Domestic Abuse Training Manual for Health Practitioners

National Domestic Violence Health Practice Forum (now called HEVAN)
Acknowledgements

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- Newcastle NHS Trust
- Newham Primary Care Trust
- Newham Asian Women’s Project
- Operation Kvinnofrid International
- Project Respond: Harrow Primary Care Trust & Brent Primary Care Trust & NW London Hospitals Trust
- Refuge
- Respect
- Judith Rogers, Nia Project
- Salford Multi-Agency Domestic Violence Partnership
- Sunlight Project
- Support & Survival Health Initiative in partnership with Wakefield Health Authority and Wakefield Community Safety Partnership
- South West Birmingham Domestic Violence Project
- SRB5 Domestic Violence Holistic Health Care Project in Redbridge & Waltham Forest (2000-3)
- Standing Together Against Domestic Violence, Hammersmith & Fulham
- St George’s Midwives, St George’s NHS Hospital Trust
- Pat Wallace, DV Consultant and Trainer, Breaking Free
- Judy Watson, Crown Prosecution Service
- Women’s Aid Federation England

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## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>4</td>
</tr>
<tr>
<td>1. <strong>Introduction</strong></td>
<td>5</td>
</tr>
<tr>
<td>1.1 How to use this manual</td>
<td>7</td>
</tr>
<tr>
<td>1.2 General guidance on running workshops</td>
<td>8</td>
</tr>
<tr>
<td>1.3 Recommended reading</td>
<td>9</td>
</tr>
<tr>
<td>1.4 Accommodation and other resources</td>
<td>10</td>
</tr>
<tr>
<td>1.5 Assessing training needs</td>
<td>10</td>
</tr>
<tr>
<td>1.6 Training objectives and learning outcomes</td>
<td>11</td>
</tr>
<tr>
<td>1.7 Pre-training questionnaire</td>
<td>13</td>
</tr>
<tr>
<td>1.8 Sample training course outlines</td>
<td>17</td>
</tr>
<tr>
<td>1.9 Group agreements</td>
<td>26</td>
</tr>
<tr>
<td><strong>CORE MODULES</strong></td>
<td></td>
</tr>
<tr>
<td>2. <strong>Module One – Domestic Abuse as a Health Issue</strong></td>
<td></td>
</tr>
<tr>
<td>2.1 Introduction</td>
<td>33</td>
</tr>
<tr>
<td>2.2 Defining domestic abuse</td>
<td>33</td>
</tr>
<tr>
<td>2.3 Who is affected?</td>
<td>43</td>
</tr>
<tr>
<td>2.4 The impact upon health</td>
<td>55</td>
</tr>
<tr>
<td>2.5 Children and domestic abuse</td>
<td>59</td>
</tr>
<tr>
<td>2.6 Pressures on women to stay</td>
<td>62</td>
</tr>
<tr>
<td>2.7 Diversity issues: sexuality, ethnicity; disability</td>
<td>72</td>
</tr>
<tr>
<td>2.8 The role of the health professional</td>
<td>77</td>
</tr>
<tr>
<td>2.9 Module One Training Resources</td>
<td>84</td>
</tr>
<tr>
<td>2.10 Module One Handouts</td>
<td>106</td>
</tr>
<tr>
<td>3. <strong>Module Two - Positive Identification</strong></td>
<td></td>
</tr>
<tr>
<td>3.1 Introduction</td>
<td>168</td>
</tr>
<tr>
<td>3.2 Indicators of abuse</td>
<td>168</td>
</tr>
<tr>
<td>3.3 Asking about abuse</td>
<td>170</td>
</tr>
<tr>
<td>3.4 Risk assessment</td>
<td>191</td>
</tr>
<tr>
<td>3.5 Where there are children in the household</td>
<td>198</td>
</tr>
<tr>
<td>3.6 Professional safety issues</td>
<td>200</td>
</tr>
<tr>
<td>3.7 Module Two Training Resources</td>
<td>204</td>
</tr>
<tr>
<td>3.8 Module Two Handouts</td>
<td>214</td>
</tr>
<tr>
<td>4. <strong>Module Three – Positive Response</strong></td>
<td></td>
</tr>
<tr>
<td>4.1 Introduction</td>
<td>234</td>
</tr>
<tr>
<td>4.2 Safety planning</td>
<td>234</td>
</tr>
<tr>
<td>4.3 Documentation and record keeping</td>
<td>241</td>
</tr>
<tr>
<td>4.4 Confidentiality &amp;information sharing</td>
<td>244</td>
</tr>
<tr>
<td>4.5 Working with perpetrators</td>
<td>251</td>
</tr>
<tr>
<td>4.6 Module Three Training Resources</td>
<td>253</td>
</tr>
<tr>
<td>4.7 Module Three Handouts</td>
<td>260</td>
</tr>
<tr>
<td>5. <strong>Module Four – Professional Issues</strong></td>
<td></td>
</tr>
<tr>
<td>5.1 Introduction</td>
<td>300</td>
</tr>
<tr>
<td>5.2 Self assessment</td>
<td>300</td>
</tr>
<tr>
<td>5.3 Partnership and multi-agency working</td>
<td>301</td>
</tr>
<tr>
<td>5.4 Module Four Handouts</td>
<td>309</td>
</tr>
<tr>
<td>6. <strong>Post Training Evaluation</strong></td>
<td>322</td>
</tr>
<tr>
<td>7. <strong>Further Reading</strong></td>
<td>327</td>
</tr>
<tr>
<td>8. <strong>Useful organisations</strong></td>
<td>339</td>
</tr>
</tbody>
</table>
Foreword

The Department of Health and the Home Office have been working closely together, particularly over the past two years to address the devastating effects of domestic violence and abuse on its victims who are primarily women and children.

Much is known now about the nature and extent and effects of domestic abuse. One in four women - and their children – experience domestic abuse at some point in their lives. This accounts for a quarter of all violent crime. Where there is domestic abuse, there is a strong overlap with the physical sexual and emotional abuse of children in the household. Furthermore, thirty percent of domestic abuse begins or escalates during pregnancy, with serious consequences for the mother and her unborn child.

There is new legislation and a cross Government Domestic Violence Delivery Plan. There are a number of Department of Health and other government department policy initiatives such as the NSF for Children, Young People and Maternity Services (2004). And Working Together to Safeguard Children (revised 2005).

The Home Office and Department of Health jointly fund the post of National Domestic Violence Coordinator for Health and Mental Health. Both Departments are working in partnership to develop evidence-based national service guidelines to equip services and professionals to respond to the mental and physical health needs of those who have experience of domestic and sexual violence and abuse.

Importantly the Department of Health is shortly to publish Responding to Domestic Abuse: A Handbook For Health Professionals. The handbook incorporates an Action Plan based on recommendations made to Ministers by an Advisory Group comprising relevant Royal Colleges (Midwives, Obstetricians & Gynaecologists, GPs, and Psychiatrists) and domestic abuse voluntary organisations.

Published with the Handbook is the Domestic Abuse Training Manual for Health Professionals – intended to support the implementation of the Handbook’s Action Plan and a practical outcome of partnership working and a tangible reflection of integrated cross government intent to improve service provision for those who experience domestic abuse.

Commissioned jointly by the Department of Health and the Home Office, the manual compiles education and training materials from a range of experienced practitioners and will provide a comprehensive framework to underpin a consistent message about good practice and safe service provision. We commend it to you.

Christine Mann Catherine Itzin Deborah Jamieson
National DV Coordinator DH/HO Violence & Abuse Programme HO National DV
Health & Mental Health

4
1. INTRODUCTION

This training manual supports the Department of Health Responding to Domestic Abuse: A handbook for Health Professionals. Trainers using this manual MUST first read and be familiar with Responding to Domestic Abuse: A handbook for Health Professionals. The training manual is designed to be a flexible resource for health service trainers. The manual will support your work in delivering essential training for health practitioners to give them the knowledge and skills to work effectively with patients who are or who have been affected by domestic abuse.

The training manual developed from work within the National Domestic Violence Health Practice Forum (now called HEVAN, Health Ending Violence and Abuse Now)1. Roxane Agnew-Davies collated training materials produced by the Forum and wrote the draft manual that was edited by Jackie Barron and Lorraine Radford.

HEVAN recommends:

- training on domestic violence within mandatory induction procedures;
- training on domestic violence within continuing professional education;
- regular, systematic, ongoing training programmes on domestic violence;
- training co-ordinated by a designated lead within the department or unit;
- commissioning training from the voluntary sector or specialists working with domestic violence;
- systems to ensure competence of trainers and compliance with training.

HEVAN has identified three levels of training needs:

Level 1: Core training for health professionals, to include in the curriculum as a minimum:

- understanding domestic abuse – definition, prevalence, nature of abuse, who is affected;
- the effects of abuse particularly consequences for health;
- the health professional’s role;

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1 HEVAN is an informal forum of domestic abuse trainers, researchers and health service professionals who promote good practice through:
- The sharing of information about and evaluation of current initiatives
- The development of policies, training, guidance, protocols and research
- Liaising and lobbying at national, regional and local levels

Contact loraine.bacchus@kcl.ac.uk or roxane@dvlt.com
- how to ask direct questions about experiences of abuse;
- what to do if a woman discloses abuse;
- keeping records (Stage I);
- information on local and national sources of specialist help;
- confidentiality and information sharing (Stage I);
- informing a supervisor.

Level 2: Additional training for health professionals with specialist responsibilities regards domestic abuse or case responsibility. This would include within the curriculum:

- local policy;
- clinical signs and symptoms and indicators of abuse;
- identification and assessment;
- keeping records (Stage II);
- assessment of risk;
- safety planning;
- confidentiality and information sharing (Stage II);
- child protection;
- developing links with other professionals, including the police;
- information on legal, welfare and housing rights;
- equal opportunities;
- responding to the needs of staff with personal experience of domestic abuse;
- audit protocol.

Level 3: In depth training for professionals with a therapeutic specialism, clinical supervisors or managers, to include:

- Specialist psychotherapy for women experiencing domestic violence;
- Supervision;
- Management of service delivery and development.

Training needs will also vary within each level according to the area of medical practice, an individual’s work responsibilities and the level of contact with patients. This manual is concerned with core training only. All the materials provided in the manual have been tried and tested by contributors working within the health care context.
1.1 How to use this manual

The manual is designed to be a flexible training resource that can be used to support the *Responding to Domestic Abuse: A handbook for Health Professionals*. This introductory section gives general guidance on assessing training needs, planning and delivering training. The training materials are organised into four modules that cover the recommended content of the core level training for health professionals:

- Module One  Domestic Abuse as a Health Issue;
- Module Two  Positive Identification;
- Module Three Positive Response;
- Module Four  Professional Issues.

The manual has been designed so that a trainer can take out the most suitable materials from the four core module sections to fit the time available and the training needs of a particular group of professionals. Training can be pitched towards different levels of need, ranging from general domestic abuse awareness-raising for all staff in a unit to specific training in small groups to help professionals working with women patients to identify and respond to a disclosure of domestic abuse. Practitioners’ responses will vary according to their level of contact with patients, their management or supervisory responsibilities and whether they play a strategic role in the development of policies and practice. Education and training must be relevant to staff’s working environment. For instance, a single one hour long didactic presentation to a group of obstetricians may cover definition, statistics on prevalence related to pregnancy and birth, have a brief exercise on myths, identification of women at risk and recommend that information on domestic abuse is made available. However, the second half of a full day of training for a group of health visitors might cover topics such as identification and assessment or child protection in depth, using group exercises to rehearse asking questions about domestic abuse and address issues in case studies. Sections 1.3 and 1.4 below give guidance on how to assess staff training needs and how to plan training packages to meet the needs and available time. The approximate timings for elements in each module are indicated throughout, to help a trainer to select material appropriately.

Workshop leaders need facilitation skills, a good working knowledge of domestic violence and an understanding of the needs of the health professionals they aim to
train. People learn more if a trainer is able to engage them and encourage them to share knowledge and experiences. Teaching methods that encourage reflective and experiential learning include exercises such as brainstorming, small group work, case study analysis and role-play, as well as traditional lectures followed by question and answer sessions and discussion. The material within each of the modules in this manual can be selected to support a range of different teaching and learning methods.

The format of the manual allows you to dip into sections of the manual, to print out and photocopy relevant materials and handouts for your training purposes.

1.2 General guidance on running workshops

Domestic abuse training may raise personal issues for practitioners. Ideally, two facilitators, at least one of whom is a woman, should prepare and co-lead any training session. When this is not possible (such as in a one-off 30 minute presentation) the facilitator must provide contact numbers or means for participants to access support. Group members may experience shock, guilt or anxiety when confronting this topic. It is likely that a group will include staff who have past or current personal experience of domestic abuse. The material might trigger reactions and emotions that require sensitive and appropriate support. Staff attending a session or course on domestic abuse should have access to information about further support or counselling.

A training facilitator needs to have a good working knowledge of domestic abuse issues, to be equipped to answer participants’ questions and to provide additional information as required. Working in partnership with specialist domestic violence service providers to develop and deliver training is highly recommended.
1.3 Recommended reading

The following readings are recommended to use alongside the training manual:


Training facilitators are encouraged to develop, maintain and regularly update their own library of reading materials, videos and learning resources.

1.4 Accommodation and other resources

You will need a room suitable for the size of the group. The room should ideally be big enough to allow participants to spread out into smaller discussion groups as required. Make sure the accommodation is at a pleasant working temperature and ensure the following are available:

- Comfortable chairs that can be moved easily;
- Tables or writing trays to work on;
- Flip chart, flip chart pens, blu tack;
- Overhead projector or power-point facilities;
- Any other audio visual equipment required (TV, video);
- Clock;
- Tissues, water to drink and facilities for making tea/coffee and eating lunch.

1.5 Assessing Training Needs

The training can be tailored to fit the time available and the needs of the group. A pre-course training evaluation questionnaire (sample on pages 9 -12) can be useful to identify training needs. Content from all four modules is usually required for any training but the curriculum will vary according to the needs and responsibilities of a particular group. Depending on the needs of the group, the training can be delivered as a one hour basic awareness training, or in varying lengths of a half day, one, two or three day intensive training blocks or as a modular course delivered over 4 or more discrete training sessions. For practitioners who need more specialist training, a two to three day intensive training event offers concise training and the chance to focus intensively on the issues away from the distraction of work. An intensive training event may also be the most economical option if training facilitators have to be brought in. However it can be difficult in some services to free staff from their everyday responsibilities so that they can attend intensive training. Delivering training through a modular
programme (possibly over lunchtime sessions) may be in these circumstances the more practical option.

1.6 Training objectives and learning outcomes

The overall aim of training is to enable practitioners to increase the skills and knowledge they require to improve their effectiveness in providing support to women affected by domestic abuse. You will need to establish the objectives and learning outcomes for each specific training course. Some possible objectives for domestic abuse training identified in *Responding to Domestic Abuse: A handbook for Health Professionals* (page 64) are:

- Improving awareness and understanding;
- Increasing sensitivity to potential signs of domestic abuse;
- Increasing health professionals’ confidence in providing support;
- Introducing new approaches – such as routine enquiry;
- Establishing core principles for responding to women experiencing domestic abuse;
- Ensuring an appropriate response when abuse is disclosed;
- Developing communication skills to improve empathetic responses;
- Improving communication and information-sharing between stakeholders;
- Ensuring a coordinated response at strategic and individual levels; and
- Improving awareness of local specialist services and resources.

The specific objectives and learning outcomes will vary according to the training needs of your participants.

Timing

Each workshop can be tailored to fit the time available and the needs of the group. For intensive training blocks, a maximum of a seven-hour day is recommended. Allow time for a meal break and breaks for drinks, which can be agreed with the group at the start of the session. Approximate timings for each activity are given for workshops included in the manual. Practice in advance for a new session can help ensure accurate timing. Plan out your own timetable using the actual times of day for each session to help you to keep to time. Allow some time at the end of each workshop to give participants a chance to debrief and get closure.

Preparation

Preparation might include:
Reading through material, selecting trainers’ notes, handout material, slides for presentation on overhead acetate (OHP) or power-point (PP);

Planning and practising presentations in advance;

Dividing the work and planning roles with a co-facilitator;

Arranging for materials and resources: notes, handouts, slides, equipment, flipchart, markers, blu-tack, pens, paper, leaflets and posters for distribution;

Finding out the domestic arrangements, such as fire exits and toilet facilities.

Planning and running a workshop

The following checklist of activities will help you to plan and run your workshop.

- Establish training needs, objectives and learning outcomes.
- Draft the basic content and agenda to meet the training needs of participants & to fit the time available
- Read the materials and rehearse, delegating tasks and roles with co-facilitator
- Make your own detailed plan for the workshop (including timings)
- Complete preparations, eg choosing venue, preparing resources and handouts, sending out pre-course questionnaires, evaluation forms etc
- After the workshop, review participants’ feedback and reflect to develop future sessions
- Consider opportunities for follow up to consolidate learning

Handouts

Training materials in the manual include handouts that can be copied for participants. These can be adapted as you see fit, but a handout is recommended to consolidate the training. References and further readings can be taken from the reading list.
1.7 Sample Pre-Training Questionnaire

Date (d/m/y) …./…./…..     Site __________________

We are interested in your professional experience of domestic abuse. This will help us tailor future training to the needs of participants. They shouldn’t take more than 10-15 minutes of your time and your help will be invaluable. All answers are kept strictly confidential.

