins of Wimbledon and Grenoside**, and President of the British Medical Association
- **Baroness Scotland of Asthal**
- **Ms Deborah Jamieson**, Chief Executive Officer, The Global Foundation for the Elimination of Domestic Violence
- **Chief Constable Carmel Napier**, Association of Chief Police Officers lead for domestic abuse, honour based violence, stalking and harassment

In attendance

- **Ms Diana Barran**, Chief Executive Officer, CAADA
- **Dr John Beer**, Chair of Action on Elder Abuse
- **Baroness Browning**
- **Dr Fiona Cornish**, President, Medical Women's Federation
- **Dr Shantanu Datta**, Chair of Consultants Committee Psychiatry Subcommittee, BMA
- **Dr Tony Delamothe**, Deputy Editor, British Medical Journal
- **Ms Mavis Dwaah**, Psychological Wellbeing Practitioner, Trust Mentoring Programme – Project Co-lead, Wandsworth Psychological Therapies & Wellbeing Service (PTWbS), South West London & St George's NHS Mental Health Trust
- **Dr Anthony Falconer**, President, Royal College of Obstetricians and Gynaecologists
- **Dr Gene Feder**, Royal College of General Practitioners
- **Mr Jeff Gardner**, Locality Director London, Victim Support National Centre
- **Mr Mark Groves**, Operations Manager, National Centre for Domestic Violence
- **Ms Marie Hanson**, Director, STORM
- **Mrs Nicky Jayesinghe**, Head of Science and Education, BMA
- **Mr William Jarvis**, Parliamentary Assistant for Robert Flello MP
- **Baroness Jolly**
- **Ms Jane Keeper**, Director of Operations, Refuge
- **Professor Averil Mansfield**, Chairman, Board of Science, BMA
- **Professor Lord McColl of Dulwich**
- **Dr Andrew McCulloch**, Chief Executive, Mental Health Foundation
- **Ms Elicia Mollineau**, Community Development Worker & BME IAPT Co-ordinator, Wandsworth Psychological Therapies & Wellbeing Service (PTWbS), South West London & St George's NHS Mental Health Trust
- **Professor Vivienne Nathanson**, Senior Director, BMA
- **Mr Robert Okunnu**, Head of Public Affairs, BMA
- **Ms Pragna Patel**, Director, Southall Black Sisters
- **Dr Mark Porter**, Chairman of Council, BMA
- **Mr George Roycroft**, Deputy Head of Science and Education, BMA
- **Ms Jo Todd**, Chief Executive Officer, RESPECT
- **Dr Kieran Walsh**, Editor, BMJ Learning

Introduction

The aim of the seminar was to discuss the role of healthcare professionals in identifying and responding to domestic abuse, including child and elder abuse. Its key focus was to understand the barriers faced by healthcare professionals, and to consider ways to develop an effective, multi-agency approach to reducing the prevalence of this major healthcare concern. In building on the 2007 BMA Board of Science report, *Domestic abuse*,^t this note explores some of the themes that emerged during the discussion. It is not intended to provide a comprehensive set of policy solutions, but to raise awareness of the many challenges in preventing domestic abuse, and to provide renewed impetus for the medical profession to respond to these challenges.

The scale of the problem

Domestic abuse occurs across the globe, affecting millions of people in all parts of society. In the UK it affects one in four women and one in six men in their lifetimes, with 89 per cent of repeat victims being women. Around 30 per cent of domestic abuse against women begins or worsens during pregnancy. In 2010/11, repeat victimisation accounted for 73 per cent of all incidents of domestic abuse. It has been estimated that half a million older people are victims of domestic (elder) abuse in the UK, and disabled individuals including individuals with intellectual disabilities can be more vulnerable to being abused. Approximately 750,000 children in the UK are affected by domestic abuse. The cost of domestic abuse to the UK taxpayer is £3.9 billion per year. There is growing evidence that abuse has severe consequences for victims and their children's long-term health. It can also lead to devastating economic impacts resulting in social exclusion, worklessness and family poverty. While there is evidence that prevalence rates of domestic abuse are higher among families in lower socioeconomic groups, it occurs across the socioeconomic spectrum. Currently, two women are murdered every week in the UK as a result of domestic abuse, with each crime costing the UK about £1million.

