Responding to Domestic Abuse in Sexual Health Settings

BASHH Sexual Violence Group
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SUMMARY

Patients experiencing domestic abuse (DA) commonly present in sexual health services and NICE recommends **routine enquiry**[5] (i.e. asking all patients about the experience of DA, regardless of any visible signs of abuse) to identify DA within these services.

Alternative approaches include **case-based enquiry** (i.e. asking all patients with risk indicators e.g. un-explained injuries, depression) or **targeted enquiry** (i.e. asking specific patient cohorts e.g. under 18s, commercial sex workers). The BASHH Sexual Violence group has produced this document to support sexual health services who want to introduce DA enquiry.

Whatever identification approach is used, it is crucial that enquiry and management of a disclosure is carried out safely. This necessitates departmental guidelines, a DA proforma, management flow chart with clear referral pathways to relevant services and role-appropriate initial DA training for staff with training updates and ongoing support and supervision.

The **enquiry process** follows 4 steps: **ASK> VALIDATE> ASSESS> ACTION**

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1. **ASK:**
   - Provide written **patient information leaflets**
   - Explain **confidentiality limitations** at outset of consultation
   - Ensure **quiet and confidential space** where **no-one >18 months old** in room and a **professional, independent interpreter/language line** is used, if needed
   - Give a **normalising statement** to introduce the topic of DA
   - **Ask the question** about whether they have ever experienced DA

IF the patient discloses DA:

2. **VALIDATE:** with messages of reassurance
3. **ASSESS:** using a proforma to capture key information quickly and identify immediacy of risk

IF **risk historical (>3/12)** offer referrals to relevant services + provide support agencies details

IF **risk current/ongoing** (i.e. within 3 months or risk something could happen again) refer patient to health adviser (HA), or Independent Domestic Violence Advisor (IDVA), if available, for a detailed risk assessment e.g. Co-ordinated Action Against DA, DA Stalking + Honour based violence risk assessment (CAADA DASH)

4. **ACTION:**

The HA or IDVA will make onward referrals including Multi-agency risk assessment conferences (MARAC) and child and/or adult safeguarding referrals, if indicated, following local guidelines.

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1. Introduction:

Domestic Abuse is defined as:

Key point 1
'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. The abuse can encompass psychological, physical, sexual, financial or emotional as well as stalking and harassment. Domestic abuse (DA) also includes so called honour-based crimes, female genital mutilation and forced marriages.'[1]

In March 2015 the serious crime act was amended to include the offence of DA as a criminal act in its own right[2].

Key point 2
DA remains the leading cause of morbidity in 19-44 year old women worldwide, greater than cancer, war and car accidents.[3] Two women, on average, are killed per week by a partner or ex-partner in the UK[4].

A number of national guidance documents cover DA:

Key point 3
The **Department of Health (DH)** DA handbook for health professionals states **'all Trusts should be working towards routine enquiry'** 'intervention by health care professionals may help stop further abuse'[4] The **National Institute for Health and Care Excellence (NICE)** 2014 DA guidance explicitly states **'routine enquiry is recommended in sexual health services'**.[5]

This document has been compiled to help Sexual Health Services (SHS) who are considering introducing DA enquiry. It provides evidence on the prevalence, vulnerability factors and potential consequences of DA, both on the individual and society and provides tools to simplify the implementation of DA enquiry. The authors of this document are aware that a number of readers may have been affected by DA. Help and support is available for you and your patients via the 24 hour national domestic violence helpline on 0808 2000 247 http://www.nationaldomesticviolencehelpline.org.uk/.

2A. Background

Key point 4
DA is a huge public health issue with high prevalence rates worldwide and wide-reaching consequences.

Under-reporting of DA is a big problem, with barriers to reporting including a fear of causing family breakdown, fear for their own or children's safety if they do report, feeling ashamed and/or responsible and a fear of not being believed[6].

Despite under-reporting the United Kingdom has significant rates of domestic abuse.

Key point 5 [7]
Over a quarter of women (28.3%) and nearly a sixth of men (14.7%) have experienced DA since aged 16, in England and Wales with an incidence of 8.5% of women and 4.5% of men affected in a 1 year period. In Scotland, 17% women and 10% of men report partner abuse since aged 16[8].

2B. List of risk factors and vulnerable groups (See Appendices 2 + 3)

Any person can be subject to DA, regardless of race, ethnicity or religious group, class, sexual orientation, disability or lifestyle. DA however disproportionally affects certain vulnerable groups, who may be less likely to access help. These are listed in Table 1 with more details in Appendix 2.

Table 1: Vulnerable groups and vulnerability factors [9 10 11]

- Women, particularly if
  - → under 24 years old
  - → cohabiting with partners
  - → living at home with children
  - → pregnant (30% of DA starts during pregnancy and DA is associated with poor pregnancy outcomes)
  - → has a disability (up to 50% disabled women experience DA)
- Young people and the elderly
- Lesbian, bisexual, gay and transgender
- People living with HIV/AIDS and sexual health service users
- Substance misusers
- People with mental health issues
- Language difficulties

- Those with a learning disability
- A person with a long term health condition
- Those from a black or a minority ethnic group (BME)
- Unemployed and homeless people
- Refugees or those with no recourse to public funds

3A. Potential medical and psychosocial consequences of DA (Tables 2+3)

DA has a significant impact on the health and well-being of survivors and their children, both in the immediate and longer term and is the leading cause of morbidity and mortality for women of childbearing age.[12,14]

Table 2: Physical Health consequences of DA [13 14 15 16 17]

- Death
- Injuries
- General health problems
  - → chronic pain syndromes
  - → gastrointestinal complaints e.g. IBS
  - → CNS complaints (e.g. migraines, hearing loss, cognitive problems)
  - → Recurrent UTIs
- Reproductive and Genitourinary Medicine (GUM) problems
  - → increased sexual risk behaviours including earlier coitarche, increased numbers of sexual partners, sex work
  - → increased rates of sexually transmitted infections (STIs) (related to non consensual sex, difficulty negotiating safe sex)
  - → menstrual irregularities
  - → chronic pelvic pain and endometriosis
  - → sexual function problems
  - → cervical neoplasia
  - → unintended pregnancies (due to perpetrator contraceptive control, forced non-condom use, non-consensual sex)
  - → poor pregnancy outcomes (e.g. low birth weight, premature labour, still birth, maternal mortality, recurrent miscarriages, repeat terminations)
  - → increased HIV acquisition risk and poor HIV health outcomes

Death

Each year since 1995, approximately half of all women, aged 16 or older, murdered in England and Wales were killed by their current partner or ex-partner[4,18]. The 2003-2005 review of maternal deaths in the UK demonstrated that 70 of the 295 maternal deaths of all causes had features of DA[19]. Around 12% of men murdered each year from 1995 were killed by their partner or ex-partner.[20, 21]

The death toll due to DA includes not only homicides but suicides and other indirect deaths linked to the consequence of DA such as street homelessness and ill-health, as well as the miscarriage and foetal deaths resulting from assault trauma.[22, 23, 24]

Injuries

Traumatic injury, particularly if repeated and with vague or implausible explanations, is a recognised clinical condition associated with DA.[25] Injuries vary from minor abrasions to life threatening trauma. An injury resulting from DA is more than 20 fold more likely to involve trauma to the head, face and neck[26] with multiple facial injuries suggestive of DA rather than other causes. Blunt force trauma to the forearms should also raise suspicion of DA suggesting defence wounds[26].

Key point 6
The absence of traumatic or physical injury does not exclude or minimise DA. Serious DA can occur in the absence of any physical injury.