Please circle the answers below that fit best with your experience
Where there is a line, please answer in detail

About you

Name:_____________________________________________________________________
Job Title:_____________________________________________________________________

1. Gender     Male Female
2. Age      18-25  26-30  31-40  41-50  51-60
3. Ethnicity__________________________________________________________________
4. Place of work________________________________________________________________
5. Specialism/department______________________________________________________
6. Profession/grade___________________________________________________________
7. Have you ever attended a course on domestic violence before?
   If yes please specify____________________________________________________________

About your department

8. Does your department have written policies and procedures or guidelines for dealing with domestic abuse?     Yes No Don’t know
9. Does your department have leaflets, pamphlets or information about domestic abuse that can be given to service users? Yes No Don’t know
10. Is there a printed list in your department of local or national domestic violence agencies and resources where abused women can be referred? Yes No Don’t know

About your clinical practice over the last month.

11. How many women in your case load did you suspect were cases of domestic abuse? None One Two 3-4 more than 4
12. How many times in the last month did you ask a woman if her illness/complaint was the result of domestic abuse? None One Two 3-4 more than 4
13. If none, have you ever asked a woman about domestic abuse?    Yes No

About your knowledge and experience of domestic abuse

14. Regarding the facts and issues of domestic abuse, do you feel:
   uninformed  slightly informed  well informed  fully informed

15. Do you ask service users directly if their injuries result from domestic abuse?
   Always    Mostly  Sometimes  Occasionally  Never
6. In your department are there identified people responsible for assessing and supporting victims of domestic abuse?  

Yes  No  Don’t know

If yes, are they: Social worker  nurse  doctor  patient advocate  

Other (please specify)………………………….

17. Which of the following resources for abused women do you know by name in your community?  

Refuge/women's aid group  support groups  legal  counselling  

Perpetrator treatment programmes  housing  

Other (please specify)…………………………………………………………………………………………

18. How often do you take each action below when you identify a patient as abused:

<table>
<thead>
<tr>
<th>Action</th>
<th>always</th>
<th>often</th>
<th>rarely</th>
<th>never</th>
</tr>
</thead>
<tbody>
<tr>
<td>document facts in medical (not hand-held) case notes</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>record patient’s comments in case notes</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>refer patient to a refuge</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>reassure patient she is not alone</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>refer patient to a refuge or domestic violence helpline</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>give printed information on domestic violence</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>refer to police Community Safety Unit</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>counsel the patient about domestic violence</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>safeguard evidence</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>record suspicion of domestic violence even if patient denies it</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>review safety plan</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>refer to a social worker</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>refer patient for counselling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>refer patient to mental health team</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>share information with health visitor</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>share information with GP</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>record the site of injuries on a body map</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>involve child protection</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>other - please specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19. How certain are you that you can:

<table>
<thead>
<tr>
<th>Action</th>
<th>very certain</th>
<th>fairly certain</th>
<th>not certain</th>
<th>not at all certain</th>
</tr>
</thead>
<tbody>
<tr>
<td>identify a patient who is abused</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>ask a patient directly about domestic abuse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>ask follow-up questions about domestic abuse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>respond appropriately to service users who experience domestic abuse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>know enough about domestic abuse to intervene for your abused patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
20. How certain are you that you can have a frank and candid conversation about the domestic abuse with a patient who is:

<table>
<thead>
<tr>
<th></th>
<th>very certain</th>
<th>fairly certain</th>
<th>not certain</th>
<th>not at all certain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black or Asian</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Gay, Lesbian or Bisexual</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Middle class e.g. nurse, lawyer</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Working class e.g. cleaner</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Someone who has a disability</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>An immigrant or refugee/asylum seeker</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>A substance (drug and/or alcohol) misuser</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Someone whose first language isn't English</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Someone who is mentally ill</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

21. There are many obstacles to the identification of adult service users who have been abused. To what degree is each of the following a problem for you in your department?

<table>
<thead>
<tr>
<th>Obstacle</th>
<th>Major problem</th>
<th>minor problem</th>
<th>not a problem</th>
<th>don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>patient fears repercussions of being identified as abused</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>patient denies domestic abuse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>patient under influence of drugs or alcohol</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>patient’s primary language not English</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>lack of privacy (accompanied by partner &amp;/or children)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>cultural norms interfere with discussing domestic abuse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>you lack training how to identify domestic abuse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>you are too busy to ask about anything other than presenting problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>community agencies and resources hard to access</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>you fear for patient’s or your own safety</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

22. How many victims of domestic abuse do you treat each month in your department?

None 1-5 6-10 11-15 16-20 21-25 don’t know

23. How many women in your department experience domestic abuse in any one year?

1% or less 2-5% 6-10% 11-20% more than 20%
24. Suppose you were told that a woman was beaten up by her male partner. How likely is it, in your own view, for the following statements to be true?

- Most likely       Quite likely       Unlikely       Don’t know
She provoked it by yelling or hitting him 1  2  3  4
The man was drunk and probably didn’t know what he was doing 1  2  3  4
He didn’t know how to communicate 1  2  3  4
He grew up in a violent home 1  2  3  4
He did it to control her /keep her in line 1  2  3  4
He did it to get her to listen or calm down 1  2  3  4
He takes out his low self-esteem on her 1  2  3  4
She may have cheated on him 1  2  3  4
He is sick/disturbed 1  2  3  4
He is violent 1  2  3  4

25. Why do you think women stay in abusive relationships? Please indicate how strongly do you agree or disagree with the following statements by circling the number that fits best.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Slightly disagree</th>
<th>Don’t know</th>
<th>Slightly agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>low self esteem</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>think it is their fault</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>financially dependent</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>really love the partner</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>emotionally dependent</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>don’t want family to break up for the sake of the children</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>she is afraid to leave</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>she likes it grew up with it/doesn’t know better</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>religion and customs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>she is weak or indecisive</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>she has nowhere else to go</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Thank you very much for completing this questionnaire.
All responses will be treated confidentially.
1.8 Sample Training Course Outlines

Below are sample courses designed to meet varied learning outcomes and to fit in with timing constraints. Sample one hour, half-day, one day, three days and modular trainings course outlines are presented. These are only illustrations, and training facilitators are invited to amend the materials and schedules according to specific objectives, the needs of their delegates and the time available.

Sample A - one hour course outline

Target audience
- administrative and support staff

Objectives
- to launch the Department of Health Guidance
- to improve understanding and awareness about domestic violence and the health professional’s role.

Learning outcome
- ability to apply Guidance for Health Professional Responding to Domestic Abuse in everyday working practice.

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>09.00</td>
<td>Introduction of facilitator. Housekeeping. Aims for the session</td>
<td>5 mins</td>
</tr>
<tr>
<td>09.05</td>
<td>Domestic violence – definition, as a public health issue (presentation)</td>
<td>5 mins</td>
</tr>
<tr>
<td>09.10</td>
<td>The extent and severity of domestic violence</td>
<td>10 mins</td>
</tr>
<tr>
<td></td>
<td>Exercise: Quiz on handout for individuals &amp; facilitator gives answers</td>
<td></td>
</tr>
<tr>
<td>09.20</td>
<td>Consequences of domestic violence – small groups exercise to generate physical, psychological, sexual, social effects &amp; effects on pregnancy and children</td>
<td>10 mins</td>
</tr>
<tr>
<td>09.30</td>
<td>The effects of domestic violence on health (presentation)</td>
<td>5 mins</td>
</tr>
<tr>
<td>09.35</td>
<td>Why men abuse women – 3 frequent myths (presentation)</td>
<td>5 mins</td>
</tr>
<tr>
<td>09.40</td>
<td>Why women stay (flip chart exercise)</td>
<td>5 mins</td>
</tr>
<tr>
<td>09.45</td>
<td>Local and national support agencies available (included in handout)</td>
<td>5 mins</td>
</tr>
<tr>
<td>09.50</td>
<td>Example of good practice in health: The RADAR model</td>
<td>5 mins</td>
</tr>
<tr>
<td>09.55</td>
<td>Closure: goodbye, reference to guidance, handout on sources of follow-up support, questions</td>
<td>5 mins</td>
</tr>
</tbody>
</table>
Sample B - half day course outline Domestic Abuse and Health

Target audience
- community psychiatric nurses

Objectives
- to launch the Department of Health Guidance; to improve understanding and awareness about domestic abuse and the health professional’s role;
- to increase sensitivity to potential signs of domestic abuse;
- to increase confidence in providing support;

Learning outcomes
- ability to apply Responding to Domestic Abuse: A handbook for Health Professionals in everyday working practice.
- Improved knowledge about indicators of abuse;
- Improved ability to respond to patients who have experienced abuse;

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>09.00</td>
<td>Introduction &amp; Welcome, Housekeeping, Agenda</td>
<td>15 mins</td>
</tr>
<tr>
<td>09.15</td>
<td>Violence against women as a public health issue DoH definition, prevalence</td>
<td>20 mins</td>
</tr>
<tr>
<td>09.35</td>
<td>Health consequences of domestic abuse</td>
<td>20 mins</td>
</tr>
<tr>
<td>09.55</td>
<td>Indicators of abuse – physical, psychological, behavioural</td>
<td>30 mins</td>
</tr>
<tr>
<td>10.25</td>
<td>Break</td>
<td>15 mins</td>
</tr>
<tr>
<td>10.40</td>
<td>Resources and help available Exercise: Identifying local support</td>
<td>30 mins</td>
</tr>
<tr>
<td>11.10</td>
<td>Pressures on women to stay – return Strategies women use to cope with abuse</td>
<td>20 mins</td>
</tr>
<tr>
<td>11.30</td>
<td>The role of health professional – RADAR</td>
<td>30 mins</td>
</tr>
<tr>
<td>12.00</td>
<td>Case Study Exercise</td>
<td>30 mins</td>
</tr>
<tr>
<td>12.30</td>
<td>Discussion - Reflections and Difficulties</td>
<td>10 mins</td>
</tr>
<tr>
<td>12.40</td>
<td>Evaluation</td>
<td>5 mins</td>
</tr>
<tr>
<td>12.45</td>
<td>Give handouts, copy of guidance, information on follow up and close</td>
<td></td>
</tr>
</tbody>
</table>
Sample C - One day course: Identification and response to domestic abuse

Target audience
- midwives

Objectives
- to launch the Department of Health Guidance; to improve understanding and awareness about domestic violence and the health professional’s role;
- to increase sensitivity to potential signs of domestic abuse;
- to increase knowledge about how to ask direct questions about domestic abuse;
- to increase confidence in providing support;
- to ensure an appropriate response when abuse is disclosed.

Learning outcomes
- Ability to apply Responding to Domestic Abuse: A handbook for Health Professionals in everyday working practice.
- Improved knowledge about indicators of abuse;
- Improvements in the confidence and skills needed to directly asking patients about abuse;
- Improved ability to respond to patients who have experienced abuse;

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>09.00</td>
<td>Registration, refreshments</td>
<td>15 mins</td>
</tr>
<tr>
<td>09.15</td>
<td>Introduction. Aims of day. Programme outline. Housekeeping</td>
<td>10 mins</td>
</tr>
<tr>
<td>09.25</td>
<td>Exercise: Introductory name game or warm up exercise</td>
<td>10 mins</td>
</tr>
<tr>
<td>09.35</td>
<td>Group agreements</td>
<td>10 mins</td>
</tr>
<tr>
<td>09.45</td>
<td>Definition of domestic violence Exercise then Trainer input</td>
<td>25 mins</td>
</tr>
<tr>
<td>10.10</td>
<td>Prevalence of domestic violence Quiz then Trainer input</td>
<td>20 mins</td>
</tr>
<tr>
<td>10.30</td>
<td>Break</td>
<td>15 mins</td>
</tr>
<tr>
<td>10.45</td>
<td>The impact of domestic abuse on health.</td>
<td>30 mins</td>
</tr>
<tr>
<td>11.15</td>
<td>Routine enquiry –Trainer input on aims, in the context of local and national policy then small group discussion</td>
<td>45 mins</td>
</tr>
<tr>
<td>12.00</td>
<td>Video e.g. Unlocking the doors and breaking down the barriers (12 mins) then small group discussions</td>
<td>30 mins</td>
</tr>
<tr>
<td>12.30</td>
<td>Lunch</td>
<td>45 mins</td>
</tr>
<tr>
<td>13.15</td>
<td>Recap on RADAR from video and aims of pm programme</td>
<td>10 mins</td>
</tr>
<tr>
<td>13.25</td>
<td>Confidentiality, safety and privacy Exercise: case studies in small groups</td>
<td>20 mins</td>
</tr>
<tr>
<td>13.45</td>
<td>Routine enquiry –asking the question Trainer input then practice</td>
<td>45 mins</td>
</tr>
<tr>
<td>Time</td>
<td>Activity</td>
<td>Duration</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>14.30</td>
<td>Documentation- Trainer input then practice with case study</td>
<td>30 mins</td>
</tr>
<tr>
<td>15.00</td>
<td>Break</td>
<td>15 mins</td>
</tr>
<tr>
<td>15.15</td>
<td>Providing information and referral for support – Group exercise on possible partners, Trainer input then case studies in small group Case study practice or talk from domestic abuse expert</td>
<td>45 mins</td>
</tr>
<tr>
<td>16.00</td>
<td>Putting guidance into practice – discussing action plans (small groups split by specialities)</td>
<td>30 mins</td>
</tr>
<tr>
<td>16.30</td>
<td>Feedback from small groups to large group</td>
<td>15 mins</td>
</tr>
<tr>
<td>16.45</td>
<td>Evaluation</td>
<td>15 mins</td>
</tr>
<tr>
<td>17.00</td>
<td>Close</td>
<td></td>
</tr>
</tbody>
</table>

**Sample D - Three Day Course Outline**

**Target audience**
- health care practitioners developing domestic abuse specialist responsibility.

**Objectives**
- to improve understanding and awareness about domestic abuse and the health professional’s role;
- to encourage and facilitate further learning and independent research;
- to increase sensitivity to potential signs of domestic abuse;
- to increase knowledge about how to ask direct questions about domestic abuse;
- to increase confidence in providing support;
- to ensure an appropriate response when abuse is disclosed;
- to improve communication, information sharing and working in a multi-agency context.