Progress in reducing the prevalence of domestic abuse

The work of the *Global Foundation for the Elimination of Domestic Violence* (which includes over 200 organisations representing over 85 countries) is estimated to have reached over 280 million people worldwide, and has reduced the cost of domestic abuse in the UK by £7 billion per year. According to the British Crime Survey (BCS), between 1995 and 2010/11, the total number of recorded domestic abuse incidents declined by 60 per cent. There has also been a significant decline in domestic abuse homicides, and an increase in successful prosecutions. A number of improvements (primarily in the criminal justice and voluntary sectors) have contributed to this reduction in the prevalence of domestic abuse in the UK:

- **a stronger legislative and regulatory framework** – introduction of the Domestic Violence, Crime and Victims Act 2004; development of strategies focused on violence against women; a national change in the definition of domestic abuse to include 16 and 17 year olds; systems to facilitate civil prosecutions alongside the criminal prosecution process; introduction of domestic abuse coordinator teams; pilots on domestic violence protection orders/protection notices

^t British Medical Association (2007) *Domestic abuse*. London: British Medical Association. Available at: www.bma.org.uk

- **a more cohesive approach to identifying and managing high risk victims** – training for all front line staff across the public, private and voluntary sectors (including educational initiatives for groups such as taxi drivers and locksmiths as they typically come in contact with victims); funding for Independent Domestic Violence Advisors (IDVAs); establishment of over 150 Specialist Domestic Violence Courts; improved information sharing between local public agencies via Multi-Agency Risk Assessment Conferences (MARACs) meetings
- **improved risk assessment and evaluation** – centralisation of the Sexually Violent Delinquent Child (SVDC) and MARACs systems; development of a police service domestic abuse stalking and harassment evidence-based risk assessment tool.

Despite this progress, domestic abuse continues to occur in one in 10 households at any given time, while two women per week, one man every 17 days, and an increasing number of children are murdered as a result of domestic abuse. Repeat offending and repeat victimisation are also increasing, and data from the BCS found a 35 per cent increase in reported domestic abuse incidents between 2009/10 and 2010/11. These figures are particularly concerning in light of the funding and resource cuts that are affecting the provision of frontline services and the viability of voluntary sector agencies.

Time for a shift in the approach to domestic abuse?

Across all sectors, there continues to be a significant level of unstructured investment, as well as overlapping and duplicated use of resources. This can make services very difficult to access for victims (who commonly give up trying to get help), as well as for perpetrators of domestic abuse who are trying to change their behaviour. In building on the improvements outlined in this note, there needs to be a shift from a reactive crisis management approach, to proactive detection of the early signs of domestic abuse. This will help prevent incidents escalating further, and is particularly relevant for cases of repeat victimisation and for tackling serial perpetrators. Key to achieving this shift is developing a system for holistic risk assessment in which all partner services/agencies work collectively to share information on a timely basis – round the clock multi-agency working. This will provide the ability to build up a comprehensive picture of domestic abuse incidents, and will ensure joint accountability in making decisions about when and how to intervene.

Why is the medical profession so important?

More effective multi-agency working, where the medical profession is fully engaged in a holistic risk assessment process, would significantly improve the approach to tackling domestic abuse in the UK. Healthcare professionals are in an ideal position to identify signs of domestic abuse before a 'crisis point' is reached. On average, female victims of domestic abuse are subjected to 37 beatings before they involve the police. Many of these may have come in contact with their GP long before seeking help from the police, and at a time when they have been hurt significantly less often. Data also show that only 23 per cent of domestic abuse incidents are reported to the police. A significant proportion of the victims of the other 77 per cent of incidents are likely to present to healthcare professionals (including GPs, accident and emergency doctors, obstetricians, midwives and nurses), which provides the opportunity for interventions.

How should the medical profession respond?

There are a number of key challenges for the medical profession:

- **Training** – do all healthcare professionals feel confident in identifying and providing appropriate support for the victims and perpetrators of domestic abuse? Anecdotal evidence suggests many are unsure about getting involved, and have concerns about when it is appropriate to breach a patient's confidentiality. Is there a need for more specialists in domestic abuse in the healthcare setting? Do they know how to ask questions and the circumstances in which asking questions or considering domestic abuse is especially important?
- **Raising awareness** – female victims of domestic abuse typically see a healthcare professional (in particular their GP) long before a 'crisis point' has been reached. How can awareness about this opportunity for early intervention be improved?
- **Supporting vulnerable groups** – how best can the needs of vulnerable adults (including disabled people and people with intellectual disabilities) who are victims of domestic abuse be met? What improvements are needed for the care of older people affected by domestic abuse?
- **Developing best practice** – there is a poor evidence base for interventions to identify and manage domestic abuse in the healthcare setting. What opportunities are there to develop and share best practice? What are the key research needs?
- **Referral services** – how can the provision of local support services for victims and perpetrators be improved? How can the impact of funding and resource cuts be minimised?
- **Collecting and sharing data** – effective multi-agency working will require robust systems to collect, record and share data for patients identified as victims or perpetrators of domestic abuse, as well as agreement on the type of data to be recorded.
- **Responsive service provision** – when domestic abuse incidents typically peak (over weekends and on bank holidays), the support available to victims is restricted to the emergency services and voluntary sector charities. This limits the ability to support victims, as well as the collection of real-time data. How can mainstream healthcare services for domestic abuse victims be better provided at the time of demand and need?
- **Practical considerations** – speaking to patients away from any partner or family member is of paramount importance in being able to discuss any potential domestic abuse incidents. This can be extremely difficult in practice, in particular with female patients. How can healthcare professionals be supported with this?

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