General Health

Studies looking at women experiencing DA have shown that they are more likely to seek health care than non-abused women, even if they do not disclose the violence,[27] with higher rates of chronic physical conditions seen in women who have experienced DA.

A health care professional (HCP) is often the first contact for survivors of DA, and women living with DA identify health-care providers as the professionals they would most trust with disclosure of abuse.[28, 29]

Reproductive and Genitourinary (GUM) problems

Gynaecological problems are the most consistent and long lasting physical health difference between DA survivors and other women (see Table 2).

Key point 7
In a GUM setting, frequent attenders with vague symptoms and no diagnosed conditions may be experiencing DA.

Mental Health Consequences (see Table 3)

Key point 8
The psychological consequences of DA can be as serious as the physical effects.

Mental health plays an important role in DA both in terms of cause and effect: women who have experienced DA are almost twice as likely to experience depression and misuse alcohol[24] and the risk of experiencing DA is increased if someone has a mental health problem.[25]

Table 3: Mental Health issues associated with the experience of DA [30, 31, 32,33]
• Depression • Post-Traumatic Stress Disorder • Low self esteem • Anxiety • Suicide • Substance misuse • Sleeping difficulties • Eating disorders • Psychosis

Intergenerational impact

DA between parents is the most frequently reported form of trauma for children[34] having an impact on the child's mental, emotional and psychological health as well as their social and educational development. [35] It can also affect their likelihood of experiencing and becoming a perpetrator of DA as an adult, as well as exposing them directly to physical harm.[36, 37] There is a strong association between DA and other forms of child maltreatment.[38]

3B. Financial cost of domestic abuse

DA has been estimated to cost the UK £15.7 billion[39] which includes costs to the criminal justice system, civil legal services, health and social care, housing and loss of earnings as well as the human and emotional costs.

Key point 9 [40, 41]
Estimated cost of DA to the UK overall: £15.7 billion. Estimated direct cost of DA to health services: £1.7 billion. NICE 2014 DA guidelines state '**even marginally effective interventions are cost effective**'.[42]

4. Identification of domestic abuse

Identifying DA enables referrals to DA/safeguarding services that can support survivors and provide interventions that may lead to reduced morbidity and mortality for all those affected or who may be at risk.

Key point 10
There are a number of ways health care professionals can identify DA. **Whichever identification method is used it is essential that there are clear departmental guidelines with clear referral pathways to appropriate services and regular staff training.**

A. No enquiry i.e. spontaneous disclosure

The patient discloses their DA experience, unprompted. Studies have shown that this is very rare[43] Table 4 illustrates the pros and cons of DA enquiry, whichever method is used.

Table 4 Pros and cons of DA enquiry (targeted, case-based and routine enquiry)

Pros of DA enquiry whichever approach:

- Gives patients permission to discuss a perceived 'off limits' topic.
- Makes survivors feel less isolated because realise others are also affected.
- Will increase the number of disclosures and enable referrals to appropriate services for

support, hopefully resulting in a reduction in harm to those affected.

- May help improve new:follow-up ratios by identifying DA as the root cause of repeat attendances. Hospital-based domestic violence interventions may reduce healthcare costs by at least 20%.[44]

- Leads to positive working relationship in terms of forging closer links with statutory and non-statutory organisations.

Cons of DA enquiry whichever approach:

- If enquiry is not made sensitively and disclosures are not responded to correctly e.g. by giving wrong information can do more harm than good.

- Potential service impact as management of a disclosure of current DA can be time-consuming if patient high risk or if child/adult safeguarding issues identified when immediate action needs to be taken.

- Staff discomfort asking about DA, uncertainty about how to respond to disclosures and lack of knowledge about correct management and referrals.

- A lack of appropriate, accessible support either within the clinic or from other services e.g. if patient needs immediate support or if has specific needs and specialist service not available e.g. transgender.

- Impact on staff emotional wellbeing as disclosures can be distressing (need supervision and support for staff).

- Need to have secure method of documentation and having an alert system so information is accessible when patient re-attends.

B. Targeted enquiry

Specific patient groups are asked about whether they have experienced DA e.g. many SHS carry out targeted DA enquiry in under-18s, as part of screening for signs of child sexual exploitation, or in those working in the sex industry.

Table 5 Pros and cons of Targeted DA enquiry

Pros of targeted DA enquiry

- Those with recognised risk factors are screened

Cons of DA enquiry whichever approach:

- This method does not identify those who don't fit the target criteria

C. Case-based / indicator-based enquiry (see Table 6 and Appendix 4)

All patients with risk indicators (see Appendix 3) are asked about DA, for example, if a patient has injuries consistent with non-accidental injury.

Table 6 Case-based / indicator-based enquiry: pros and cons

Pros of case-based screening for DA:

- Better identification rate by targeting only those with risk indicators
- Saves time as not all patients are asked about their experience of DA
- Makes patient feel like you are being attentive to their situation
- Raises DA awareness in those asked about DA and normalises the topic

Cons of case-based screening for DA:

- Relies on staff being aware of all the risk indicators (see Appendix 3) and alert to the more subtle signs and to be proactive when these are recognised if this enquiry approach is to be effective
- May make patients feel stereotyped
- Potential for missing window of opportunity to reduce harm

D. Routine Enquiry: (see Table 7 and Appendix 5)

Routine enquiry defined as 'asking all patients about the experience of DA, regardless of any visible signs of abuse'.[45]

Routine DA enquiry was introduced in all GU services in Scotland from 2008 as well as a number of maternity, A+E and SHS services in England and Wales.

Table 7: Routine enquiry: pros and cons

Pros of routine screening for DA:

- Normalises the subject matter
- Patients don't feel stereotyped as no-one being specifically targeted
- Demonstrates that we are caring from them as a whole person
- Patients say they want to be asked routinely + directly
- Takes the 'guesswork' out of it – i.e. no need to look for risk indicators

- Reduced risk that window of opportunity to ask DA survivors will be missed

Cons of routine screening for DA:

- Cost and time implications of asking everyone

Interestingly, a study in GP practices in Bristol showed that just 5% of females and 3% of males had ever been asked about DA by their GP when case-based enquiry had been practiced. In studies among GPs who have implemented routine enquiry, doctors are often surprised by who discloses DA, as survivors often do not conform to their stereotypes[46].

This evidence suggests perhaps that case based enquiry may not be the most effective approach and perhaps routine enquiry may be the way forward. However, whichever approach a service chooses to take it is essential that DA enquiry is carried out safely.

Key Point 11 - Safe DA enquiry requirements to ensure disclosures managed sensitively and effectively

- Training (lasting more than 1 day) with regular training updates + supervision
- Departmental guidelines
- DA proforma for contemporaneous and accurate documentation
- Management flow chart and clear referral pathways to DA services

5. How to approach the topic of DA (see also Appendix 6)

Key point 12 – Your Role

A. Ask
B. Validate
C. Assess
D. Action

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A. ASK

a) Provision of written patient information leaflets including information on local, national and specialist support organisations. These need to be available in all waiting areas, within clinic rooms and in toilets where information posters with tear off slips are useful.

b) Confidentiality limitations explained at the outset of the consultation, in case an adult or child safeguarding referral needs to be made for example saying

`Everything you tell us today is confidential unless you tell me something that worries me about your safety, or the safety of another individual, at which point I might need to discuss this with another professional in order to keep you safe'.