**Learning outcomes**
- Improved knowledge about domestic abuse and its impact on health;
- Ability to maintain and develop knowledge;
- Improved knowledge about indicators of abuse;
- Improvements in the confidence and skills needed to directly asking patients about abuse;
- Improved ability to respond to patients who have experienced abuse;
- Improved awareness of other agencies roles;
- Basic understanding of risk assessment and safety planning.
Day 1
- Morning session: Aims, definitions and prevalence

9.30 am  Welcome and ground rules  15 mins
9.45 am  Pre-course questionnaire or quiz  15 mins
10.00am  Course aims and steps to achieving them  15 mins
10.15am  Defining domestic abuse – physical abuse, sexual abuse  15 mins
10.30am  Abuse of power & control (Duluth wheel) case studies  15 mins
10.45am  Coffee
11.00am  Caring for the carers: Personal and professional issues
            What the research shows  15 mins
            Expectations and challenges anticipated by group  15 mins
11.30am  Facts and figures – relate to earlier quiz & caseload  30 mins
12.00    Lunch  60 mins

Afternoon session: Domestic Abuse Awareness I

1.00 pm  Factors contributing to domestic abuse  45 mins
1.45 pm  The role of the health professional  45 mins
2.30 pm  The impacts of domestic abuse on women  30 mins
3.00 pm  Tea
3.15 pm  The impacts of domestic abuse on children  30 mins
3.45 pm  Video/case studies to illustrate variety of experiences  15 mins
4.00 pm  Feedback and discussion  15 mins
4.15 pm  Achievements, commitments and evaluation  15 mins
4.30 pm  Closure
**Day 2**

### Morning Session: Domestic Abuse Awareness 2 & Identification

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.30 am</td>
<td>Welcome, feedback Day 1, objectives day 2</td>
<td>15 mins</td>
</tr>
<tr>
<td>9.45 am</td>
<td>Myths, and their resolutions</td>
<td>45 mins</td>
</tr>
<tr>
<td>10.30 am</td>
<td>Identifying women at risk through observations</td>
<td>30 mins</td>
</tr>
<tr>
<td>11.00 am</td>
<td>Coffee</td>
<td>15 mins</td>
</tr>
<tr>
<td>11.15 am</td>
<td>Case studies exercise</td>
<td>15 mins</td>
</tr>
<tr>
<td>11.30 am</td>
<td>Setting up an environment to help disclosure</td>
<td>15 mins</td>
</tr>
<tr>
<td>11.45 am</td>
<td>Barriers to disclosure, with case studies</td>
<td>30 mins</td>
</tr>
<tr>
<td>12.15 am</td>
<td>Making a difference (video)</td>
<td>15 mins</td>
</tr>
<tr>
<td>12.30 pm</td>
<td>Local policy</td>
<td>15 mins</td>
</tr>
<tr>
<td>12.45 pm</td>
<td>Lunch</td>
<td></td>
</tr>
</tbody>
</table>

### Afternoon session: Asking questions to help disclosure

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.45 pm</td>
<td>‘Ask me’: sample questions and guidance</td>
<td>15 mins</td>
</tr>
<tr>
<td>2.00 pm</td>
<td>Practice and Feedback from small groups</td>
<td>30 mins</td>
</tr>
<tr>
<td>2.30 pm</td>
<td>Women’s experience of health professionals</td>
<td>15 mins</td>
</tr>
<tr>
<td>2.45 pm</td>
<td>Discussion to explore barriers &amp; difficulties and/or further practice</td>
<td>15 mins</td>
</tr>
<tr>
<td>3.15 pm</td>
<td>Tea</td>
<td>15 mins</td>
</tr>
<tr>
<td>3.30 pm</td>
<td>Key messages</td>
<td>30 mins</td>
</tr>
<tr>
<td>4.00 pm</td>
<td>Small group work: action points for changing practice</td>
<td>20 mins</td>
</tr>
<tr>
<td>4.20 pm</td>
<td>Achievements, evaluation and close</td>
<td></td>
</tr>
</tbody>
</table>

**Day 3**

### Morning session: Documentation and Offer of information/ Referral

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.30 am</td>
<td>Welcome, feedback Day 2, objectives day 3</td>
<td>15 mins</td>
</tr>
<tr>
<td>9.45 am</td>
<td>Guidelines to documentation</td>
<td>30 mins</td>
</tr>
<tr>
<td>10.15 am</td>
<td>Practice and Feedback from small groups</td>
<td>45 mins</td>
</tr>
<tr>
<td>11.00 am</td>
<td>Coffee</td>
<td>15 mins</td>
</tr>
<tr>
<td>11.15 am</td>
<td>Local and national sources of specialist help</td>
<td>15 mins</td>
</tr>
<tr>
<td>11.30 am</td>
<td>Challenges of partnership working</td>
<td>15 mins</td>
</tr>
<tr>
<td>11.45 am</td>
<td>Confidentiality</td>
<td></td>
</tr>
<tr>
<td>11.45 am</td>
<td>Case studies exercise</td>
<td>30 mins</td>
</tr>
<tr>
<td>12.15 pm</td>
<td>Review of information available</td>
<td>15 mins</td>
</tr>
<tr>
<td>12.45 pm</td>
<td>Lunch</td>
<td>60 mins</td>
</tr>
</tbody>
</table>

### Afternoon session: Risk assessment, Safety plans

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.45 pm</td>
<td>Risk assessment &amp; key messages on safety plans</td>
<td>15 mins</td>
</tr>
<tr>
<td>2.00 pm</td>
<td>Practice and Feedback from small groups</td>
<td>30 mins</td>
</tr>
<tr>
<td>2.30 pm</td>
<td>Discussion to explore and resolve difficulties</td>
<td>15 mins</td>
</tr>
<tr>
<td>2.45 pm</td>
<td>Safety planning with children</td>
<td>15 mins</td>
</tr>
<tr>
<td>3.15 pm</td>
<td>Tea</td>
<td>15 mins</td>
</tr>
<tr>
<td>3.30 pm</td>
<td>Caring for the carers: supervision and training</td>
<td>30 mins</td>
</tr>
<tr>
<td>4.00 pm</td>
<td>Small group work: action points for changing practice</td>
<td>20 mins</td>
</tr>
<tr>
<td></td>
<td>(Review process of identification, evaluation, documentation, referral),</td>
<td></td>
</tr>
<tr>
<td></td>
<td>in context of department and liaison with management</td>
<td></td>
</tr>
<tr>
<td>4.00 pm</td>
<td>or Review, individual feedback and commitments</td>
<td>20 mins</td>
</tr>
<tr>
<td>4.20 pm</td>
<td>Completion evaluation form or post-questionnaire</td>
<td>15 mins</td>
</tr>
<tr>
<td>4.30 pm</td>
<td>Close</td>
<td></td>
</tr>
</tbody>
</table>
Sample E – A Modular Training Course Outline, 8 x 90 minute training blocks

Target audience
- health visitors

Objectives
- to help health visitors to apply the Department of Health Guidance to their everyday working practice;
- to improve understanding and awareness about domestic abuse and the health professional’s role;
- to increase sensitivity to potential signs of domestic abuse;
- to increase knowledge about how to ask direct questions about domestic abuse;
- to increase confidence in providing support;
- to ensure an appropriate response when abuse is disclosed;
- to improve communication, information sharing and working in a multi-agency context;
- to further develop health visitors’ child protection knowledge.

Learning outcomes
- Understanding of the Department of Health Guidance;
- Improved knowledge about domestic abuse and its impact on health;
- Improved knowledge about indicators of abuse;
- Improvements in the confidence and skills needed to directly asking patients about abuse;
- Improved ability to respond to patients who have experienced abuse;
- Improved awareness of other agencies roles and knowledge about referral options;
- Basic understanding of risk assessment and safety planning.
- Understanding how domestic abuse affects children and an ability to begin to draw on this knowledge to safeguard children.
Module 1 - Domestic Abuse and Health
What is domestic abuse? Brainstorm exercise
Definition of domestic abuse presentation
What the abuse involves – power & control wheel
How common is abuse? – overhead on prevalence supported by handout
The impact on health – quiz, discussion and handout
Why women stay?

Module 2 - Children and Domestic Abuse
The impact of domestic abuse on children
Pregnancy and domestic violence
Implications for health – case study discussions
Children and contact

Module 3 - Overview of the Health Professional’s Role
Department of Health Guidance and health visitor’s role
Core messages
Flow chart
Staff safety issues
Case study discussions

Module 4 - Creating a Supportive Environment
What women want
Why women might be afraid to talk about abuse
Information and resources

Module 5 - Asking about Abuse
Routine enquiry – what research shows
Ask me’ : sample questions and guidance
Practice and Feedback from small group

Module 6- What to do if a woman discloses
What you can do – flow chart
Providing support and information – basic principles
Risk factors
Safety planning
Referral
Module 7 - Keeping records
   Documenting the abuse
   Practice examples
   Information sharing and confidentiality

Module 8 - Safeguarding Children
   Domestic violence and child protection
   Failure to protect
   Supporting mothers in parenting
1.9 Group agreements

An atmosphere of safety and trust is vital to the effectiveness of learning. Some group members may feel uncomfortable, or unfamiliar with, the material or a specific approach to learning. Successful facilitation will put participants at ease and enable them to contribute enthusiastically. The group needs to feel that you are credible, accessible and trustworthy. As a facilitator, you need to feel confident, well prepared, able to listen to the group and respond appropriately to concerns, needs and demands. You need to work in partnership with participants so that their needs can be addressed and their expectations met as far as possible, in the context that you acknowledge your own needs and expectations when appropriate.

To help to build a supportive learning environment, you may find it helpful, especially for longer and experientially based training sessions, to develop a group agreement. The term ‘group agreement’ is preferred to the more traditional term ‘ground rules’ because ‘rules’ can be perceived as over-controlling by some participants.

Example opening statements to introduce an agreement:

A priority for the day is that our group is both safe and effective: that each participant feels physically and emotionally safe, and that we achieve our aims.

or

I would like to talk about the way we manage our meeting today so that we share an understanding of what is permissible and expected within the group. For example, we might agree as a group that only one person speaks at a time and that we will respect every person’s viewpoint, even if we disagree with them.

or

There is a breadth of knowledge, beliefs and experience to share within the group. This also means that you may have different expectations of how groups like this work. We want the session to feel as safe as possible for everyone. Given the sensitive nature of the subject, and the way we work, which is to invite you to participate rather than be passive recipients, we need to agree how we are going to work together, rather than assume that we have a common understanding.
Method

Option A (short session)
Trainer presents principles written on a flipchart to the group, saying

*Given the short time we have available, we drew up a list of principles for the session, and would like to offer our suggestions to you for discussion and agreement.*

Option B (half-day or more)
The trainer asks for ideas from the group, writing them up on a flip chart and then finalising each with the group. The flip chart sheet can be pinned up as a reminder and the facilitator prepared to remind the group of what has been agreed if there are any problems.

Option C
As each participant introduces themselves and their hopes for the session, the trainer also asks them to share a concern or anxiety. Each concern can be addressed by suggestions for an agreement within the group. For instance, someone aware that their manager is present generates the opportunity for a discussion about focus on personal learning rather than judging others.

After the list has been generated, ask if anyone has any questions or comments, anything to add, and then ask for their agreement to work within these rules. The trainer can look at each participant individually and wait for a nod or affirmation.

Content
Some possible group agreements might include:

Confidentiality
*If anyone shares personal experiences or what happens to them at work, please do not repeat it*

or

*Our group will work best if we can learn from each other. Any information that someone chooses to share – whether personal or work-related – should be treated as confidential – limited to this context, time and setting. When feeding back from small groups, please ensure everyone in your group are happy for any information to be shared with the whole group. It is fine after today for you to share your own learning, the training material presented by us as facilitators, or the handouts but please do not talk about anyone else in the group, or what they said or did, or by
referring to them either by using their name or by any characteristics they could be recognised by. Is that clear and does anyone want to add to what we need to agree on confidentiality?

Listening and being heard
*Practice your listening skills by waiting for someone to finish speaking.*

*or*

*We hope that everyone will participate. Domestic violence is a sensitive and difficult issue to discuss and it is easier to participate if we feel heard and know we are being listened to. Please make an effort to listen to what is being said and do not assume you know what someone is about to say.*

Respect
*Please be respectful rather than attacking with personal remarks.*

*or*

*As a group of people working together, it is important that we demonstrate respect for each other as well as for others outside this room. One way of doing that is by using appropriate language that is not oppressive, that does not make someone feel uncomfortable, unsafe or excluded. We all have different attitudes and experience of discrimination and oppression, so if someone says something in a way that you are not comfortable with then please explain why in a positive and supportive manner.*

*(Give example e.g. I prefer to talk about women experiencing domestic violence because the phrase ‘battered women’ sounds as if it is a personal characteristic of women; just as we don’t talk about measled people, we talk about people having measles).*

*Please show respect for one another as well as one another’s point of view, and avoid language that may be perceived as racist, sexist or homophobic.*

Time out
*Take time out if you need to, in whatever way you need.*

*or*

*Domestic violence can lead to anyone feeling upset or distressed by the issues themselves or by exercises in the workshop. If you need to, please take time out, either outside of the room or by deciding to stop participating and sitting back.*
Please take responsibility for looking after yourself and taking space if you need it. You can think about the movie you just saw or plan dinner tonight without having to explain what you are doing. However, if you leave the room please do two things:

- if you want or need company or support ask a facilitator or a colleague to come with you
- please come back when you are ready or at least five minutes before the end of the session, to give you an opportunity to get closure and so the rest of the group isn’t worrying about where you are and if you are okay.

**Being non-judgmental**

This group will learn more by not having to be right, and safer if we agree not to judge anyone – even ourselves, since we have the worst judge of all inside—or

We all have our own set of values, attitudes and beliefs. It is important that we agree to respect one another’s right to hold different views, especially because domestic violence can bring up powerful reactions and feelings. The chances are that all of us in this room will not be in total agreement with each other. If something is said that you find difficult to believe, or with which you disagree, please try to think before you respond, and disagree in a positive way. Women who have experienced domestic violence have been subjected to punishment, criticism and humiliation. Part of our role can be to model non-judgmental relationships, starting with each other. One way to do that is to use ‘I’ statements, like ‘I feel’; ‘I think’ rather than implying what you think is a fact or universal truth (‘which would mean you say ‘lots of people think that’ or ‘it’s a fact’).

**Support**

Learning about domestic violence raises issues personally and professionally. Please take responsibility for identifying your own sources of support to work through these, inside the group and outside it. Think about your own personal or professional networks that you can use. Please think about whether you are willing to supporting colleagues, so that we create a safe group for us to work. We can support colleagues as best we can mainly by upholding our group agreements. This is already a special group, in that you are willing to listen and learn about a
problem society has so long ignored. Let’s not act as if any one of us is to be attacked or blamed for what has been caused by society.

**Time keeping (for courses longer than a one-off session)**

There is a lot to cover during the course so the training will be quite intensive. Good time keeping depends on trainers and each participant. We will finish at the stated time and appreciate each of you in the group arriving and returning from breaks on time, and helping each other to do so.

or

We need to start and finish on time, to protect other parts of the course that are just as important.

There can be other types of interruption. Please switch off your mobile phones unless you are on call for emergencies.

Trainees can build in flexibility in the programme for groups to plan their own agenda to some extent, such as fifteen minute discussion time at the end of each session. However, whatever time plans are agreed should be adhered to. The facilitator must ensure that group work is kept to time and that there is equality of time allocation in relation to feedback from small groups, for example.

**Expertise within the group**

Facilitators are not the group experts on everything. Enabling participants to learn through each other is an important principle for the group and to take back to practice.

We are all responsible for our own learning: if you don’t understand, please ask: either me or someone else! It also means the point might not be clear to other people. And if someone doesn’t seem to understand what you are saying, try to make your meaning clear in another way by finding a different way of explaining your point.
Confidentiality
If anyone shares personal experiences or what happens to them at work, please do not repeat it.

Listening and being heard
Practice your listening skills by waiting for someone to finish speaking.

Respect
Please be respectful rather than attacking with personal remarks.

Time out
Take time out if you need to, in whatever way you need.

Being non-judgemental
We all have our own set of values, attitudes and beliefs. Agree to respect one another’s right to hold different views. Use ‘I’ statements: ‘I feel...’ ‘I think...’

Support
Think about your own personal or professional networks.

Time keeping
We need to start and finish on time. Please switch off your mobile phones unless you are on call for emergencies.

Expertise within the group
We can learn through each other.

We are all responsible for our own learning.
Module One

Domestic Abuse as a Health Issue

Training Guide
MODULE ONE – DOMESTIC ABUSE AS A HEALTH ISSUE

2.1 Introduction

This first core training module contains trainee’s notes and materials to be used to increase professionals’ knowledge about domestic abuse, the impact upon health and the role of the health professional.

2.2 Defining Domestic Abuse

Aims: To define domestic abuse as a basis for shared understanding
To raise awareness about the range and types of abuse
To explore issues raised by the selection of a definition

Flipchart and marker if exercise

Time: 2-30 minutes (including exercises tailored to length of session and size of group).

Method

Definition - two minute exercise
Display the Home Office definition of domestic violence (Slide 2.A, and 2.B), read the definition and include in participants’ handouts.

Definition - five minute exercise

Highlight differences in the definitions and explain why definition is important:

- It can influence the statistics we collect showing how much domestic abuse happens.
- It can affect women recognizing and naming their experiences.
- Professionals may not recognise domestic abuse in their everyday practice e.g. they may overlook women who live alone, women who are separated or women experiencing emotional abuse.

Ten minute definition
Show Slide 2.D.
Invite the group to suggest how the terms imply different understandings of domestic abuse. Highlight the issues created by the choice of definition e.g.

- The most commonly used term in Britain is ‘domestic violence’;
- ‘domestic violence’ sounds as if it only happens in a joint home. But women who live alone and who have left their partners still experience violence, abuse and harassment;
- ‘domestic violence’ suggests that it might be less serious than ‘non-domestic’ violence. It is no cosier or more homely than violence in other contexts, it is more life-threatening and some people as a result call it ‘domestic terrorism’ or ‘intimate terrorism’;
- Some groups use the term ‘domestic abuse’ rather than ‘domestic violence’ to draw attention to the severity of psychological abuse, even if there is no physical injury, and/or to capture the broad range of abuse experienced by women, such as mental cruelty and rape;
- Terms spouse abuse’ or ‘marital violence’ present a de-gendered concept of domestic abuse. The terms suggest an ‘equality of violence’ in abusive relationships, that each partner in the relationship is equally likely to play the role of perpetrator or victim, that the frequency and severity of force used by each is similar and that the consequences of violent acts are the same. None of these are true.
- The term ‘intimate partner violence’ is sometimes used to reflect the fact that abuse happens in gay, lesbian, bi-sexual and transgender relationships as well as in heterosexual relationships.
- To highlight that the vast majority of assaults are by men on women, domestic violence is sometimes called ‘woman abuse’ or ‘wife assault’;
- ‘Wife battering’ is less used these days because it implies the woman becomes helpless pulp rather than an active decision maker in a dangerous situation;
- The range of abusers is not confined to partners or ex-partners, but can include fathers, brothers, sons, cousins, in-laws, extended family.

Exercises for exploring the nature of domestic abuse and its range of forms.
What is domestic abuse? 10 minute exercise: Case study
Aim: To increase knowledge about the nature of domestic abuse.
Method: Present a case (see Case Studies, Handout 2.A) to highlight different types of abusive behaviour and ask participants to discuss their thoughts and reactions. This exercise could be extended into small groups, each working on a different type of case study and feeding back to the large group on women’s different experiences of domestic abuse, and common features across cases.