Note that an adult can decline an adult safeguarding referrals if they have capacity, and there are no others (e.g. children) at risk. If however a child is involved child safeguarding policies **must** be adhered to.

c) Introduce subject of DA in a safe and sensitive manner

- Ensure that it is a **quiet and confidential space** where there is **no-one accompanying the patient who is over the age of 18 months.**[47]
- If the patient is not able to speak English a **professional, independent interpreter or language line** must be used as it is not appropriate to use a friend or family member to interpret, particularly when asking about DA.

If these criteria are met then it is safe to:

d) Give a normalising statement to introduce the topic of DA, for example:

"We know that domestic abuse affect many people, so it is now our policy to ask all our patients about this…".

e) Ask the question about whether they have ever experienced DA, for example:

'Have you ever been physically hurt or made to feel afraid by someone close to you?'

See Appendix 6 for alternative DA enquiry questions.

B. VALIDATE

If the patient discloses DA:

f) Give messages of reassurance:

(1) You have the right to live free from violence and abuse

(2) Abuse is not your fault

(3) You are not alone

(4) We can help you find support

C. ASSESS (see Appendices 6, 7, 8, 9, and 10)

Key point 13
Poor responses can jeopardise women's safety and can lead to re-victimization or feelings of hopelessness.[48]

a) Make patient feel safe and supported
b) Be clear about what is available in terms of immediate and ongoing support
c) Have a robust and clear management flowchart (see Appendix 7) developed in line with the trust policies, and following discussions with adult/child safeguarding teams
d) Have clear referral pathways with other relevant services, particularly out-of-hours, and forge close links with these
e) Ensure clear, accurate and contemporaneous documentation ideally using a short DA proforma (see Appendix 8). Notes should be dated, timed and signed on every page and patient informed that documentation may be requested if there is a police investigation
f) Assess whether there is current (last episode of DA within 3 months) or on-going risk (last episode > 3/12 ago but survivor concerned something could happen again? e.g. perpetrator moving back to their area/ child contact etc) or whether historical abuse (last episode >3/12 ago) (see Appendix 8).

If historical abuse (>3/12)

Offer referrals to DA organisations/mental health services/ GPs

Provide list of support agencies and barcode sticker (or similar) with 24-hr national DA helpline number (see Appendix 11).

Contact the 24-hour National DV helpline on **0808 2000 247** www.nationaldomesticviolencehelpline.org.uk or Womens Aid www.womensaid.org.uk for further information on local/specialist DA services and for patient information leaflets

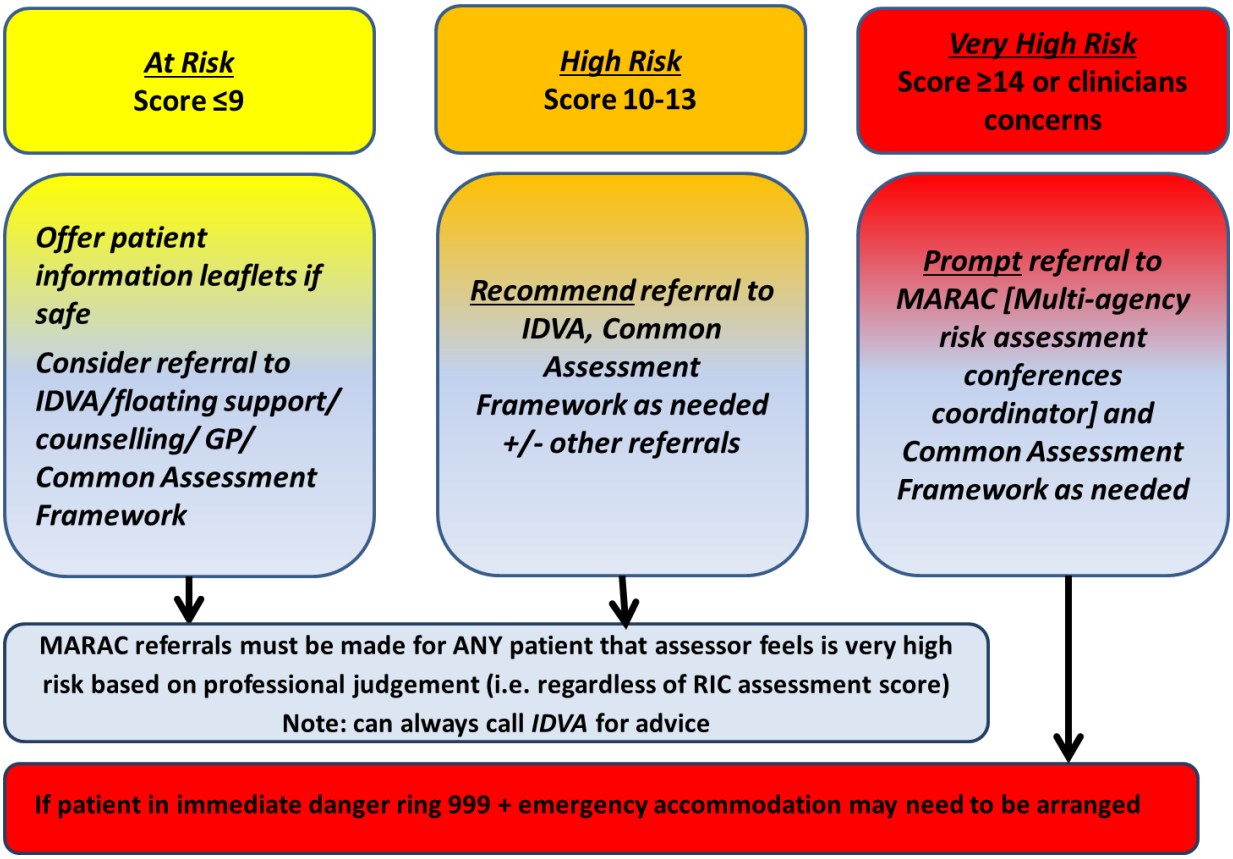
If current or on-going risk

Complete a risk assessment such as the Co-ordinated Action Against Domestic Abuse Domestic Abuse Stalking and Honour based violence risk assessment (CAADA DASH) form (Refer to www.caada.org.uk for detailed advice on how to complete and make referrals and see Appendix 9) either by the SHS team member or by an Independent Domestic Violence Advisor (IDVA), if one is available.

Key point 14
Risk in domestic abuse situations is dynamic and can change very quickly. As and when things change the risk assessment must be re-visited and reviewed[49]

The CAADA DASH assessment (Appendix 9) is a checklist of 24 questions used by all police services for identifying and assessing risk in DA cases and is based on evidence from Domestic Homicide Reviews as to what the risk indicators are of further assault and risk of homicide. Use of a standardised scoring of risk helps identify what actions should take place. The patient is scored out of 24 and an action plan is followed based on this as follows:

D. ACTION



Multi-agency risk assessment conferences (MARAC) (See Appendix 10 for an example of a MARAC referral form) and IDVA referrals are made to the services covering the patient's residential borough.

Key point 15
Note that if a MARAC referral is made this does not mean immediate response, as MARACs only happen monthly. **If the patient is at risk of death/severe injury then the case should be reported immediately to the police.**

If the patient has vulnerabilities that require an adult safeguarding referral - follow your Trust/departmental adult safeguarding procedures.

If there are children affected/living within the home, a child safeguarding referral will need to be made – follow your local child protection policies and procedures.

If referrals to social care are indicated the HCP should focus on referrals being a supportive measure not a punitive one and that the DA survivor feels supported and empowered, as loss of power and control is a key tactic used by perpetrators.

If possible, arrange a follow-up appointment at the SHS with an HA, or another clinical DA champion if an HA is not available, for support and to ensure that contact has been made by DA organisations or other services, if referrals made.

6. Allocation of roles within the department

In order to minimise the impact on the service it is suggested that once a DA has been disclosed, the patient is referred to a Health adviser (HA), or IDVA if available, only once all medical examinations/tests are completed. The HA or IDVA completes the CAADA DASH and makes onward referrals, if indicated. It may be helpful to nominate DA champions who could receive more in-depth DA training providing support to staff, to discuss cases that do not fulfil CAADA DASH assessment criteria.

7. Staff training, support and supervision (see Appendix 1)

Safe management of DA disclosure, by whichever means of enquiry, requires staff training, regular training updates and supervision with different levels of training depending on the HCPs role. For example, basic training for all staff, including receptionists, which can be carried out by experienced staff, with detailed training for HAs and DA Champions, which may require involvement from a local DA service).

APPENDICES Page

Appendix 1 – Training, Supervision and support for staff

Tiered raining

1. What type of training and how frequently should this be?

We would recommend the following training for all staff:

e-learning modules on DA (as well as modules on sexual violence)

plus

Mandatory adult and child (Level 1-3 commensurate with role) safeguarding training

and familiarity with Trust adult and child safeguarding policies

plus either

Basic team training for all staff (admin, HCAs, nurses, doctors) with annual update

or

In-depth DA training for Health advisers and DA champions – lasting one day with annual updates

Additional specific training to consider in forced marriage, so called 'honour based' abuse and Female Genital Mutilation (FGM).

2. What should the training include?

- Details on the psychology of DA, the types of abuse, vulnerability factors, risk indicators and the impact of DA on children.
- How to ensure it is safe to ask the questions and tactics for getting to see the patient alone.
- How to introduce the topic of DA.
- How to ask the questions (direct and indirect).
- How to respond to a disclosure in terms of reassurance, what the next steps are, knowing what services are available and how to refer to these.

More in-depth training for HAs and DA champions should be provided on how to complete a CAADA DASH (which helps decide what referrals are needed and how quickly these need to be made), how to make IDVA and MARAC referrals.

3. Who can provide the training?

Safeguarding leads within health organisations provide an introduction as part of the adult/child safeguarding training.

Cascade training/information sessions by sexual health practitioners with a special interest in this field could be an option. Some centres have trained a DA lead within their department who provides training to the rest of the staff and is the 'go-to' person which has worked with excellent outcomes.

DA trainers providing training for HAs and DA champions need to have more specialists training and it would be beneficial to involve a DA organisation in the in-depth training. Involvement of police in training may also be considered.

Support for staff on a day-to-day basis

On a day to day basis in clinic it is useful for staff to be able to discuss cases with a senior practitioner contemporaneously, to ensure the patient is managed appropriately. This can be those who have received the in-depth DA training (such as HAs and DA champions) or departmental safeguarding lead. In addition, the Named Nurse for safeguarding adults/children will also provide support, guidance and supervision to staff.

Safeguarding Supervision:

1. *What is safeguarding supervision?*

Domestic abuse disclosures can be complex to manage. It may affect the emotional health and well-being of staff working within the sexual health setting. Safeguarding supervision can help restore and maintain the emotional well-being of the workforce providing a supportive ear from someone of the staff members choosing. In the Boorman review[50] it is recommended that the NHS develop strategies for managing the health and wellbeing of the workforce. The purpose of safeguarding supervision is to create a time and space for learning from experience, allow reflection, connect learning and actions and form strategies to enhance good practice. Safeguarding supervision is a formal process that aids professional development. It is not clinical supervision and it is not performance management. The focus is on support through reflective learning and development led by the supervisee and facilitated by the supervisor.

2. *Types of Safeguarding supervision*

Safeguarding supervision can be provided in a variety of ways; in a peer group, mixed discipline group, one to one planned sessions and ad hoc one to one sessions.

3. *Who can facilitate safeguarding supervision and what is the process?*

Supervision is facilitated by a safeguarding supervisor who must have the relevant knowledge of adult and child safeguarding policy and procedures. Safeguarding supervision is a formal process and requires a contract of agreement between the supervisor and supervisee. It is important to note, that supervision pertaining to safeguarding individual adults or children needs to be documented along with any agreed actions or outcomes within the patient records[51,52] and the supervisee will be responsible for completing the agreed actions. All forms of supervision records could be called upon as evidence in serious case reviews or if the need arises in other legal matters.

In some organisations safeguarding supervision is mandatory and in others it is suggested good practice. It may be that all staff access safeguarding supervision at a minimum once a year and if required more often this can be negotiated with the supervisor/ safeguarding team.

It is recommended that the required frequency and style of supervision sessions for the service is established at the outset and is included in the individual organisation's guidance on the management of domestic abuse.

Appendix 2 - Details of vulnerable groups

Women

DA is mostly men to women with the overwhelming majority of perpetrators being male, with studies demonstrating up to 97% of all DA incidents are carried out by male perpetrators[53]. Studies looking at the general population have shown nearly a sixth of men have been subject to DA at some point since the age of 16 compared to over a quarter of women[54]. Not only are women more likely to experience DA, but, they are also more likely to experience more severe violence, be seriously injured, experience repeated events and experience more than one type of DA. Approximately half of female homicides each year in England and Wales were perpetrated by their partner or ex-partner[55].

Key point 16
The World Health Organisation estimates that 1 in 3 women experience violence globally[56].

Young People

In 2012, the Home Office definition of domestic violence and abuse was widened to include those aged 16-17 following the 2011/12 Crime Survey for England and Wales[57] self-completion module which found that those aged 16 to 19 were more likely to suffer partner abuse in the last year than any other age range. DA is perhaps even more under-reported in young people as it has been suggested they may be more accepting of this form of behaviour than adults and they may not be able to access mainstream support services.

Lesbian, bisexual, gay and transgender people

Women-who-have-sex-with-women have similar prevalence rates of DA to the female heterosexual population (1 in 4), although a third of these experiences relate to male perpetrators.

Much higher rates are seen among men-who-have-sex-with-men (MSM) half of whom have been subjected to DA[58] and even higher rates still among the transgender population where up to 80% have experienced DA in their lifetime.[59] LGBT people may be less likely to report to police because of fears of prejudice, being judged or revealing sexual/gender identities.[60]

Women living with HIV

DA increases the risk of acquiring HIV (1.5 x increased risk of acquiring HIV among women who experience DA[61]) and HIV is a risk factor for experiencing abuse (for example after disclosure of status). A WHO global survey of women living with HIV showed that 89% experienced gender-based violence and a UK study showed 52% had experience intimate partner violence.[62] Women may be less likely to access healthcare due to the dual stigmas of HIV and DA.

Men

Around 1 in 6 men in the UK report having experienced some form of DA since the age of 16 with around 12% of male homicides each year being perpetrated by their partner or ex-partner.[63] Men are however less likely to report abuse to the police, and this may because they consider it too trivial or they are worried about being judged or not believed.[64, 65]

Sexual health service attenders

DA also results in a 3x increased risk of acquiring other STIs[66] (due to loss of sexual decision making capacity[67]) and poor sexual health outcomes (due to difficulties disclosing an STI, complying with medication, or attending follow up appointments[68]). An anonymous DA prevalence study within a central London GUM service demonstrated much higher rates of DA in female GUM attendees with 46.6% reporting a lifetime experience.[68]

Substance misusers

Substance misuse is a well-documented risk indicator for DA[69] and may either be a cause of, or a consequence of, DA[70]. It is therefore imperative that identifying victims of abuse also includes recognising underlying substance dependence in order that signposting to relevant support agencies can take place.