What is domestic abuse? 15-minute individual or pair exercise
Aim: To increase knowledge about the nature of domestic abuse.
Materials: Pens; post-it notes or strips of paper; blu-tack 4-6 flip charts, depending on the size of the group and trainers’ preference, with headings (Physical Violence, Sexual Abuse, Emotional/Psychological Abuse, Financial Abuse).
Method: Trainer to secure charts to wall side by side. Working individually or in pairs, ask participants to write down examples of this type of abuse (one per post-it note). Each person/pair has ten notes to complete. The focus is on what an abuser does, eg. hitting, kicking, not the effects of abuse e.g. bruises, fractures. Ask each person is then asked to stick their note under the appropriate heading on the separate flipcharts. The facilitator might explore the points above, or discuss any issues raised (e.g. most examples are physical) See trainer’s notes below.

What is domestic abuse? – Trainer’s notes.
Use the following checklist to explore with participants the nature and range of domestic abuse. Point out particular types of behaviour that participants might not mention eg being locked in the house, sleep deprivation.

Physical abuse
Murder: 2 women per week in England and Wales are killed, the most common way women are murdered in the UK is by strangulation

Suffocation: Throwing objects: cups, telephones, tables, TVs
Shaking: Pushing or shoving against wall or down stairs
Slapping, smacking or punching: Twisting arms
Breaking bones: Bending fingers back
Stamping on toes: Using an object as a weapon a belt, a bottle, a chair, a spanner
Holding by the throat or choking: Banging head
Pulling hair: Kicking
Biting
Burning: with cigarettes, hot water, irons, kettles
Punching or kicking abdomen while pregnant
Tying up
Being forced to take drugs: forced down throat, injected, spiked drinks
Cutting or stabbing: with knives, cutlery, razor blades Drowning
Pouring over acid or petrol
Shooting
Starving
Driving dangerously
Locking in the house
Beating so bruises won’t show
Sleep deprivation

**Sexual abuse**
Rape: vaginal, anal, oral: with penis or objects
Forced prostitution
Forced sexual acts with others and/or in front of others
Sexual acts with animals
Cutting or disfiguring breasts/genitals
Refusal to practice safe sex or allow contraception
Forced into pornography: photographed or filmed images displayed on the internet.
Religious prohibitions about sex at particular times of menstrual cycle ignored

Threats of or actual sexual abuse children

Forced sexual acts in front of children

Forced sex after childbirth

Deliberately infecting with sexually transmitted disease: genital herpes, HIV

Threats to ensure compliance with sexual demands

Sexual insults: slut, whore, ugly, undesirable, frigid; boasts about better sex with other women

**Psychological/emotional abuse**

Telling her she is mad

Threats (give examples)

Controlling behaviour (give examples)

Isolation (give examples)

Threatening to commit suicide if she leaves

Using children to convey threats

Stalking

Constantly criticising

Sexual jealousy

Monitoring her movements

Enforcing household ‘rules’ (give examples)

Telling her it is all her fault

Harming pets

Threatening to hurt children or family

Humiliation in public (give examples)

Degradation eg forced to eat from dog’s bowl

Urinating on her

Alternating kindness with cruelty

Denying the violence
Dominating reality so his view is ‘right’

Telling her no one will believe her

**Financial abuse**

Financial abuse is like living with an ‘obsessive accountant’ – having to produce receipts and change, beg for money, justify bills – all affecting women’s capacity to seek help.

Keeping her short of money

Taking or destroying property

Running up debts

No money for sanitary towels

Taking away her shoes

Litigation abuse

Stealing from her

Forcing children to steal from her

Not allowing her to work

Getting her sacked from work

Taking all her wages

**Check in discussions of physical abuse that participants recognise**

Pregnancy is often a trigger for the onset or escalation of violence;

The most common area for attack is abdominal (normally hidden by clothes);

The most common method of domestic violence murder in the UK is by strangulation (overtaken by stabbings in London)

30% of homicides are witnessed by children.

Pick up on any difficulty participants may have in talking about sexual abuse to illustrate the difficulties for women talking about their experiences.

Note examples of obsessive sexual jealousy in a relationship .g. accusing her of having affairs with any man who makes eye contact vs sexual insults e.g. frigid/a whore.

Check brainwashing has been recognised as a controlling tactic.
Highlight almost all domestic abuse is a combination of many forms of abuse – it is difficult to separate them and more difficult to talk about some than others.

Mention women say the emotional and psychological harm caused by domestic abuse is more difficult to overcome than the physical injuries. Women are likely to mention feeling small or disappearing as a person, losing self esteem, living in fear, blaming themselves etc.

Abusive men have a standard set of insults such as ‘you’re stupid/useless/ugly/fat/terrible wife/lover/cook/housekeeper’ or ‘you’re lucky to have a partner/no-one else would put up with you’.

‘Normal’ and ‘abusive’ behaviour may not seem distinct if we look at single isolated instances eg most of us have shouted, but domestic abuse involves multiple incidents and deliberate acts in a systematic pattern of behaviour designed to induce fear and control a partner.

Less physical violence does not necessarily mean the woman is safer, but may reflect the extent of power the abuser has over the woman (eg she no longer takes the risk to answer back, or she and the children quail just at a look, because they know what might happen).

Circle examples on the list of acts that would usually be criminal offences (using CPS guidelines for charging accessible on the Home Office website): those not circled show the lack of protection for women; those circled do not reflect the rates men are arrested and charged.

Social isolation is perhaps the most powerful tactic of all e.g. by taking her wheelchair to work, locking the phone away, not letting her go out, taking away her shoes or more subtle versions e.g. saying how much rather he would have a night at home with her than go to visit her mother, he loves her so much he wants to be just with her.

**For longer sessions you may find it useful to show SLIDE 2.E, the Duluth Domestic Abuse Intervention Program’s Power & Control Wheel.**

The Domestic Abuse Intervention Project in Duluth, Minnesota developed the wheel as a teaching tool for work with perpetrators to illustrate the range of violent, abusive, threatening and controlling behaviour used to sustain power and control over the partner in an abusive relationship. As well as committing acts of physical or sexual violence, a perpetrator will try to control his partner through:
**Intimidation**
Abusers shout, yell, smash crockery, punch doors, walls, tables. Throw things. Wake her from sleep. They have unpredictable mood swings that keep her ‘walking on egg-shells’.

**Emotional abuse**
Abusive men swell and call their partner names like slag or whore; a bad mother or housewife; ugly, useless, crazy, stupid; others make racist or spiteful remarks. They try to make her feel unattractive, incompetent, unworthy and unlovable. They try to erode her independence and confidence by criticism, denigration, public humiliation over weeks, months or years. Occasionally he will be kind to her or indulge her to ‘keep her on her toes’.

**Isolation**
This includes tying her up, locking her in rooms/inside home; not allowing her to work, to socialise, to attend medical appointments. Acting so badly that friends or family stop visiting or she stops asking them round. Timing her errands; checking her mileage. Stalking her; following her to work and watching if any man speaks to her, then beating her after she has been out because he feels she gave someone the ‘wrong look’ so must be having or inviting an affair. Going everywhere with her so that she is never let out alone. Taking the telephone to work, locking it away or screening itemised bills to prevent her making calls. Continually checking up on her. Not allowing her to learn English, hiding her passport, threatening her with deportation. Kidnapping her if she tries to leave and holding her hostage.

**Minimising or denying the abuse**
While some abusive men show remorse and apologise after an assault, many act as if the violence hadn’t happened, or as if the woman was to blame, or as if she has exaggerated what happened. The perpetrator may ‘explain’ his behaviour by telling her it only happened because he loves her so much and is frightened he may lose her; that it was for her sake; that she caused the abuse by making him angry; external factors such as alcohol, drugs, stress, unemployment caused his violence; that the sexual or depraved act was her duty. He may use his influence and charm to diminish her in the eyes of others so that she appears to be troublesome, exasperating or difficult to live with.
Using children
The perpetrator may threaten the woman that, if she tells anyone about the domestic abuse, the children will be taken away; he may threaten to harm or abduct the children if she tries to leave. He may refuse to give money for the children; accuse her of not looking after them properly or of depriving them of a home and family. He may undermine her relationship with the children, constantly criticising her and trying to involve children as his allies. Contact visits after separation may be used to abuse her and them. He may force her to terminate pregnancy, to have many pregnancies or may make her pregnant through rape. He may control the children insisting they keep quiet, follow his ‘rules’, force them to kick, beat, swear at the mother or to witness his attacks. 90% of domestic violence is directly witnessed by children; 10% witness the mother being sexually abused.

Exploiting male privilege
The perpetrator will do things that he claims men are entitled to do - treat her as his inferior, like a servant, with no rights; write a list telling her how to behave; tell her what to wear; not allow her any say in family decisions; insist that his opinions, needs or wishes dominate. The most rigorous traditional stereotypes are likely to be enforced in a family in which there is domestic abuse. She may be refused respite from her ‘role’ in child care and housework when she is ill. His ‘right’ to have sex may take precedence over her medical need for rest after childbirth. He may expect meals on demand, instant responses to his demands at any time of day or night.

Economic abuse
He may prevent her from going to college or getting a job, take her wages, control all the money, make her account for everything spent. His behaviour may result in her losing her job, her home or having huge debts. Money may be used for his leisure activities, his gambling, drinking or drug habits rather than to feed the family. He may damage her property, her car, clear the house of furniture.

Coercion and threats
Threats used include threats to track her down and kill her or himself if she leaves, threats to hurt her family, to send someone after her or the children, threats to kill the family pet, to get her deported, to tell the police about her illegal activities. He may stalk her after she leaves.
2.3 Who is affected?

Prevalence of domestic abuse
Trainers, and health professionals, can use statistics about the incidence of domestic violence, to:

- counteract a woman’s fear that she is alone;
- challenge victim blaming (that abuse is due to some personal characteristic or attribute);
- raise awareness about the proportion of service users that may be in danger.

Prevalence of domestic abuse: 5 minute session:
Aim: Increase knowledge about the prevalence of domestic abuse.
Materials: Overhead projector/slide show equipment, Slide 2.F, Handout 2.B.
Method: Presentation. Display SLIDE 2.F on prevalence and read through the statistics. Direct participants to further information in Handout 2.B which they can read later.

Where possible, provide local statistics on the number of incidents reported, number of women and children supported by agencies, local studies.

Prevalence of domestic abuse: 10 minute session:
After the 5 minute presentation above, ask the group for their reaction and supplement the discussion with further information from Handout 2.B.

Prevalence of domestic abuse: 15 minute exercise: Domestic Violence Quiz
Aim: To raise awareness about the prevalence of domestic abuse.
Materials: Photocopies of Quiz Handout 2.C or Quiz Handout 2.D, pens, and answers on the back of the quiz sheet.
Method: Quiz. This can be completed individually or in small groups, followed by a discussion of the answers with the whole group. The facilitator can use the opportunity to include further information from Handout 2.B or simply to gain some insight into the level of awareness among the group.
The prevalence of domestic abuse in caseloads 5-15 minute exercise:

Aim: To raise awareness about the prevalence of domestic abuse among women patients.

Following on from previous exercises, participants can begin to consider how the prevalence of domestic abuse may affect their practice environments. For example, what are the levels of domestic violence in health visitor caseloads or in a practice population?

Trainers can suggest extrapolating from prevalence figures i.e. ask participants to estimate the prevalence of domestic violence in their own practice population by extrapolating from these figures. Further questions could include:

- What is the likely impact on your caseload?
- What are the implications for identification, support, protection and prevention?
- Are there any surprises?
- To what extent do participants feel the need to re-think the prevalence of domestic violence in their own areas of practice?

Gender issues and domestic abuse

1 minute response

Suggested response for trainer: We must not overlook the possibility that a health professional may meet a male victim of domestic abuse. He too has the right to be identified, and there are support services for abused men. Everyone has the right to be safe. However, we focus on women and children because they are the most frequent victims. It is important though to remember that men can also be victims of domestic abuse and that abuse can happen in gay and lesbian relationships as well as in heterosexual relationships.

5-10 minute response

Show Slide 2.G.

Trainer’s notes for facilitating a discussion on gender and domestic abuse:

Anyone who suffers domestic abuse has the right to support. The training is primarily focused on the experiences of women due to the overwhelming prevalence of domestic abuse against women. While men do suffer from domestic abuse, in over 90% of cases, domestic abuse is perpetrated by men against women and women experience the most serious and the most frequent assaults,
including almost all sexual assaults (e.g. Walby and Allen, 2004; British Crime Surveys (BCS): 2000, 1996; British Medical Association (BMA), 1998, p.7) For example:

- In 1,200 incidents of domestic violence across two London boroughs, 99% of victims were women and 99% perpetrators men (Home Office Research Study 193: Kelly et al, 1999);
- In 4,764 incidents of domestic violence recorded by Derbyshire police over 1997, 91.6% were incidents in which the victim was female (Williamson, 2000);
- 89% of people who suffer four or more domestic violence assaults are women (Walby & Allen, 2004).

However, other types of domestic abuse include elder abuse (ESRC, 2002); abuse by same gender partners or ex-partners, abuse of mothers by children, and abuse of women from ethnic minorities through forced marriages or by her extended family. Most of the information applies to any person experiencing domestic violence, whatever their gender, status, age, ethnicity, sexuality or characteristics: everyone has the right to be safe. However, a review article by Shadigan & Bauer (2004) concluded that heterosexual women are 5 to 8 times more likely than heterosexual men to experience violence by an intimate partner, but also that men and women in gay and lesbian relationships experience partner violence at a rate comparable to women in heterosexual relationships.

Women are more likely than men to experience repeated domestic violence and threats and are:

- twice as likely to be injured - The inequalities of physical power between men and women will have a profound effect: men are usually larger and stronger than women, so the same acts (e.g. shoving) have different consequences. Men use more dangerous forms of violence, make more frightening threats, do more damage and are almost always the perpetrators in sexual assaults (Walby & Allen, 2004);
- more likely to be frightened and upset after being assaulted (Walby & Allen, 2004);
- Men and women usually have different motives when they are violent (Browne, 1987; BMA, 1998; Barnett & LaViolette, 1993). Men most frequently abuse women because they want to ‘show who is boss’, gain
control or around infidelity. Women who are violent against partners act most often in self-defence, to stop an on-going or threatened attack. In the most extreme case of homicide, at least 60% of men initiated the violence that preceded their death (Radford 1993; Wilson and Daly, 1999).

Explaining Domestic Abuse – The Things People Say (5 to 30 minute exercises)

Aims: To raise awareness about factors associated with domestic abuse.

To help participants to review their own beliefs.

To equip participants to deal with commonly held unhelpful beliefs they may encounter.


Flipchart paper and markers if required for exercises.

Time: 5-30 minutes (including exercises tailored to length of session and size of group)

Introduction
Trainers might explore the principle that how you see a problem will influence what you think should be done about it. Personal beliefs about domestic abuse can sometimes get in the way of providing appropriate support. It is important that participants are able to reflect on and review their own beliefs in a non-threatening environment. Open discussion and sharing information in small groups is more likely to promote change in beliefs than overt, direct challenge, which can result in withdrawal and a closed mind. The trainer might precede exercises by reminding the group of their agreements (to promote safe effective working together).

Unhelpful beliefs about domestic abuse can create a vicious circle of inaction (Sinclair, 1985):

Unhelpful beliefs lead to:
Excusing offender
Inaccurate analysis

Blaming the victim of problem leads to:
Frustration and helplessness

Ineffective intervention leads to:
Failure to stop violence
There are at least four sorts of commonly held unhelpful beliefs about domestic abuse:

- beliefs that blame the victim;
- beliefs that excuse violence;
- beliefs about the role of society;
- beliefs that minimise the risk.

Show Slide 2.I and, depending on the time available, allow participants to discuss one or more of the common beliefs. Ask participants: a) whether they think the research on domestic abuse supports or refutes the statement of belief; b) to decide what they might say to a woman patient about this issue.

Ask for feedback. Use the trainer’s notes and Handout 2.E to discuss the belief statements with the group. Give participants Handout 2.E for future reference.

**Trainer’s Notes**

‘She provoked him – she must ask for it/deserve it – what did she do?’

Nobody deserves to be abused. There is no justification for violent crime. The biggest risk factor for suffering domestic violence is being a woman (see British Crime Survey analysis by Walby & Allen, 2004). Domestic violence does not just happen to ‘bad’ people. Being good does not stop a woman being victimised.