Elderly

Abuse of the elderly is recognised as a common yet under-studied and under-reported problem. The reported prevalence amongst European studies varies significantly, depending on definition, between 2.2% and 61%.[71,72,73] Risk factors for abuse include social isolation, physical disability and cognitive impairment.

Other risk groups

- People with mental health issues (see Section 3A/ Table 3 for more details)
- People with no recourse to public funds.
- Language difficulties.
- Those with a learning disability
- A person with a long term health condition
- Those from a black or minority ethnic group
- Those unemployed, homeless
- Refugees or those with no recourse to public funds

Appendix 3 – Risk indicators for domestic abuse

PHYSICAL

- Traumatic injuries with vague or implausible explanations
- Old injuries, multiple injuries at different stages of healing
- Bruises, abrasions, bite marks, strangulation, old injuries, nasal fractures, burns,
- Head/face/neck injuries
- Injuries to abdomen, genitals, chest or defence wounds on forearms
- STIs including HIV / recurrent STIs, recurrent UTIs
- Unwanted pregnancies, repeated miscarriages and terminations
- Gynaecological problems including chronic pelvic pain, sexual function issues

EMOTIONAL

- Depression and anxiety, eating disorders, sleep disturbance
- Post-traumatic stress disorder
- Suicidal ideation or attempts, deliberate self harm
- Substance misuse
- Feelings of dependency, reports of isolation from family/friends
- Anger, guilt, loss of hope, shame, loss of confidence / self esteem

BEHAVIOURAL

- Repeat attenders/ frequently missed appointments
- Repeated attendances for emergency contraception
- Vague complaints or symptoms
- Minimising or hiding injuries
- Non-compliance with treatment or advice

SIGNS OF CONTROL

- Reluctant/ afraid to speak in front of partner or family member
- Aggressive/dominant partner or family member (speaks for patient, refuses to leave room, always at appointments)
- Perpetrator asserting contraceptive control

Appendix 4 Case studies–CASE/RISK INDICATOR-BASED ENQUIRY

Case 1: Shimla, a 19 y/o Ghanaian pregnant woman, has recently had an arranged marriage and arrived in the UK. She is accompanied by her mother-in-law who does all the talking telling you to sort Shimla out 'down there'. She insists being present during the examination when it is noticed that Shimla has undergone a recent type 3 FGM with associated inflammation and infection and bruising on her inner thighs. The mother-in-law is asked to leave the consultation room, which she is reluctant to do. Once alone, the Doctor asks Shimla whether anyone close to her had harmed her or made her feel afraid. She discloses that she was forced to have FGM recently and has been verbally and physically abused by her husband and his family.

Learning point: All patients should be seen both during the initial consultation and during examination by themselves. If there are language difficulties a professional, independent medical interpreter should be arranged.

Case 2: Katerina is 20 from Azerbaijan and attends the SHS every 3 months with her male partner. He always attends the appointments as she has limited English and he translates for her. She is worried she has HIV but he keeps telling her to be quiet. The doctor tells the partner he will use a medical interpreting service and asks him to wait in the waiting room. Whilst in the consultation he keeps texting her and he even knocks on the door to ask what is taking so long. You ask her if anyone close to her has harmed her or made her feel afraid and she breaks down and tells you that he beats her and makes her have sex with other men for money. He is the third man she has been sold to. **Learning point**: As for Case 1

Case 3: Tina is a nurse and a regular visitor to clinic. She is usually chatty and upbeat. Today, she has come for a cervical screen today but seems anxious and subdued and says she is not sleeping well. You ask her how things are at home and with her new relationship and she tells you that Joanne is a 'control freak' and takes all her money, won't let her see her friends or family, has stopped her going to night school and forces her to take cocaine with her

Learning point: Where there is unconfirmed concerns by staff in a consultation, continuity of care can support a future safe disclosure. Consider documenting on nature of demeanour to highlight any changes.

Appendix 5 Case study – ROUTINE ENQUIRY

Case 1: A 36 y/o lawyer attends for an asymptomatic STI screen. He tells you he has just come out of a 2 year relationship with a male partner after discovering his partner has been having unprotected sex with other men in local saunas.

Client becomes upset when asking routine questions about DA. Client is a pharmacist and unable to attend work at the moment due to anxiety attributed to stalking by ex-partner. Client changed locks and blocked calls however ex keeps attending his flat and parking opposite the flat. One occasion he was waiting outside the front door of the third floor flat having been let into main front door by a neighbour who recognised him. The ex-partner physically assaulted him forcing his way into the flat. The client is anxious, every time he returns home, that his ex-partner will be waiting for him by his front door.

He has not reported to the police.

Learning point: Stalking and threat to kill by ex partner, 50% succeed[74]. Change in the legislation re stalking in 2012[75]

Case 2: A 24 year old woman attends for ongoing contraceptive supplies and cytology. On routine DA questioning she discloses that she has not been in a relationship for 6 months saying she is 'well out of that one'. She describes her partner becoming emotionally abusive and possessive. Felt able to end the relationship – has a five year old child from a previous relationship and concerned about impact increasing arguments having. Ex reacted badly and continues to 'pester her' by text and she feels the situation is getting worse not better.

Client making light of the situation and trying to laugh his persistence off however when asked if she is concerned his behaviour might escalate she tells you that she has heard he has been abusive to previous partners though unaware of this before she left him. She has heard he has served time in prison for assault of a previous partner – anxious that he might return. She plans to call her brother who lives nearby if he ever turned up at the door. Her brother has called him previously and told him to back off or they would call the police. She has not contacted police yet.

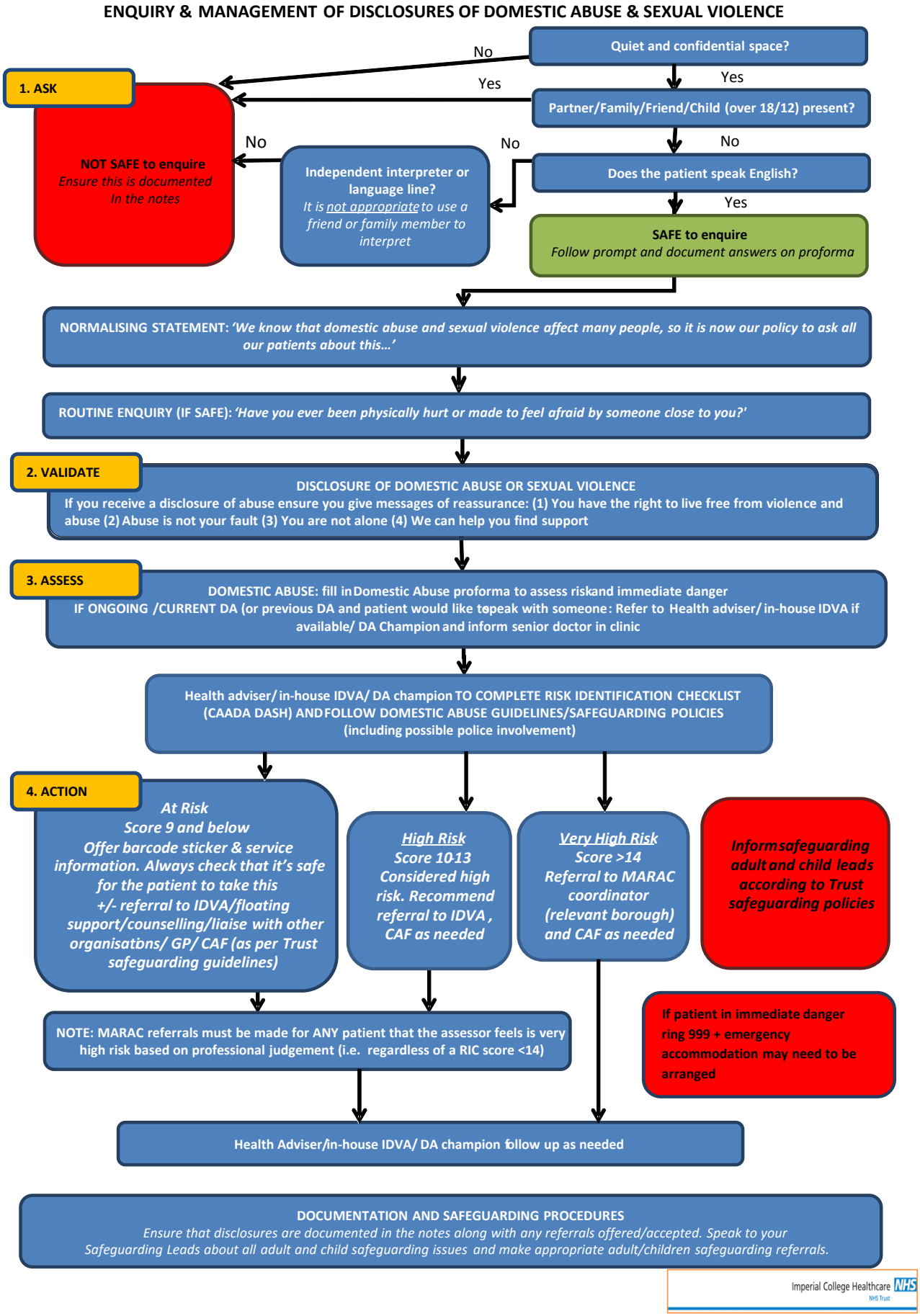
Learning point: As there is a child involved, a safeguarding children's referral is made with the patient's consent as well as appropriate referrals for the woman.

Appendix 6 Alternative ways to introduce the topic of DA

Questions need to be simple, straight forward, easy to understand and non-judgmental

- Have you ever been hurt or threatened by someone close to you?
- Are you frightened or fearful of anyone in your home?
- Have you recently been emotionally, verbally or physically hurt by someone close to you?
- Are you at risk of violence or abuse from anyone close to you?
- Are you able to tell me how you got those marks/injuries? Why?
- Are you afraid of anyone close to you?

Appendix 7 - Management flow chart



PATIENT ID LABEL

Appendix 8

Imperial College Healthcare NHS Trust

DOMESTIC ABUSE PROFORMA

Date: **Seen by:** **Designation:**

Confirm patient details ☐ ***and document safe contact mobile 'phone number:*** .....
Is it safe to call on this number ***YES / NO***
What time/s is it safe to call on this number? .....
Can we leave a discrete voicemail? ***YES / NO***
Explain to patient that call will be a private/withheld number ☐

Who is it that (…you are frightened of / is hurting you / etc) ? Name/relationship to patient?.....
.....

2. Can you tell me what has happened? (last and worst episode) .....
.....

3. When did this last **happen?** .....

4. *Have you had any support?* YES / NO ***If YES,*** *please provide details if possible*:

.....

5. Do you have any children*?* YES / NO ***If YES****, have they ever witnessed the abuse, been in the house when this has occurred or have they in some other way been affected by it? Please provide details:*

.....

.....

-If Domestic Abuse within the last 3 months go to IMMEDIATE ASSESSMENT
-If more than 3 months since the last occurrence go to QUESTION 5

5. Are you concerned that something could happen again? (e.g. moving back into area/ child contact etc)? *YES / NO*

If YES*, please provide brief details of on-going risk and go to* ***IMMEDIATE ASSESSMENT***

.....

If <u>NO</u> on-going risk:

6. Offer list of support agencies and barcode sticker with 24-hr National DV helpline no. *Accepted* *YES / NO*

AND Junior staff to discuss with DA champion, HA or IDVA in real-time = END of Management

IMMEDIATE DANGER ASSESSMENT FOR THOSE AT ONGOING RISK:

A. ***Is your partner/perpetrator here with you?*** *YES / NO*
B. ***If you have any children*** *where are they****?***

.....

C. ***Is it safe for you to return home today?*** *YES / NO*
D. ***Do you have any immediate concerns?*** *YES / NO*
If Yes, What are these.....
E. ***Do you have a place of safety?*** *YES / NO*
If Yes, where is this?.....

THEN:

1. After any examination / tests (do as needed)
2. Refer to the HA team/ IDVA/ DA Champion ☐ * And inform the senior doctor in clinic ☐

***IF A PATIENT DECLINES TO SEE THE HA TEAM/ IDVA / DA Champion PLEASE FOLLOW GUIDELINES/PROFORMA OVERLEAF**

BASHH

PATIENT ID LABEL

Imperial College Healthcare NHS Trust

What to do if patient needs to leave clinic/declines to see HA/IDVA/DA champion

1. Reason for leaving the clinic before seeing the HA team/ IDVA DA champion……

……

2. Have you informed the patient of our concerns YES / NO

-If not, please document the reasons for this……

3. What is their current safety plan……

……

4. ***Booked for follow-up appointment with HA/IDVA/DA Champion? YES/NO (as patient declines)***

5. Given DA Barcode sticker or other DA services information ☐

6. Patient aware that we may need to make a CAF or Safeguarding Adult referral if there is a young person or vulnerable adult at risk? ☐

Patient response:……

……

7. Discussed case with and handed over to HA team/IDVA/DA champion in real time: YES / NO

8. Any other relevant information?

<u>Other proforma questions to consider</u>

Have the police ever been involved?

Does anyone else know about the abuse? For example; a teacher, friend, relative or support agency?

Do you have a social worker? If so, why? (Obtain name and contact details)

Do you have a mental health issue? Any self-harm? If so, do you have a Community Psychiatric Nurse (CPN)? Or other supporter? (Obtain name and contact details).

Do you have any current injuries? Request to document these.

Establish the type(s) of abuse. This can lead to additional practical support and advice, for example, if this is financial abuse.

Do you consent to referral to social care/vulnerable adult services/support organisations? Document any reason why consent is denied.

Appendix 9 - Risk Assessments

SPECSS brief assessment

The evidence based SPECSS+ Risk Identification, Assessment and Management Model is a quick-fire assessment to ascertain the level of risk in someone disclosing DA. It is based on evidence and identifies the highest risk indicators that makes a DA survivor at risk of serious harm or death and is a useful acronym when assessing patients.

- **S**eparation
- **P**regnancy
- **E**scalation
- **C**ommunity/**C**ultural aspects
- **S**exual Violence
- **S**trangulation

The Coordinated Action against Domestic Abuse: Domestic Abuse, Stalking and Harassment and Honour Based Violence (CAADA DASH) Tool

The CAADA DASH form is a standardised tool for those assessing DA survivors helping practitioners to make an assessment of the patient's level of risk of harm. It has been designed on the evidence-based SPECSS Model, as well as evidence from extensive research and retrospective reviews of domestic homicides and other high risk cases, to identify the factors that are more likely to result in serious harm and /or death. The assessment tool helps the practitioner decide when to refer cases to the Multi-Agency Risk Assessment Conference (MARAC), when to refer to IDVA or other services and how to manage risk effectively.

Although there is guidance on what criteria would necessitate a MARAC referral, it is important to note that even if the patient falls below this criteria, MARAC referrals must be made for ALL patients that the assessor feels is very high risk based on professional judgement (i.e. even if the CAADA DASH score is <14).