‘It can’t be that bad or she’d leave’

Women can be trapped in abusive relationships for a multitude of reasons. She may not know where to go for help; she may be afraid of what he will do if she were to leave or if he were to find her. The abuser may threaten to kill her, to stalk her, to take her children away, to hurt others she loves, to kill her pet or to kill himself if she leaves. She may have been told she cannot take the children away from their father; she may hope he is going to change; she may be under pressure from her family or community to stay. Sometimes the perpetrator has convinced her that the abuse was her fault. Most often, women have tried to leave and to get help … but no-one listened; family, friends or professionals reacted with disbelief or blame and failed to support her. Moreover, the time of leaving/ just after leaving is often the most dangerous, and leaving a relationship does not necessarily stop ongoing harassment and violence (see British Crime Survey analysis by Walby & Allen, 2004).
'It only happens in low income/working class families'

Domestic violence perpetrators come from every social and economic background. Women from all backgrounds are abused by partners or ex-partners: no matter what their education or income. However, in some communities it is more hidden: women with lower incomes may be ‘counted’ as they are more likely to turn to the public sector for help or refuge (BMA, 1998). In North London, 25% of professional women and 30% of working class women experienced domestic violence at some point in their lives; 7% professional women and 10% lower-income women experienced domestic violence within the previous year (Mooney, 2000). In the same survey, 20% of professional men admitted hitting their partner, compared to 21% of working class men and 17% of lower middle class men.

"He was abused himself: men who abuse women come from violent families"

Men who witness domestic violence as children may be at greater risk of being violent as adults but many men who grew up in violent families don't go on to become abusers and many men who are violent to a partner came from families with no history of abuse (Mullender, 1996). Living with violence as a child is no excuse for violence as an adult.

'He has a problem controlling his temper'

Most domestic abuse is systematic and premeditated, not a momentary loss of self-control. Most violent men control themselves so as not to assault the partner in public, not to cause injuries that will show and only hit their wife and children. If they have enough control to do this, they could use their control to walk away.

'Black men are more violent to women because of their own experiences of racist oppression and violence'

Black men do face racist oppression but the statistics show domestic violence is not greater within any ethnic minority group (Mirlees-Black, 1999). In the London Borough of Camden, 67% of domestic violence perpetrators were white and 25% were Asian or Afro-Caribbean (proportionate to the percentage of those communities within the borough) and 6% of women reporting experiencing violence were Asian, directly correlated with the percentage of Asian women in the borough. Chauvinist views about women exist in most cultures, although gender power may be displayed in different ways.
‘Drunks are violent’; ‘If he stopped drinking the domestic violence would stop’

Many men who drink are not violent. Many men are sober when they abuse their partners (British Crime Survey, 1996); in the Home Office Research Study (191, 1999) only 32% assaults occurred while the assailant was under the influence of alcohol. The majority of abusers are not alcoholics and the majority of men classified as high level drinkers do not abuse their wives. Some men use drink to deny responsibility and as an excuse for violence; many women know before a perpetrator starts drinking that he will be violent. Women are 17 times more likely to contact the police when a perpetrator is drunk or drugged because he is less predictable: but drugs or alcohol did not cause the violence (Stella Project, 2003)

‘Asian women are passive and conform to a male dominated culture and religion with harsh traditions (that may include wife beating, maiming and killing)’

Women from different cultures experience domestic abuse, and the risk does not differ significantly according to ethnicity or religion (Home Office Research Study, 1999). Women who are Christian, Hindu, Jewish, Muslim and Sikh experience domestic abuse. There is no such a thing as one Asian culture. The belief that domestic abuse is acceptable in Muslim communities is false and unsubstantiated. However, family honour (izzat) and shame (sharam) can play an important part in some Asian families and further limit women’s ability to find help; Asian women are 2-3 times more likely to attempt suicide than other women and more likely to self harm (Humphreys, 2003).

‘He’s a good dad, so she should stay for the sake of the children’

The impact of domestic abuse is serious and cumulative. In at least 50% of families in which violence occurs, children will also be directly harmed, Witnessing domestic violence can cause cognitive, emotional and social (relationship) damage, whatever the age of the child. Research shows the emotional and physical health of children improves when they are safe from violence (Hester, Pearson & Harwin; 1999).

‘It’s not really domestic violence; it’s just the odd row/domestic tiff’

Domestic violence is almost always repeated and escalates in severity and frequency over time. Repeated abuse is damaging and potentially life-threatening to women and children. Although some women fight back or defend themselves when they are being assaulted, this does not mean that she 'is as bad as him'.
‘Some women just go from one abusive relationship to another’

Abusers are not easy to identify. It is often only with the benefit of hindsight that the characteristics that turned out to be abuse can be clearly seen. At the beginning of a relationship the abuser may appear charming, attentive and caring. He may promise to change and she may believe he will.

‘It’s a private matter; we shouldn’t interfere’

Domestic abuse is not a private matter. Violence is a crime and a public matter. Domestic abuse affects women and children, neighbours, family, friends, colleagues and communities. If we suspect a woman is experiencing domestic violence, we should try to let her know that we are there if she needs or wants support. Ignoring the abuse will add to the sense of isolation she probably already feels. If she does not want to talk about it, she won't.

‘There is no point in getting involved because the women always go back’

Leaving the partner does not guarantee safety. Women are at most risk of life-threatening violence when they attempt to leave or have recently left a partner (Home Office Research Study 191, 1999). 35% of women interviewed about domestic violence in Canada, experienced increased violence from their partner after separation (Johnson & Sacco, 1995). Think of ‘trial runs’ at escaping which become impossible to sustain for various reasons. The vast majority of women who have escaped successfully left a number of times prior to the final break.

NB. If a training group member suggests that giving information to women experiencing domestic violence is dangerous, the trainer might reply: under the Human Rights Act (2000) professionals who do not take any action when a woman discloses domestic violence risk being sued if she is murdered by her partner and the family finds the professional knew and did nothing. That is, we have a duty of care to provide information, although we can respect a woman’s decision not to take written information away. Health authorities also have statutory responsibilities within the Crime and Disorder Reduction Partnerships.

What people think about domestic abuse - Attitude survey findings – 5 to 10 minute exercise.

Social attitudes set the scene for domestic violence. If a man’s friends believe he should be ‘the boss’ and approve of slapping a wife to ‘keep her in line’, he is much more likely to be violent (Health Canada, 1995). Violence and aggression is
much less evident in egalitarian marriages that share power (Barnett & LaViolette, 1993). An abuser’s perceptions of ownership and control can be supported and reinforced by wider attitudes, lack of sanctions against him or poor protection for victims.

**Aims:**
- To raise awareness about factors associated with domestic abuse;
- To help participants to review their own beliefs;
- To equip participants to deal with commonly held unhelpful beliefs they may encounter

**Materials:**
- overhead projector/slide show equipment, Slide 2.I.

**Method:**
- 5 to 10 minute presentation.
  - Show Slide 2.I and discuss how attitudes about the acceptability of domestic abuse may persist.

**Who are the perpetrators? 5 – 10 minute exercise**

Abusers come from every part of society, every socio-economic group, educational level, religious or ethnic group. There is no single ‘type’ of domestic violence perpetrator. However male perpetrators of domestic violence may sometimes use similar controlling techniques against their partners and may ‘justify’ their abuse in similar ways (Jordan, Quinn & Walker, 2004; Schornstein, 1997).

**Aim:**
- To increase knowledge about characteristics of perpetrators of domestic abuse.

**Materials:**
- Overhead projector/slide show equipment
  - Slide 2.J. (For longer sessions video material can be used to introduce this topic, see resources).

**Method:**
- Presentation, 5 to 10 minutes. To illustrate the similarities in controlling behaviour and explanations for the abuse
  - show Slide 2.J and discuss the key points drawing from the trainer’s notes below.

**Trainer’s notes:**

He denies his abuse: many violent men do not believe they have a problem; they lie about their violence or deny it outright. Others minimise the severity, suggest
the woman is exaggerating, over-reacting or imagining it. A man who uses domestic violence against his partner is more likely to deny allegations of violence and abuse made by his ex partner in the family courts and more likely to make counter allegations.

He blames the woman or factors ‘outside’ his control: most abusers do not hold themselves responsible for their behaviour. Some may show remorse but also believe and tell others they were driven to the abuse by forces beyond their control (such as drink, her provocation, stress).

He may believe in and enact the stereotypic male role: he may believe that he ‘owns’ his partner and that violence is an acceptable means to control her. Some abusers hold traditional ideas and see themselves as head of the household, and in total control of it ‘or else’. The abuser may be an ‘instrumental offender’, obsessively watching and stalking his partner or ex-partner, determined that no-one else (including the children or family) shall have access to her attentions. He may abuse to humiliate and punish, to ‘teach her a lesson’, or because he thinks she has not kept the house tidy.

He is pathologically jealous and possessive: suspicions or accusations about her sexual infidelities may be presented at first as an aspect of his ‘devotion’ and his fear of losing her or being unloved. Some abusers show extreme sexual possessiveness and may become more violent if they fear abandonment. He may use jealousy as a reason to isolate her, to monitor her movements or to stalk her.

He may mask emotions as anger: An abusive man is very unlikely to admit fear or distress; he is more likely to hide these emotions behind the ‘acceptable manly feeling’ of anger (which he, unlike others, equates with violence). Many women say their partner swings (unpredictably) between extremes; he is either ‘fine’ or ‘furious’. He is action-oriented, and is physically aggressive to ‘shut her up’ or to prove his superiority over his partner’s skill at expressing herself. Others appear publicly as immature, poorly socialised and impulsive, expecting an immediate outcome. If frustrated, these men may fly into rages, yelling and cursing. However, in common, across all attempts to classify abusive men, the majority use their ‘temper’ or ‘anger’ as a controlling device and an excuse.

He may refuse to let other people close: he distrusts everyone; forms only superficial friendships, rarely confides in anyone, and sees asking for help as
unmanly. Others see him as a charming man (Horley, 2002), but they know Dr. Jekyll; his wife is the only person who sees Mr. Hyde.

Control issues: While some abusers have poor impulse control (fly into a rage), many abusive men are very selective in their use of violence. They plan their attacks, abuse only their partners, can be calculating in their abuse of non-visible body parts or turn on the charm if discovered by police. He uses violence to get his own way.

He may manipulate her by using intermittent punishment and reinforcement: Between the episodes of abuse he may assume the role of lover, protector and ‘nice guy’ using kindness, affection and comfort to control the woman, or he may grant ‘privileges’ (such as visiting her sick mother), to secure her gratitude and relief. A perpetrator of domestic violence often establishes control over his victim by inflicting systematic, repeated (but unpredictable) trauma, designed (albeit unconsciously) to instil terror and helplessness. The end goal is to destroy her autonomy by varied means including isolation and replace it with pathological dependency. Once this dependency is established, his ‘kindness’ in granting small privileges (such as undisturbed sleep) can undermine his partner’s resistance more powerfully than her fear. The intermittent nature of the abuse can fool women into thinking they have some control or influence over the abuser’s behaviour, and can resurrect the hope that the violence will stop. A woman experiencing domestic violence becomes confused by any kindness the abusive partner shows her: she is his hostage at home. The abuser may try to ensure that he is the only person who can offer her comfort and support. As he eases the emotional pain that he himself has created, he becomes not only the greatest source or her pain but the sole source of her support.

He may have dependency fears: expressed sometimes to the woman as an inability to live without her, and coercion for her to remain because he has threatened to commit suicide.

He may have low self-esteem: some men feel impotent or powerless, and their use of violence has been attributed to their attempt to obtain a short-term sense of mastery.

He may have witnessed or experienced violence in childhood: He may have witnessed his father abusing his mother; he may himself have been abused by his
parents, so to him it may not seem wrong, but normal (NiCarthy & Davidson, 1997). However, the research is inconclusive: experiencing violence in childhood may also lead to a hatred of violence and a determination not to be abusive (Mullender, 1996).

**Community responses – 5 to 10 minute presentation and discussion.**

Community and policy responses may reinforce an abuser’s belief that ‘he has the right’ to use violence and reinforce the woman’s belief that nothing can be done to stop it.

**Aim:** To help professionals to contextualise attitudes to domestic abuse within a social context; to raise awareness of how attitudes may influence responses.

**Materials:** Overhead projector/slide show equipment, Slide 2.K.

**Method:** Display Slide 2.K and discuss some research findings on the community and policy response to domestic abuse.

**Trainer’s notes:**

Abusers are given "permission" to go on controlling or violating their partners if others ignore the abuse, blame the victims or fail to provide an appropriate response/intervention. Domestic violence offenders have not been held accountable for their violent behaviour and very few are sanctioned or prosecuted. Many crimes of domestic violence go unreported. Of about 77,000 incidents of domestic violence reported in London, only 5% result in arrests. In an analysis of the police and prosecution response by Her Majesty’s Inspectorates, only 2% of charges brought for domestic violence incidents resulted in a conviction (HMIC, 2004). Between 1989-1999, the reported incidence of rape rose by 165% but the conviction rate fell from 24% to 9% (Home Office, 1999) and to 7.5% in 2003. The onus has been on the woman and her children fleeing their home, rather than removing the perpetrator. This expectation contrasts with other crimes, such as burglary, when the victim would not expect to leave their home except in the crisis, to inform the police and have the burglar arrested.

Violence against children continues. In 2003, 9% of UK parents reported using ‘severe’ physical punishment on children under 12, including slapping around the head and face, hitting with a hard object, kicks and punches (Stanko, 2003)
The lack of services in a community can also contribute to women feeling alone and trapped. Every day women desperate to enter a refuge are unable to find any space. There is a severe shortage of alternative safe and affordable accommodation (ESRC, 2002).

Gender inequalities such as the pay gap and lack of child care options make it difficult for women to live apart from abusive partners. Pay differentials still exist, despite equal-pay legislation. A shortage of affordable child-care provision may prevent or impede their ability to work.

However, social attitudes and behaviours are changing. Domestic violence is discussed much more openly, in the media and within government; it is no longer seen acceptable to treat it as a secret to be endured for years in silence. The police are delivering a powerful message directly to abusive men (including those within their own ranks) that assaulting a woman is a criminal offence for which they will be held accountable (whether or not they intimidate the woman into withdrawing the charges). Many police forces have established Community Safety Units that specialise in hate crimes, including domestic violence. The Crown Prosecution Service has introduced special measures to protect women while they present evidence in court. Supporting People has enabled thousands of women to access specialist support in their own homes and communities to help them escape domestic violence.
2.4 The Impact of Domestic Abuse on Health

Naming experiences as ‘domestic abuse’

Recognition that the partner’s behaviour is domestic abuse can come after a single incident, but for some women may take years. Many women do not relate to the terms ‘domestic violence’ or ‘domestic abuse’ nor do they believe that abuse can happen to them.

The frequency and severity of the violence can influence perceptions. For example, if an abuser shoves a woman in the middle of an argument in January but does not physically attack her again until October when he prods her during another argument, her perspective of events may not lead her to conclude she is in a violent relationship.

The context in which abuse occurs is also important. Many non-violent but controlling forms of behaviour are classified as part of a ‘normal’ relationship rather than as abusive. For instance, it is widely accepted that women should take the major responsibility for child-care; so many women with young children experience considerable social isolation – a feature of an abusive relationship. Although women might say it is ‘unfair’ or ‘unreasonable’ they are very unlikely to classify this as abusive.

External factors that might indicate that the relationship is going through ‘a bad patch’ and will ‘return to normal’ can also influence whether a woman defines her experience as abusive. Many men are not violent at the start of the relationship. When abuse does occur, perhaps after the birth of a baby, the woman may see this as due to the strain put on the relationship by the arrival of a child. She may assume that as the child gets older, goes to child-care or starts school, the relationship will improve.

Without the benefit of hindsight, many women can experience the eruption of violence as a ‘one-off’ and trust and believe an apology or show of remorse. Making the connections between different aspects of abuse or different incidents is difficult, particularly in the context of an abuser blaming her and/or external factors.

Women might say or think:

- ‘He didn’t mean it’ ‘He was drunk’ ‘It was my fault…’ ‘If I was more feminine / sexy / caring / motherly, he would be nicer to me.’
• She might want to believe that the relationship has a future, so finds explanations for the violence which minimises its impact and intentions, and thus enable her to continue to view the relationship positively.
• She may minimise or deny the injuries and the impact of abuse.
• She develops strategies to manage the violence: this maintains some semblance of her being in control.
• Her coping might be focused on trying to do or not do certain things, or defiantly acting certain ways knowing the consequences: either approach means that the repeated abuse can be understood – by herself and others – as yet again her responsibility.
• She is likely to believe his distorted perspectives: taking responsibility for the abuse feels better to her than recognising that she is totally helpless to stop or control it; the abuse becomes ‘normal’.
• She is likely to feel vulnerable, anxious, depressed, confused, guilty. She may show hostility to anyone confronting her with the reality of the violence.

As a woman starts to recognise the violence, she may face another set of reactions or questions, such as:

‘I feel so alone’
‘Who would believe me?’
‘There’s nothing I can do’
‘I’m so ashamed’

Redefining the relationship as abusive requires a woman to change her view of the dynamics of the relationship, so that –

• She recognises herself as being victimised, and her partner as an abuser.
• She realises that she cannot change or control his behaviour – that he is responsible, and that he chooses whether, when and how to abuse her – or not.

This is often a depressing, lonely point in the process for her – a woman will have very low self-esteem, feeling despair, helplessness, fear and shame. She may be in shock, as the reality of her situation ‘hits’ her.
The effects of domestic abuse on women

Aims
To enhance understanding of the impact of domestic abuse on the health of women
To relate the effect of domestic abuse on health to the role of the health practitioner.

Introduction
Points that a trainer might raise in discussion with the group include:

- Health is not just about physical or medical outcomes but psychological and social outcomes
- The consequences will vary greatly with each individual
- The most common form of domestic murder is by strangulation
- Injuries and abuse happen at home: supposedly a place of safety
- Link the effects of domestic abuse with possible indicators to observe in practice.
- Women report that the impact of domestic abuse on their self-esteem and confidence is more damaging than physical injuries they experience (Hoff, 1990; Kirkwood, 1993)
- Abuser’s tactics of control often include restricting women’s access to health care e.g. restrictions on attending for routine antenatal care (McFarlane et al 1992; McWilliams and McKiernan 1993), delayed treatment of physical injuries. Women may be prevented from seeking medical care ‘in case they tell’. This may be associated with a long term health impact e.g. in terms of scars, untreated fractures, disability and chronic pain.
- The abuser’s control tactics can include limiting his partner’s ability to follow a healthy lifestyle e.g. poor eating habits/nutrition, sleep patterns, social activities etc.
- Domestic abuse is often associated with women engaging in risky and health-damaging behaviours (Stark et al, 1979) e.g. smoking, substance abuse, self-harm, attempted suicide.
- Domestic abuse is likely to have a cumulative impact on a woman’s health and well-being.
Abuse can aggravate an existing condition or compromise its treatment (Campbell, 1998).

The above has serious implications for health in practice and service delivery.

The impact of domestic abuse and health : 15 minute Quiz
Aim: to increase knowledge about the impact of domestic abuse on health.

Resources: Quiz sheets Handout 2.F, pens and answers.

Method: Quiz. This can be done individually or in small groups, followed by a discussion of the answers with the whole group. Refer participants to Handouts 2.B & 2.G

Sum up discussion by showing Slides 2.L. & 2.M

The impact of domestic abuse upon health : 30-40 minute exercise using case studies.
Aim: To increase knowledge about the impact of domestic abuse upon health.

Method: Small group discussion using case studies.
Divide the participants into small groups, giving each group a copy of one of the case studies (Handout 2.A), depending on time available. For each case study, ask them to consider the following points for 10 minutes:

- The impact of the abuse upon her emotional health.
- The impact of the abuse upon her physical health.
- The impact of the abuse upon her sexual health.
- Identify points of contact with healthcare workers.

Ask each group to feedback to the whole group for a few minutes about one case study, and facilitate a wider discussion. Refer participants to Handouts 2.B & 2.G

Sum up the discussion by showing Slide 2.L. & 2.M
2.5 Children and Domestic Abuse

Children and domestic abuse (10-30 minute exercises)

Aims: To raise participant’s awareness of the impact of domestic abuse on children.


Method: Group storm/discussion with trainer recording on flipchart ‘The effects on children of living with domestic abuse’.

Display Slides 2.N. and 2.O Give copies of Handout 2.I.

Impact of domestic abuse on the mother-child relationship (20-40 minute exercises)

Aim: To explore the impact of domestic abuse on a mother’s relationships with children. This exercise should follow on from the exercise above, children and domestic abuse.

Materials: Flipchart, marker pen.

Method: Present on flipchart (or storm with group) the additional effects of domestic abuse on a woman if she has children, to include the following:

Mothers experiencing domestic abuse can:

- Be undermined as an individual and a parent;
- Find it difficult to bond with or stay emotionally distant from the child;
- Feel emotionally and physically drained, with little to give to the child;
- Not know what to say about the domestic abuse;
- Believe the child is fine and has not witnessed abuse;
- Be unable to address the children’s behaviour;
- Rely on them to behave in ways to minimise the risk to her or them;
- Lack financial support or any means to escape;
- Take out her frustration on the children;
- Be unable to provide appropriate structure, security, boundaries or safety;
- Fail to recognise or meet children’s educational needs;
- Be triggered by the children’s behaviour into re-living past abuse;
- Women often attribute their eventual escape from domestic abuse to the emotional and practical support provided by their children (Hoff, 1990);
Ask members of the group (or the pairs) to consider the impact on the child of each of the above. Emphasise that it is the violence by the perpetrator, rather than the personality of the woman, that has created her difficulties. Her parenting has been jeopardised by living with the ongoing danger of abuse.

Show a video e.g. Home Truths (made by Leeds Animation Workshop in partnership with Leeds Inter-Agency project; designed for use with children aged 8-13). Follow-up with questions about how living with domestic abuse to mothers affected each child in the video and the outcomes of the cases described.

**Case studies about children (15-30 minute exercise)**

**Aim:** To enable participants to consider children’s experiences of domestic abuse.

**Materials:** case studies written from children’s perspectives about their experiences of living with domestic violence (Handout 2.H) and Handout 2.I.

**Method:** Small group work.

Ask participants to read the case studies in Handout 2.H and consider how children feel in these situations, e.g. what they can do, and what they would like to happen? The participants should work in small groups and share their views with the larger group. How do they react to these children? What should they do as practitioners? What other agencies might be involved and how should the health practitioner communicate with them? What dilemmas are raised for practitioners?

After getting feedback from the group, summarise and show Slides 2.N and 2.O

Give Handout 2.I.

**Trainer’s notes:**

Points to emphasise or draw out from any of the exercises:

- Living with domestic abuse affects children’s physical, emotional and psychological health;
- The clear link between woman abuse and child abuse;
- Supporting the non-abusive parent is effective child protection;
- Long-term as well as immediate impacts of violence e.g. on educational attainment, career prospects, relationships;
- Child Protection guidelines must be followed when indicated;
- Children are individuals so sweeping generalisations even about children in the same family, are inappropriate. There is no single common response;
- Children’s responses to domestic abuse vary according to age, race, class, gender, role or birth order in family, disability, relationships with parent(s), availability of sources of support outside family (Saunders et al, 1995). For instance, there may be particular pressures on black children living in a racist society, and/or living with threats of abduction abroad and/or pressure to act as translators;
- Children say talking about the abuse and being told what is happening are the most helpful factors in enabling them to deal with it (McGee, 2000);
- There are not enough support services for children &/or help available is not accessible;
- Witnessing or experiencing violence does not mean children necessarily grow up to be violent and many perpetrators of domestic abuse did not grow up in a violent home;
- Refer to the website www.thehideout.org
2.6 Pressures on women to stay

Trainer’s notes
This section aims to promote professional understanding of the pressures that keep women in abusive relationships or contribute to ambivalence about leaving.

Why do women stay? 10 minute exercise
Aim: To raise awareness about why it is difficult to separate from an abusive partner.

Materials: flip chart, marker pen, overhead projector/slide show equipment, Slides 2.P and 2.Q.

Method: Group discussion
Trainer begins with the following question to the group: ‘Many people ask me “Why do women stay?” what do you think my answer should be?’ Trainer facilitates group contributions and records their responses.

Sum up drawing on trainer notes below and display Slides 2.P and 2.Q

Option 2 exercise:
The trainer draws the outline of a house in the middle of the flipchart, saying that a woman experiencing domestic abuse lives inside the house. The trainer asks ‘What keeps her trapped?’ The trainer represents each response from the group as bars around the house, keeping the woman trapped.

Issues in leaving a relationship : 20 minute exercise
Aims: To raise participant’s awareness about why it is difficult to separate from an abusive partner.

To help participants to develop empathy with women’s ambivalence about leaving their partners.

Materials: flip chart, marker pens.

Method: Small group work.
Ask participants to form small groups. Give each group three sheets of flip-chart paper and a marker pen.
Stage 1 (10 minutes):
Ask participants to write on one flip-chart ‘Why do you want a relationship?’ and on the other ‘What issues do you consider when leaving a relationship?’

Stage 2 (5 minutes):
Ask for feedback from one group, asking others to contribute if they have additional comments

Stage 3 (5 minutes):
Trainer heads a chart for discussion by the whole group ‘What additional factors do women experiencing domestic violence face if they leave abusive men?’

Short exercise:
Trainer facilitates group discussion on the 3 questions from the front of the room.

<table>
<thead>
<tr>
<th>Why people want relationships</th>
<th>Issues to consider when leaving</th>
</tr>
</thead>
<tbody>
<tr>
<td>To love &amp; be loved</td>
<td>losing all aspects in other column</td>
</tr>
<tr>
<td>Companionship &amp;/or protection</td>
<td>fear of living alone</td>
</tr>
<tr>
<td>Financial support</td>
<td>right to income or capacity to earn</td>
</tr>
<tr>
<td>Want children</td>
<td>effects of separation on children</td>
</tr>
<tr>
<td>Sex</td>
<td>family pressures</td>
</tr>
<tr>
<td>Secure future</td>
<td>reactions of community</td>
</tr>
</tbody>
</table>

Sum up drawing on trainer notes below and display Slides 2.P and 2.Q

5-10 minute exercise:
The trainer asks participants to imagine that they have to go home tonight after the training and pack up their things in black bin-liners to move to temporary accommodation. They cannot take furniture or pets. What would they select and how would they feel? Ask them to share with a partner.

Sum up drawing on trainer notes below and display Slides 2.P and 2.Q
Why do women stay? Or What makes it so difficult to leave? 30 minute exercise:

Aims: To raise participant's awareness about why it is difficult to separate from an abusive partner.

To help participants to develop empathy with women’s ambivalence about leaving their partners.

Materials: flip chart, markers, overhead projector/slide show equipment, Slides 2.P and 2.Q.

Method: Brainstorming with the whole group or working in small groups.

Using a flip chart draw a circle in the centre with the words ‘Security and Safety’ in the middle. Draw a series of spokes coming out from the circle so it looks like a wheel or the sun.

Ask participants to think of the social, cultural and financial factors which make it difficult for women to leave. Write responses at each end of a ‘spoke’ to represent the issues identified.

As a participant mentions each factor add some information or commentary.

Sum up drawing on trainer notes below and display Slides 2.P and 2.Q.

Gains and losses for women leaving violent relationships: 15-20 minute exercise

Aims: To raise participants’ awareness about pressures to remain within abusive relationships.

To help participants to develop empathy with women’s ambivalence about leaving their partners.

Materials: flip chart, 2 markers, overhead projector/slide show equipment, Slides 2.P and 2.Q.

Method: Group discussion.

The trainer asks the group to identify the gains, advantages and disadvantages for a woman in leaving a violent relationship. Gains and losses are recorded under two headed columns, in different colours, on the flipchart.
(It may be easier to start with the gains. Then say: ‘We are all hoping that she will leave, given the gains she will experience. But it is not an easy decision to make: what might hold her back?’)

Feedback from group might look like the following:

<table>
<thead>
<tr>
<th>Gains</th>
<th>Losses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety of woman &amp; children</td>
<td>Loss of life – increased risk of murder</td>
</tr>
<tr>
<td>Self-confidence/self-esteem</td>
<td>Relationship &amp; a father for children</td>
</tr>
<tr>
<td>Training/work opportunities</td>
<td>Home, job</td>
</tr>
<tr>
<td>New friends/relationships</td>
<td>Extended family, friends, community</td>
</tr>
<tr>
<td>Improved health</td>
<td>Stress of post separation abuse &amp; court cases</td>
</tr>
<tr>
<td>Independence</td>
<td>Income if dependent on partner</td>
</tr>
<tr>
<td>Improved relationship with children</td>
<td>Loss of children in residency dispute</td>
</tr>
<tr>
<td></td>
<td>Possessions</td>
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<td></td>
<td>What is known and familiar</td>
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<td>Pets</td>
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</tbody>
</table>

Sum up drawing on trainer notes below and display Slides 2.P and 2.Q

**Ask:**  Which gains or losses are more immediate and which are more long term?

Which are more abstract/vague and which are more tangible/concrete?

Which are more certain/uncertain?

Which are easier to explain to a 4 or 6 year old child?

**Why do women stay / return? 45 minute case study exercise**

**Aims:** To explore possible explanations for women’s responses to domestic abuse.

To help participants understand the complex and varied pressures on women;

To equip participants with knowledge that will help them to challenge victim-blaming beliefs.
**Materials:** Case study (Yvonne and Nigel, Handout 2.J), paper and pens, overhead projector/slide show equipment, Slides 2.P and 2.Q.

**Method:** Small group work + supported role-play.
Divide participants into two groups.

**Stage 1: small group work (15 minutes)**
Give each group a case study, paper and pens. They have 15 minutes to work on the following:

**Group A:**
To consider the short and long term **gains** if Yvonne were to return to Nigel

**Group B:**
To consider the short and long-term **losses** if Yvonne were to return to Nigel.

**Stage 2:**
Supported role-play (15 minutes). Each group selects someone to take the part of Yvonne, so one Yvonne is focused on the gains and the other on the losses if she were to return. They are seated facing each other, with the group members behind them to provide support and ideas. The two Yvonnes are asked to discuss the different gains and losses in returning to Nigel. Other group members prompt their Yvonne, enabling her to respond with their case to arguments from the other side.

**Stage 3:**
Whole group discussion (15 minutes)

During this stage, the trainer might:

- Ask the ‘Yvonnes’ how they felt about their roles.
- Ask other group members for their observations.
- Ask the group to summarise learning points.
- Ensure the group recognizes the extent to which external pressures dictate women’s choices.

Sum up drawing on trainer notes below and display Slides 2.P and 2.Q.

**Why do women stay: Trainer notes:**
The list should include in no particular order:

- Changing children’s schools (ask participants if they had 3 children of different school ages when they would leave – always one who is doing GCSEs, SATs tests, A levels, just changed to schools from nursery to
primary, primary to secondary etc. What if you have children who have been statemented or with special needs? What about secondary schools where there are not enough places in a particular area and are not intaking students in particularly years or catchments?)

- Financial issues – having to leave employment; moving on to income support; carrying debts; what about women with no recourse to public funds?

- Housing issues – refuges often have only one room for a family, and move on housing is increasingly difficult to access, problems in some housing authorities with providing out of area accommodation. Problems with joint tenancy agreements with a violent ex-partner, or selling a jointly owned house. What about a ‘sense of home’ and the strong belief that ‘I shouldn’t be the one to leave’. What about women who have houses with specific adjustments for their disabilities. Much of the social housing is in areas with high crime rates and failing schools.

- Leaving a supportive community – relatives and friends and informal supports. What about issues for black and minority ethnic women leaving supportive communities, language groups and religious communities? Will women and children be able to cope with the isolation of living without the support of their community?

- Leaving family pets, particularly if they have been subjected to neglect or violence from the abuser.

- Child contact problems – no contact orders are virtually impossible to gain (less than 1% of 65,000 applications in 2003) and therefore the notion that she can ‘never get away’ may well be true if her ex-partner uses the family courts to demand contact.

- Protective legislation (non-molestation orders, occupation orders and restraining orders) are effective with men who have ‘something to lose’ and are very dependent for their effectiveness on having police who will act on breaches and courts which will sentence appropriately. Orders remain expensive (more than £1000) for women who are employed.

- Social attitudes which are unhelpful – condemnation of single mothers, ‘stand by your man’, shame and dishonour experienced by women and children in some communities if they separate, blaming women for
provoking the violence and abuse, believing ‘charming’ men who are socially acceptable in public and abusive in private

- Social attitudes towards romantic love leave women unprepared for dealing with men who are ‘loving on the one hand’ and ‘abusive and violent’ on the other. Little understanding of the process through which abusers blame their victims for the violence, and victims, over time can come to feel both ashamed and responsible for the violence perpetrated against them.

- The question itself implies it is the victim’s responsibility to end violence and that there is something wrong with her if she puts up with it. The questioned could be re-framed - Why does no one stop the violence? Or Why does he get away with it?

- Violence may not stop if she leaves the relationship. Women do leave, but abusers continue to stalk, harass and assault them (Walby & Allen, 2004).

- Many of the gains of leaving are abstract, uncertain and long term whereas many of the losses are concrete, definite and immediate (and obvious to a child).

- Many women do not know about their rights or options for help.

- Some women face particularly difficult obstacles to coping alone, including migrant women, women with mental health needs or physical disability, very young or elderly.

- Every woman wants the violence to stop. Women try many strategies to prevent abuse, and always hope it will never happen again. If a woman returns to a relationship, it is not to the violence that she is returning but to the hope that it has stopped.

**Some feelings experienced by women in abusive relationships**

**Hope:** The hope that an abusive man will change is one reason that women stay or return. Their hope can be fuelled by the intermittent nature of the abuse, by their partner’s remorse, by a promise it will not happen again or that he will seek help. Many women want the violence to stop and the relationship to be saved. However, some women leave when they realise their relationship has been changed irreparably by fear. Others leave because they see that nothing, of all the strategies they tried or could try, will stop the abuse. Still others realise the enormity of the domestic abuse, rather than minimizing or discounting it in the context of hope.
**Fear:** Staying with an abusive partner may be a realistic evaluation of the abuser’s potential for lethal violence and the victim’s belief or experience that others are unable to guarantee her safety or protect her if she leaves. She may fear more violence, his threats to kill her or his threats of revenge (Barnett & LaViolette, 1993). Women are at greatest risk of homicide at the point of separation or after leaving a violent partner (Daly & Wilson, 1988) Some women stay because they fear repercussions by others, like death threats for bringing disgrace and dishonour to the family.