Key point 14 (as before)
Risk in domestic abuse situations is dynamic and can change very quickly. As and when things change the risk assessment must be re-visited and reviewed[lxxvi]

CAADA DASH example form

Name of victim: **Date:** **Restricted when completed**

Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned. Tick the box if the factor is present ☑. Please use the comment box at the end of the form to expand on any answer. It is assumed that your main source of information is the victim. If this is not the case please indicate in the right hand column	Yes (tick)	No	Don't Know	State source of info if not the victim e.g. police officer
Has the current incident resulted in injury? (Please state what and whether this is the first injury.) *Physical abuse can take many forms from a push or shove to a punch, use of weapons, choking or strangulation. Injuries can include scratches, bruising, bleeding, broken bones etc.*	☐	☐	☐	
Are you very frightened? Comment:	☐	☐	☐	
What are you afraid of? Is it further injury or violence? (Please give an indication of what you think (……) might do and to whom, including children). Comment: *Do you have any fears in relation to what (……) may do to you or someone else? Are there any threats that have made you scared or worried?*	☐	☐	☐	
Do you feel isolated from family/friends i.e. does (……..) try to stop you from seeing friends/family/doctor or others? Comment: *Do you feel able to spend time with friends and family? Does (…….) insist on accompanying you to all your appointments?*	☐	☐	☐	
Are you feeling depressed or having suicidal thoughts?	☐	☐	☐	
Have you separated or tried to separate from (…….) within the past year? *This does not have to be a long period of separation – it can include separation for a few days, weeks or even months. Has (……) ever made any threats about what would happen if you tried to leave?*	☐	☐	☐	
Is there conflict over child contact? *Are there ever any problems during handover or when arranging contact? Does (…..) use the children as a way to continue to intimidate/harass or hurt you?*	☐	☐	☐	
Does (……) constantly text, call, contact, follow, stalk or harass you? (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.) *This can include obsessive phone calls, texts or emails, messages on social media. It can also include uninvited visits to your home, workplace etc, or insisting on taking you to and from work/home/appointments. Sometimes these behaviours are framed in the context of 'concern' or 'love'.*	☐	☐	☐	

Tick box if factor is present. Please use the comment box at the end of the form to expand on any answer.	Yes (tick)	No	Don't Know	State source of info if not the victim
Are you pregnant or have you recently had a baby (within the last 18 months)?	☐	☐	☐	
Is the abuse happening more often? *If you're not sure think about how many incidents there have been in the last year and when they happened. Have there been more incidents lately?*	☐	☐	☐	
Is the abuse getting worse? *If you're not sure think about how many incidents there have been in the last year and what took place.*	☐	☐	☐	
Does (……) try to control everything you do and/or are they excessively jealous? (In terms of relationships, who you see, being 'policed at home', telling you what to wear for example.) *Your answer may overlap with Q4 and Q8. Examples of controlling and jealous behaviour can include (but is not limited to) isolating you, making you account for your time / whereabouts, how you spend money, checking your phone/email/social media accounts, accusing you of cheating, etc.*	☐	☐	☐	
Has (……..) ever used weapons or objects to hurt you? *Think about whether (…..) has used anything other than their body to hurt you. An object can include common household items, furniture, sports equipment, etc.*	☐	☐	☐	
Has (……..) ever threatened to kill you or someone else and you believed them? (If yes, tick who.) You ☐ Children ☐ Other (please specify) ☐	☐	☐	☐	
Has (……) ever attempted to strangle/choke/suffocate/drown you?	☐	☐	☐	
Does (……..) do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? (If someone else, specify who.) *This can include unwanted touching, forcing actions which are not consensual, not complying with your request for safe sex, exposing you to STIs, withholding sex as a punishment, criticising your sexual history or any other behaviour/action that hurts you or makes you feel uncomfortable.*	☐	☐	☐	
Is there any other person who has threatened you or who you are afraid of? (If yes, please specify whom and why.) *Are there family members of friends/associates of (……) that you are afraid of? Has (……) ever threatened to get someone else to hurt you/your family/child?*	☐	☐	☐	
Do you know if (……..) has hurt anyone else? (Please specify whom including the children, siblings or elderly relatives. Consider HBV.) Children ☐ Another family member ☐ Someone from a previous relationship ☐ Other (please specify) ☐	☐	☐	☐	
Has (……..) ever mistreated an animal or the family pet?	☐	☐	☐	

Tick box if factor is present. Please use the comment box at the end of the form to expand on any answer.	Yes (tick)	No	Don't Know	State source of info if not the victim
Are there any financial issues? For example, are you dependent on (.....) for money/have they recently lost their job/other financial issues? *This might include forcing you to put your benefits in (.....)'s name, denying you access to money, making you account for your spending, preventing you from seeing shared bank accounts, making you give bank details/passwords, forbidding you to work, taking loans out in your name*	☐	☐	☐	
Has (.....) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? (If yes, please specify which and give relevant details if known.) Drugs ☐ Alcohol ☐ Mental Health ☐	☐	☐	☐	
Has (.....) ever threatened or attempted suicide? *This may include threatening to harm themselves if you/children leave, making statements such as "If I can't have you then no-one can".*	☐	☐	☐	
Has (.....) ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? (You may wish to consider this in relation to an ex-partner of the perpetrator if relevant.) Bail conditions ☐ Non Molestation/Occupation Order ☐ Child Contact arrangements ☐ Forced Marriage Protection Order ☐ Other ☐	☐	☐	☐	
Do you know if (.....) has ever been in trouble with the police or has a criminal history? (If yes, please specify.) DV ☐ Sexual violence ☐ Other violence ☐ Other ☐	☐	☐	☐	
Total 'yes' responses				

For consideration by professional: Is there any other relevant information (from victim or professional) which may increase risk levels? Consider victim's situation in relation to disability, substance misuse, mental health issues, cultural/language barriers, 'honour'- based systems, geographic isolation and minimisation. Are they willing to engage with your service? Describe:

Consider abuser's occupation/interests - could this give them unique access to weapons? Describe:

What are the victim's greatest priorities to address their safety?

Do you believe that there are reasonable grounds for referring this case to MARAC? Yes / No

If yes, have you made a referral? Yes/No

Signed: **Date:**

Do you believe that there are risks facing the children in the family? Yes / No

If yes, please confirm if you have made a referral to safeguard the children: Yes / No

Date referral made .....

Signed: **Name:**	**Date:**

Appendix 10 - Example of MARAC referral form

Marac referrals should be sent by **secure email or other secure method**.

Referring agency			
Contact name(s)			
Telephone / Email			
Date			
Victim name		**Victim DOB**	
Address			
Telephone number		**Is this number safe to call?**	Y / N
Please insert any relevant contact information, eg times to call			
Diversity data (if known)	B&ME ☐ Disabled ☐ LGBT ☐ Gender M / F		
Perpetrator(s) name		**Perpetrator(s) DOB**	
Perpetrator(s) address		**Relationship to victim**	

Children (please add extra rows if necessary)	DOB	Relationship to victim	Relationship to perpetrator	Address	School (If known)

Reason for referral / additional information

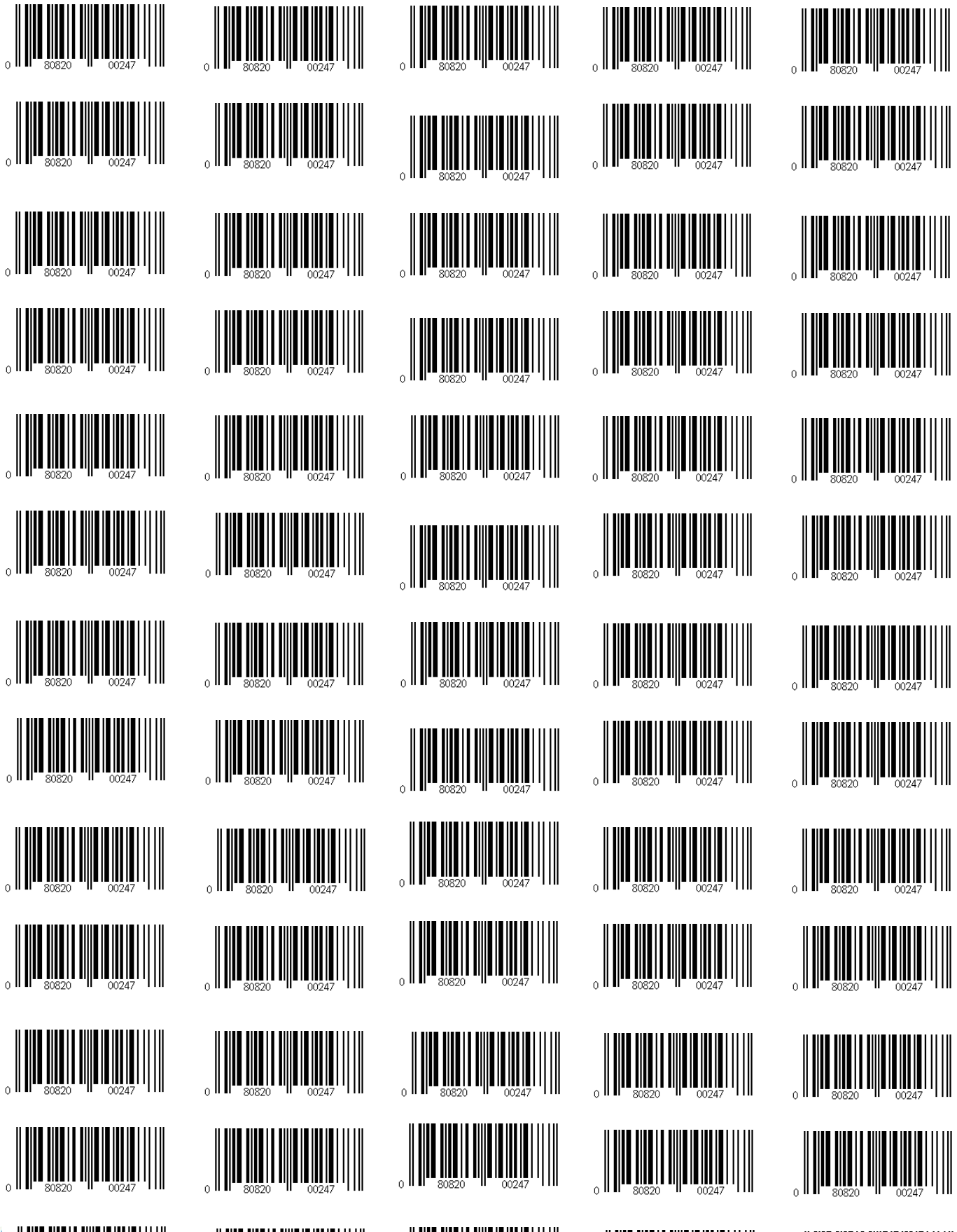
Professional judgement	Y / N	**Visible high risk (*14 ticks or more on SafeLives – Dash risk checklist*)**	Y / N
Potential escalation (*3 or more incidents reported to the Police in the past 12 months*)	Y / N	**Marac repeat (further incident identified within twelve months from the date of the last referral)**	Y / N
If yes, please provide the date listed / case number (if known)			
Is the victim aware of Marac referral?	Y / N	**If no, why not?**	
Has consent been given?	Y / N		
Who is the victim afraid of? (to include all potential threats, and not just primary perpetrator)			
Who does the victim believe it safe to talk to?			
Who does the victim believe it not safe to talk to?			
Has the victim been referred to any other Marac previously?	Y / N	**If yes where / when?**	

Name and agency	
Telephone / Email	
Date	
Victim name	
Victim DOB	
Victim address	
Marac case number (from agenda)	

		Please insert any changes / errors / other information (eg aliases or nicknames) below
Are the victim details on the MARAC list accurate?	Y / N	
Are the children(s) details on the Marac list accurate?	Y / N	
Are the perpetrator details on the Marac list accurate?	Y / N	

Note records of last sightings, meetings or phone calls	
Note recent attitude, behaviour and demeanour, including changes	
Highlight any relevant information that relates to any of the risk indicators on the checklist (eg the pattern of abuse, isolation, escalation, victim's greatest fear etc)	
Other information (eg actions already taken by agency to address victim's safety)	
What are the victim's greatest priorities to address their safety?	
Who is the victim afraid of? Include all potential threats, and not just primary perpetrator	
Who does the victim believe it safe to talk to?	
Who does the victim believe it <u>not</u> safe to talk to?	

Appendix 11 - Barcode template for printing out on stickers as a discrete method of providing the 24 hr DV helpline number to patients



Appendix 12 - Glossary

A+E	Accident and Emergency
BASHH	British Association of Sexual Health and HIV
CAADA	Co-ordinated Action Against Domestic Abuse A national charity dedicated to ending domestic abuse, now known as SafeLives.
CAF	Common Assessment Framework A national standard for assessing need at an early stage, improving interagency working and the coordination of service provision.
Coitarche	age of first sexual intercourse
CPN	Community Psychiatric Nurse
CNS	Central Nervous System (brain and spinal cord)
DA	Domestic Abuse
DASH	Domestic Abuse Stalking (and Harassment) and Honour based violence An evidence-based risk assessment tool that is used to assess the level of risk a victim of domestic violence is facing. A trained professional completes a checklist, usually consisting of 24 questions, regarding the perpetrators history of violent and/or controlling behaviour towards that victim and others. A score of 14 positive responses or more is considered high risk and the victim should be referred to a MARAC. The individual completing the DASH can also refer the victim to a MARAC with a lower score if, in their professional opinion, the victim is at significant risk – e.g. a positive response to the question regarding history of attempted choking or strangulation.
FGM	Female Genital Mutilation
GU/GUM	Genitourinary Medicine
HA	Health Adviser
HCP	Health Care Professional
HIV	Human Immunodeficiency Virus
IBS	Irritable Bowel Syndrome

IDVA	Independent Domestic Violence Adviser A professional trained to support victims of domestic abuse. They offer practical and emotional support to help reduce the risk of further violence. Clear and measurable improvements in victim safety have been demonstrated in studies where high risk clients engage with an IDVA.
LGBT	Lesbian, Gay, Bisexual, Transgender
MARAC	Multi-Agency Risk Assessment Conference A local, multi agency victim-focussed meeting where information is shared regarding the highest risk cases of domestic abuse between representatives from police, health, social care, and other statutory and voluntary organisations.
NICE	National Institute for Health and Care Excellence
RIC	Risk Identification Checklist The DASH questionnaire used to quantify the risk a victim of domestic abuse faces at the time of completing the checklist.
SHS	Sexual Health Services
SPECSS	Separation, Pregnancy, Escalation, Community/Cultural aspects, Sexual violence, Strangulation (Stalking is also sometimes included in the acronym.) An evidence based rapid assessment tool which can be used to quickly assess the level of risk in an individual disclosing domestic abuse. The acronym details the key risk factors which have been shown to be closely associated with domestic abuse.
STI	Sexually Transmitted Infection
SV	Sexual Violence
UTI	Urinary Tract Infection
3/7	three days
3/12	three months
3/52	three weeks

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