**Guilt or feelings of failure:** A woman may feel trapped by guilt, responsibility or shame, if she has internalised the abuser’s efforts to convince her she is to blame. Her family may also hold her responsible for ‘bringing shame on the honour of her family in the eyes of the community’ (forced marriages, 2004) despite the fact the abuse is out of her control. Her shame may prevent her confiding in anyone else, and her isolation may increase her vulnerability by depriving her of opportunities to hear another perspective. Women from ethnic minorities may also be reluctant to disclose abuse because they do not want to contribute to further discrimination against or stigmatisation of other members of their group (Davies, 1998).

**Love or compassion:** ‘Love’ can be confused with traumatic bonding and survival strategies. Women might believe their partner is in need of help and that they should stand by them. They may feel compassion because their husband said he will crack up, harm or kill himself if she leaves. An abuser can manipulate her love, loyalty, duty and commitment to the relationship.

**Feeling trapped by practicalities:** Women remain trapped if they are not aware of other options. Women may be financially dependent, without any financial help from their abuser if they leave. An abuser can also reduce any woman’s income potential by forbidding classes, work or by causing absenteeism following assault. Women may have nowhere to go and a housing officer who suggests they return. They may be unaware they can go to the police and press charges. Any woman may stay because there is no realistic alternative for her and her children, no matter how badly she is treated. Some make a decision to stay because of the costs to them and their children of being ostracised from the community. Women with no recourse to public funds stay with abusive husbands to avoid deportation and to keep their children.
Minority ethnic women are over-represented amongst women who continue to suffer substantial problems emotionally and materially six months after separation (Humphreys, 2003). Particular attention should be offered to women who may be vulnerable to discrimination based on race, ethnicity or disability.

**Lack of support:** In one study, 63% of women who had little support returned to their abusers; in contrast, only 19% of those with strong support systems returned (Barnett & LaViolette, 1993). Social isolation imposed by the abuser may have restricted the woman’s friendships and systematically undermined her family relationships. Professionals, like the police or social services, may say they cannot protect or help her. Black and ethnic minority women, in particular, might be effectively isolated by forced marriage (forced marriage, 2004), threatened by ostracism from their family and community, and pressured to use their own community-based strategies. They may already be disenchanted with statutory services based on past experience of or anticipated discrimination. It is hard to be a single parent without support.

**Fear of being alone:** 70% of women who leave their partners return because of feelings of loneliness (Barnett & LaViolette, 1993). Women may have been brainwashed (as part of the abuse) into believing they are incapable of independence, that they will never find another partner and that no-one will be interested in them. Women might be isolated because of their changed circumstances.

**Religious conviction:** Some women are committed to marriage, and their faith proscribes that they will never remarry if their marriage fails. Their priest, minister, rabbi or imam may have prioritised spiritual principles over safety or happiness.

**Social pressures and values:** Gender socialisation, family upbringing and personal morality may combine to entrap a woman. She may try to hold the family together, based on the belief that a woman’s role is to maintain family integrity at all costs. She has been reared to be the caring sex, so when her partner cries and promises to change, she reaches out to comfort and forgive. Her commitment, previously regarded as a positive attribute, in the case of domestic violence becomes pathologised as co-dependency, and can result in victim-blaming.
Coping strategies

Women may use a range of strategies to cope with the abuse. These might involve escape plans (to get away or to avoid abuse) and protection plans (trying to minimise injury during an attack). To help her to get appropriate support, it is important for professionals to take into account what a woman may have done to cope with the abuse (see Module Three section on safety planning). Any discussion of a woman’s coping or survival strategies should be set in the context of the abuser’s behaviour. For instance, it may seem self-evident that a woman can telephone for help. However, abusers take the house phone to work; divert all calls through their mobile, or lock the phone in a cupboard. We should be wary of making snap judgements about a woman’s coping or exit strategies. In some circumstances, passivity – doing nothing - can be how the woman has learned to respond his behaviour to prevent severe injury.

Survival strategies during an assault can be distinguished from those in the longer term. For instance, while a woman is being attacked, she may not be able to escape or use a phone. However, even in the midst of an assault an abused woman is rarely passive; just because she is apparently complying or submitting does not mean she isn’t actively engaged in promoting her safety. In parallel, she may also try and adopt a variety of internal strategies; what might traditionally be called ‘defences’ are re-construed by feminist counsellors as strategies for survival, worthy of respect (Chaplin, 1988).

Immediate protection strategies during a crisis include short-term flight, getting external intervention and self-defence. Safety plans might help the woman develop a pre-arranged escape plan including:

- an agreed destination for herself or the children;
- a route to leave the house;
- interim hiding places;
- the safest time to escape;
- preparation of an emergency bag with essential items and/or;
- how she accesses help. Getting help might include calling the police or planning with neighbours or relatives.

Women sometimes plan possible means to minimise physical injury e.g. by curling into a ball, protecting the head, blocking punches or kicks, or wearing thick clothes. Women sometimes plan to hide weapons with which they have been
threatened, or that have been used in the past. Short-term protection for the children might mean re-negotiating bed-times, a lock on their bedroom door or re-arranging sleeping arrangements within or outside the house. Some women ensure the abuser is never alone with the children or keep children busy or outside the house. It can be helpful to ask women to practice a plan for a quick get-away, and to ‘buy time’ before the search begins: for instance, one got into the habit of walking the dog three times a day; another put out the rubbish at midnight (so when she needed to escape, she pretended to do that task, and once outside, she kept going).

A safety plan (see Module Three below) might explore how a woman identifies signals of impending danger; if she can specify the chain of events in detail, so that she can look for opportunities to escape at each stage. However, for many women the eruption of violence is completely unpredictable, ‘out of the blue’, and it is crucial she is not made to feel responsible for missing non-existent signs. Nevertheless, rehearsing options can increase the margin of safety or minimise injury.

For young women at risk of forced marriage or being abused by their family, there is excellent advice on strategies to increase their personal safety contained in Forced Marriage (2004).

2.7 Diversity issues: sexuality, ethnicity, disability

Introduction
Domestic abuse happens to women from every background, religion, culture, class, age group. Young and old women, working class and middle class women, disabled and non-disabled women, black and white women, lesbian, bisexual and heterosexual women may all experience domestic abuse. However, research and experience have clearly illustrated that, although any woman may experience domestic violence and will face difficulties getting help, these difficulties are compounded and heightened by additional discrimination faced by black and Asian women, older women, younger women, lesbian women, those with a disability, sex workers, travellers, asylum seekers, those who misuse drugs or alcohol, and those with mental health needs. These women may experience stereotyping and prejudice, and/or face practical difficulties that further impede their escape from domestic abuse. They may be more dependent on statutory
services or more visible within them. Sometimes abusers may use their “difference” to abuse them further – for example by making fun of their disability, calling them discriminatory names, emphasising stigma and exacerbating feelings of shame.

Trainers may want to ensure participants understand that

- the barriers and pressures lie within society rather than within the woman herself;
- women are not a homogeneous group, and categories such as ‘black’ (which includes many ethnicities) and disabled (not just wheelchair users) are also heterogeneous categories;
- a woman may belong to more than one marginalised group, e.g. both black and lesbian, or both a drug user and a prostitute;
- a woman might experience additional pressures if her abuser is from a marginalised sector;
- professionals’ awareness of equality and diversity issues with respect to domestic abuse can affect their understanding and identification of women at risk, and their response;
- offering the same service to everyone might leave some women disadvantaged;
- professionals should work toward making services accessible and sensitive to need;
- there should be a local equal opportunities policy;
- local services specific to marginalised groups may be needed.

**Additional issues for women from marginalised groups : 10 – 20 minute exercise**

**Aim:** To raise awareness about the additional issues faced by women from marginalised groups.

**Materials:** Flip chart paper, pens, Handout 2.L

**Method:** Small group discussion followed by feedback and discussion in main group.

Divide the participants into pairs or small groups. Ask each group to consider how the following might compound a
woman’s experiences of domestic abuse: race, immigration status, age, sexual identity, disability, class.

Also ask each group to consider how an aspect of a woman’s identity can be used against her (by her abuser) in an abusive and undermining way.

Ask for feedback from each group.

Refer to trainer’s notes below and Handouts 2.L

Equality issues: 30 minute exercise.

Aim: To illustrate visually and experientially the obstacles facing women from different groups.

Materials: A large room is needed for this workshop, sufficient for a person to take 25 steps forward from one end of the room to the other.

Handout 2.K photocopied and cut into strips, each with one identity to give to individual participants.

Questions (below) for trainer to read out.

Copies of Handout 2.L

Ask participants to stand in line at the end of the room.

Give each participant a strip of paper showing them their identity. Each participant only knows their own ‘identity’, not that of anyone else. Stand at the front of the room. Tell the participants that you are going to read out a list of statements. They can only take a step forward if they can answer ‘yes’ to the statement.

Before starting check everyone understands the instructions e.g. say ‘If I say you are a woman, would you take a step forward or not?’

Read out each question (below) in turn, slowly and clearly. Allow participants time to consider their responses before moving on to the next question.

When all the questions have been read out, ask the participant(s) who has taken the most steps to reveal their identity. Ask how they feel.

Follow this by asking the participant(s) who has taken the second most steps to reveal their identity. Ask how they feel.
Repeat this for the third most advanced participant, and then for the last three (furthest from the trainer) or if time allows, ask all participants in descending order, until all the identities have been revealed.

Focuses the discussion on the difficulties faced by particular groups throughout the feedback.

Refer to trainer's notes below and Handouts 2.L

**Trainer’s statements: Equality and diversity exercise**
(to be read aloud to the group each holding their statement)

- The police represent a source of support to you and you feel relatively comfortable about calling them.
- If you go to the housing department, it is likely that you will find assistance from a member of staff like yourself.
- If you wish to complain about a service and you ask to see the manager, it would be reasonable to expect them to be like yourself or understanding of your situation.
- You are confident that Social Services will have no particular concerns about you raising your children.
- You can afford to use a solicitor.
- You are entitled to welfare benefits if you leave.
- You can get information in your first language.
- The neighbours may call the police on your behalf if they hear you being hurt.
- If you leave, you are reasonably confident about keeping residence of your children.
- If you leave, the local authority will be able to find you suitable temporary accommodation.
- When thinking about being permanently re-housed, your only safety concerns are about being found by your abuser.
- If you go to a refuge, your abuser would find it difficult to track you down.
- You will benefit financially or be no worse off if you leave.
- You can use a telephone in an emergency.
- You have some knowledge of how the ‘system’ works.
- If you disclose the domestic violence, people will usually believe you.
- Members of your community will support you if you decide to leave.
- If your abuser applies for contact with the children but you do not think it is safe, the court will believe you and refuse contact.
- You can apply to the court for a non-molestation order.
- If you go to a refuge, you are likely to find a woman like yourself.
- If you leave, you will not be at risk of deportation.
- You can live independently without help
- More than one person is at risk if you leave
- You are at risk from more than one person
- You are confident that the health services can help you

**Trainer's notes:**

- Institutional racism can isolate a woman seeking help;
- Nationality status can increase pressure due to the threat of deportation and lack of recourse to public funds;
- Reluctance of staff to use National Interpreting Service, Language Line or local interpreters;
- Discrimination on women from different classes can include telling professional women that no one will believe they are being abused;
- Age discrimination on older and younger women: her age may be used to justify abuse;
- Discrimination on women with disabilities can include threatening them with institutional care, making them feel guilty for their ingratitude or labelling the woman as the disability;
- Homophobia against lesbians and bisexual women: their sexual orientation may be used to justify the abuse.
2.8 Role of the health professional

Introduction

This section aims to explore:

- The role of any health professional in working with domestic abuse;
- The responsibilities of a health professional encountering domestic abuse at work;
- Why women may not talk directly and openly about their experiences of abuse.

It is important to begin any session by highlighting some of the reasons why health professionals should act to help stop domestic abuse:

1. Health professionals are often a first point of contact for women, and they deal with the after-effects of domestic abuse on an everyday basis. Women who have experienced abuse use health services frequently and require wide-ranging medical services. They are likely to be admitted to hospital more often than non-abused women and are issued more prescriptions.

2. Women at risk might not come into contact with any other professionals who can offer a lifeline.

It would be wrong for us to wait for other professionals to help vulnerable patients when we have the perfect opportunity to create an environment in which women feel comfortable to reveal domestic abuse and ask for much-needed support.

3. A woman’s health records can play an important part in bringing perpetrators to justice.

They can also be an influencing factor in housing and immigration decisions.

4. Some NHS colleagues will experience domestic abuse.

Due to the high prevalence of domestic abuse across society, it’s inevitable that some health professionals will suffer at the hands of someone close to them. Our policies need to be robust enough to give them the support they need.

5. Women say they want us to take the initiative.

Time and again survivors of domestic abuse have said they wish somebody had asked them if they were experiencing problems in their personal relationships.
Health Professional’s Role : 10 minute exercise

Aim: To introduce participants to the health professional’s role as set out in the Department of Health Guidance.


Method: Read a case study (see Handout 2.A) and ask the group to suggest what role they think the health professional should have. Record aspects of the role identified on a flip chart. Show Slides 2.R and 2.S and refer to Handout 2.M to reinforce the key messages for health professionals in the Department of Health Guidance. You should also draw participants’ attention to their local Trust’s policy.

Health Professional’s Role : 20-30 minute exercise

Aim: To outline the responsibilities of health professionals when working with women experiencing domestic abuse.


Method: Ask the participants to form small groups of 4-5 people; if a mixed professional group, form groups according to specialism. Ask them to consider their roles and responsibilities toward women experiencing domestic violence for 10 minutes, taking notes on a flipchart. A representative from each group feeds back to the larger group. You can also use case studies for a context.

Once the first group has fed back, ask the others if they have anything to add or comment.

The trainer might bring out or emphasise the following points:

- Health professionals play a key role with respect to domestic abuse;
- Nearly every woman experiencing domestic abuse uses the health care system on her own or someone else’s behalf;
The health care system may be the woman’s first, and/or only, point of contact with professionals;

- Abused women are more likely to be in contact with the Health Service than any other agency (Pahl, 1995);
- 80% of women in a violent relationship sought help from the Health Service at least once (Adam, 2000, p.7);
- Women suffering from the effects of domestic violence typically make 7-8 visits to health professionals, either on their own or someone else’s behalf (Harris, 2002);
- 18% women experiencing domestic violence go to a physician in the first year of abuse; 56% in the second year and 31% have contact in the third year (Stevens, 2000, p.32);
- Unless the primary cause of the woman’s symptoms is identified, the violence is likely to continue unchecked and she is likely to continue to present with physical and psychological symptoms;
- All a perpetrator of domestic violence requires is that we do nothing to stop him;
- Sometimes working with the effects of domestic abuse professionally can bring to the surface personal issues – particularly if the professional is experiencing or has experienced abuse herself. The health care professional’s personal needs are as important as those of the patients. A professional can approach managers for help or call the freephone National Domestic Violence Helpline for advice on 0808 2000 247.

The trainer can close a thirty minute session on this topic by summarising the key points using Slides 2.R and 2.S, referring to Handout 2.M to reinforce the key messages for health professionals in the Department of Health Guidance. You should also draw participants’ attention to their local Trust’s policy.

**Why don’t women at risk speak up?**

**Introduction**

As professionals begin to appreciate the nature and extent of domestic abuse, many question ‘If it really is so bad, why on earth don’t women tell me?’ or “How can there be that many women I have seen throughout my practice that didn’t talk about it?” Research has shown that only one in nine assaults are reported to the police (Mirlees-Black, 1999) and that, on average, a woman is beaten 35 times
before her first call to the police (Jaffe & Burns, 1982). It is important to help health professionals understand that any woman at risk may experience powerful barriers to disclosure.

5 to 15 minute exercise:
*Aim:* To raise awareness among health professionals of the range of reasons why it may be difficult for a woman to talk about domestic abuse.

*Materials:* Flipchart, pens, overhead projector/slide show equipment, Slide 2.T, Handout 2.N

*Method:* This topic can be introduced to the group as a brainstorming exercise, asking members of the group to suggest reasons why women find it difficult to tell health professionals about domestic. If time is limited the training facilitator can lead the discussion by highlighting key points covered in Slide 2.T. Give out copies of Handout 2.N.

**Trainer's notes**
There are three primary forces that impede women’s disclosure:
- the behaviour of the perpetrator,
- the woman’s internal process, and
- the attitudes and behaviour of the wider community.

**The perpetrator**
A perpetrator of domestic abuse may have tried to enforce secrecy and silence by threats, shaming and humiliation. He may have threatened her life, access to her children or her family. He has probably told her that if she attempts to leave he will track her down and may have already demonstrated his capacity to do so. In many cases, the woman only discloses when her realistic fear of the damage he will try to inflict if he finds out that she sought help is overshadowed by her desperation that she cannot stop his violence or cope any longer in an intolerable situation.

The perpetrator of domestic abuse may also have attacked her credibility (or her own confidence in being believed). If he can not silence her entirely, he can ensure no-one listens by marshalling an impressive variety of arguments: it never happened, the victim is lying, she exaggerates, she brought it upon herself and in any case it is in the past and won’t happen again (Herman, 1992). He may have
already convinced her immediate social network that ‘she is mental’, can not be trusted, and that she is an inadequate wife and/or parent. These strategies will be even more effective if she happens to have a mental health diagnosis or uses alcohol or drugs to cope with her experiences of being abused. He may have successfully restricted the network to which she might turn, by public humiliation that embarrasses her and others, and by conflict and threats that result in friend’s avoidance and family withdrawal. In other words, friends and family may have been influenced by the perpetrators’ attempts to discredit her. He may have threatened her wider family, such that she risks their safety and/or their rejection is she talks about her experience. She may fear their reaction if they were to hear about the true extent of the horror. The perpetrator may have prevented her working, attending college, and may monitor her movements so closely she has little opportunity to communicate her distress to anyone. The perpetrator is likely to accompany her to the GP, A & E department or Psychiatric Unit, presenting as a solicitous and concerned husband, who by his presence effectively silences and blames her.

**The woman**

Women who have experienced domestic abuse over a long period are likely to have very low self esteem and to feel unconfident in talking to professionals. They may fear they will not believed or be fearful of the consequences of telling a professional about the abuse (e.g getting social services involved, appearing disloyal to her partner or family). Many will show signs of post-traumatic stress as a normal reaction to violence and threats. Features of post-traumatic stress include denial, minimisation, low self-esteem and shame. These can independently or in conjunction with remnants of affection and hope to create internal barriers that prevent the woman from disclosing the abuse.

**The community**

The abused woman’s difficulties occur in a society in which the stigma of domestic abuse and judgemental attitudes to the victim are widespread. The image of the abused woman is often met with repulsion, confusion and contempt, compounding her own sense of shame and guilt. In addition, even in this society, she may believe that she has no-where to go to escape from reprisals; she may have found ignorance and rejection in agencies she tried to approach; she may be uncertain of her rights, and without money or resources. A woman may castigate herself for
somehow deserving the abuse, for placing herself at risk and for failing to achieve
the ideals of marriage and the nuclear family: precisely the arguments reinforced
by the abuser and by society at large.

In short, the impact of these pressures on women who experience domestic abuse
are such that they may need help to understand and acknowledge their
experiences. **The responsibility for naming domestic abuse does not simply rest with women themselves.** In every other sphere of health, the professional
assumes a role in assessment of the problem, and helps the service user to expand on their experience. Whether the primary problem (domestic abuse) is
recognised or not depends on the attitude and behaviour of the professional as
much as the woman. Health professionals have not always found it easy to rise to
the challenge. Women suffering the effects of domestic abuse typically make 7-8
visits to health professionals, either on their own or someone else’s behalf before
disclosure (Harris, 2002). At least 80% of women experiencing abuse, if not all,
seek help from health services at some point (DoH, 2000). A woman is much more
likely to seek medical help than turn to the police (Schornstein, 1997). Yet, of up to
ten types of agency women approach, health professionals have been the least
likely to identify the abuse and refer her to an appropriate service.

**Useful references**

[http://www.homeoffice.gov.uk/rds/pdfs04/dpr32.pdf](http://www.homeoffice.gov.uk/rds/pdfs04/dpr32.pdf)

violence: exploring the health service contribution. Evaluation of the Crime
Reduction Programme Violence Against Women Initiative health projects. Home
Office Online Report 52/04. [www.homeoffice.gov.uk/rds/pdfs04/rdsolr5204.pdf](http://www.homeoffice.gov.uk/rds/pdfs04/rdsolr5204.pdf)

**Are we part of the problem or part of the solution? 15 to 20 minute exercise**

**Aims:** To give health professionals the opportunity to critically reflect upon
their role when working with women who have experienced domestic
abuse; to clarify their roles and responsibilities.

**Materials:** Overhead projector/slide show equipment, Slide 2.U

**Method:** Use the medical power and control wheel (Slide 2.U) to explore the
question: Are we part of the problem or part of the solution? See also
Show the medical power & control wheel SLIDE 2.U and invite participants to give examples of how medical responses could create problems for victims of domestic abuse – eg breaking confidentiality, giving advice that pushes her for a decision, ignoring her need for safety etc.

Invite participants to suggest how medical responses can empower a victim of domestic abuse – eg respecting her choice, helping her develop a safety plan and referring her to specialists (such as the domestic violence helplines or specialist advocacy services).

Barriers to working with domestic abuse: 15 minute exercise

Aims: To give health professionals the opportunity to review their concerns about working with women who have experienced domestic abuse; to provide further information about training needs that will help with the design of further training sessions; to increase professionals’ confidence in working with women who experience domestic abuse.

Materials: paper, pens.

Method: Invite participants in small groups of 4-5 to discuss their concerns or anxieties about working with domestic abuse. Collect written feedback to preserve anonymity and present material below so concerns can then be addressed through training and supervision.

Trainer’s notes:

Health professionals may feel reluctant to recognise and discuss domestic abuse with clients because:

- They fear offending patients, or opening a ‘Pandora’s box’ of issues they cannot deal with;
- Of frustration in finding appropriate interventions;
- They lack training;
- Of inability to control the situation and ‘cure’ the problem;
- They lack the time to deal appropriately with abuse;
- Of their own experiences (see Richardson et al, 2002; BMA, 1998).

If these fears are not addressed, they can negatively impact on good practice. (See Modules Two, Three and Four for further information).
Module One

Domestic Abuse as a Health Issue

Training Resources
Slide 2A

Definition of domestic violence

Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality

*Home Office, 2004*
The core Home Office definition is supplemented by the following to provide context:

Domestic violence can go beyond actual physical violence. It can also involve emotional abuse, the destruction of a spouse's or partner's property, their isolation from friends, family or other potential sources of support, control over access to money, personal items, food, transportation and the telephone and stalking. Violence will often be witnessed by children and there is an overlap between the abuse of women and abuse (physical and sexual) of children. The wide adverse effects of living with domestic violence for children must be recognised as a child protection issue. They link to poor educational achievement, social exclusion and to juvenile crime, substance misuse, mental health problems and homelessness from running away. It is acknowledged that domestic violence and abuse can also manifest itself through the actions of immediate and extended family members through the perpetration of illegal activities such as forced marriages, so called 'honour' crimes and female genital mutilation. Extended family members may condone or even share in the pattern of abuse.
Definition of Domestic Violence

Domestic violence is essentially about the misuse of power and the exercise of control by one adult person, usually a man, over another adult, usually a woman, within the context of an intimate relationship. Such abuse may manifest itself in a variety of ways including physical violence, emotional or psychological abuse, sexual violence and abuse, financial control and abuse and the imposition of social isolation or movement deprivation.

Greater London Domestic Violence Strategy (2001)
Slide 2D

Domestic Violence Terms

Spouse Assault

Domestic Violence

Marital Violence

Woman Abuse

Family Violence

Domestic Abuse

Wife Battering

Intimate Partner Violence

Wife Assault
Domestic Violence Prevalence

23% of women and 15% adult men report having been physically assaulted by a partner at some time in their lives (Mlrlees-Black, 1999)

Between 1 in 8 and 1 in 10 women report domestic violence in the past year (Mooney, 2000)

Women report more frequent assaults, more severe injuries and are more likely to report fear as a result of domestic violence (Walby & Allen, 2004)

Two women are killed by their current or former partners (Povey, 2004)

Domestic violence accounts for 16% of all violent crimes (Dodd, Nicholas, Povey & Walker, 2004)

30% starts or escalates during pregnancy (BMA 1998)

Weapons are less likely to be used but victims more likely to be injured (BCS 1996)

Rape is a significant element of domestic violence

7% of women have been raped or seriously sexually assaulted and in 54% of cases the rapist is the current (45%) or ex (9%) partner of the victim (Walby & Allen, 2004)
Domestic Abuse and Gender

Betsy Stanko (2000) UK Survey: A Day To Count

Of all the domestic violence incidents that day:
- 81% men violent to women
- 8% women violent to men
- 7% men violent to men
- 4% women violent to women

On average, 45% women murdered each year in England & Wales are killed by a partner or ex-partner
- 8% men are killed by a partner/ex-partner

*Criminal Statistics*

Services set up to cater for male victims closed in 1996 due to lack of demand

*Mullender, 1996*

Over 2003/2004 across England 342 domestic violence services supported 142,526 women and 106,118 children

*Women’s Aid*

Over 2003/2004, over 18,500 women and over 23,000 children spent at least one night in a refuge in England

*Women’s Aid*
Slide 2H

The Things People Say

It can’t be that bad – otherwise she’d leave

It only happens in low-income/working-class families/in council estates

It’s his childhood – he grew up in a violent home

Black men are more violent to women because of their own experience of racist oppression and violence

He has a problem controlling his temper

He only does it when he’s drunk (or on drugs)

Asian women are passive and conform to male dominated culture and religion with harsh traditions (that may include wife beating, maiming and killing)

She should stay for the sake of the children

There is no point in getting involved because the women always go back
Attitudes that set the scene for domestic violence

Almost 2 in 3 men admit they would use violence in ‘conflict situations’ with their partners

1 in 5 young men think forcing their wives to have sex is acceptable

1 in 8 men said it would be okay to hit a ‘nagging’ woman

1 in 5 boys believe it’s ok to hit a woman; 1 in 10 girls agree

81% young men believe women can provoke violence by flirting

It is her duty to stay no matter what abuse she endures

What happens between a man and a woman behind closed doors is their own business

A two-parent family is the ideal

The man is the bread-winner and the woman is home-maker and carer

Men are superior; masculinity is based on physical dominance; force can solve problems

Abusers come from every part of society. There is no single profile, but common features may include:

**Denial** – he lies about his violence or says the woman is exaggerating.

**Blaming the woman or factors ‘outside’ his control** – he was ‘driven’ to it against his will

**Enforcing the stereotypic male role**: he is head of the household, in total control ‘or else’.

Using his ‘temper’ or manly ‘anger’ as a controlling device & excuse for violence.

**Refusing to let people close**: he distrusts everyone; friendships are superficial

**Being abnormally jealous**: determined to keep control of his possession

**Control issues**: He usually has rigid control of when and how he attacks

**Acting the ‘nice guy’ intermittently**: uses kindness and comfort or grants ‘privileges’ (such as visiting her sick mother) to control the woman,

**Dependency fears**: expressed to coerce woman to stay, or he will commit suicide.

**Low self-esteem**: some men may use violence to overcome feeling impotent and to try to obtain a short-term sense of mastery.

**Childhood abuse**: Most children from violent families do not grow up as abusers, but childhood abuse is a factor in some cases
Slide 2K

Community responses

A tiny percentage of men who assault women are charged (HMIC, 2004)

Minimal or no sentencing of perpetrators of domestic violence (HMIC, 2004)

Women sometimes report that their priest or religious leaders said it was their duty to stay (Radford & Cappel, 2002)

Lack of resources e.g. refuges, alternative accommodation

On the ‘day to count’ 200 women asked for safe refuge and could not be accommodated in already full refuges (Stanko, 2000)

Failure of agencies to recognise and intervene

Lack of policies to protect women and children

Women "without recourse to public funds" will be refused benefits and may be threatened with deportation and the removal of their children to care
Domestic violence impacts on women’s health in at least three ways:

traumatic injuries following an assault

e.g. fractures, miscarriage, facial injuries, puncture wounds, bruises and haemorrhages

somatic problems or chronic illness consequent on living with abuse

e.g. headaches, gastrointestinal disorders, low birth rate, inflammation

psychological or psychosocial problems secondary to the abuse

e.g. attempted suicide, substance use, depression, anxiety

(Williamson, 2000; Schornstein, 1997)
### Examples of the effects on women

<table>
<thead>
<tr>
<th>Physical effects</th>
<th>Psychological effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bruising</td>
<td>Fear</td>
</tr>
<tr>
<td>Recurrent sexually transmitted infections</td>
<td>Increasing likelihood of misusing drugs, alcohol or prescribed anti-depressants</td>
</tr>
<tr>
<td>Broken bones</td>
<td>Depression/poor mental health</td>
</tr>
<tr>
<td>Burns or stab wounds</td>
<td>Wanting to commit or actually committing suicide</td>
</tr>
<tr>
<td>Death</td>
<td>Sleep disturbances</td>
</tr>
<tr>
<td>Gynaecological problems</td>
<td>Post-traumatic stress disorder</td>
</tr>
<tr>
<td>Tiredness</td>
<td>Anger</td>
</tr>
<tr>
<td>General poor health</td>
<td>Guilt</td>
</tr>
<tr>
<td>Poor nutrition</td>
<td>Loss of self-confidence</td>
</tr>
<tr>
<td>Chronic pain</td>
<td>Feelings of dependency</td>
</tr>
<tr>
<td>Miscarriage</td>
<td>Loss of hope</td>
</tr>
<tr>
<td>Maternal death</td>
<td>Feelings of isolation</td>
</tr>
<tr>
<td>Premature birth</td>
<td>Low self-worth</td>
</tr>
<tr>
<td>Babies with low birth weight/stillbirth/injury/death.</td>
<td>Panic or anxiety</td>
</tr>
<tr>
<td>Self-harming behaviour</td>
<td>Eating disorders</td>
</tr>
</tbody>
</table>
Harm To Children From Domestic Violence

Overlap - child is also abused and neglected

Child homicides

Child sexual abuse

Witnessing domestic violence

Child drawn into domestic violence (relaying threats, battery through the law, contact issues)

Child intervenes to protect

Child feels responsible

Living with the impact of domestic violence - peace at home, mother’s fears, child’s emotional & developmental well being

Mother’s health undermined

Child as carer
### Examples of the effects on children

<table>
<thead>
<tr>
<th>Physical effects</th>
<th>Psychological/behavioural effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bruising</td>
<td>Fear, panic, guilt and anxiety</td>
</tr>
<tr>
<td>Broken bones</td>
<td>Depression/poor mental health</td>
</tr>
<tr>
<td>Burns or stab wounds</td>
<td>Introversion or withdrawal</td>
</tr>
<tr>
<td>Death</td>
<td>Thoughts of suicide or running away</td>
</tr>
<tr>
<td>Neurological complications</td>
<td>Post-traumatic stress disorder</td>
</tr>
<tr>
<td>Tiredness and sleep disturbance</td>
<td>Anger, aggressive behaviour and delinquency</td>
</tr>
<tr>
<td>General poor health</td>
<td>Substance misuse</td>
</tr>
<tr>
<td>Stress-related illness (asthma, bronchitis or skin conditions)</td>
<td>Loss of self-confidence</td>
</tr>
<tr>
<td>Enuresis or encopresis</td>
<td>Assumes a parental role</td>
</tr>
<tr>
<td>Running away leading to potential homelessness</td>
<td>Hyperactivity</td>
</tr>
<tr>
<td>Eating difficulties</td>
<td>Tension</td>
</tr>
<tr>
<td>Damage following self harm</td>
<td>Low self-esteem</td>
</tr>
<tr>
<td>Teenage pregnancy</td>
<td>Sexual problems or sexual precocity</td>
</tr>
<tr>
<td>Gynaecological problems</td>
<td>Suicide</td>
</tr>
<tr>
<td>Self-harm</td>
<td>Eating disorders</td>
</tr>
<tr>
<td>Difficulty in making and sustaining friendships</td>
<td>Truancy and other difficulties at school</td>
</tr>
<tr>
<td>Damage to the unborn child in pregnancy</td>
<td></td>
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</tbody>
</table>
Slide 2P

**Why Women Stay**

A survey published in 1994 found that women gave the following reasons for staying in abusive relationships:

- thought he would change (72%)
- afraid of what he might do (63%)
- didn't want to upset the children (54%)
- nowhere to go (49%)
- too much in love with him (49%)
- didn't want to end the relationship (31%)
- thought the violence was a one-off (22%)
- family pressure not to leave (22%)

Why Don’t Women Leave?

Impact of the abusive relationship on the woman – depressed, confused, disabled, locked in, dependent, fearful

Others encourage/want/force her to stay children or family, religion/culture

The perpetrator’s behaviour – tracks her down and brings her back, threatens her and the family if she tries to leave, snatches the children, controls all the money, monitors her movements, locks her in

Lack of options for a safe exit – nowhere to go, police don’t protect, cannot relocate, abuse continues after separation
Your role in responding to domestic abuse should be limited to:

- Focusing on the woman’s safety (and her children’s safety)
- Giving her information and referring her to relevant agencies
- Making it easy for women to talk about their experiences
- Supporting and reassuring her
- Being non-judgemental
- Being prepared to work in partnership with other agencies

You should not:
- Assume someone else will take care of things, you may be her only contact
- Act as a caseworker once you have referred
- Tell her what to do, she has to decide the best options
Slide 2S

What You Can Do

- Create a supportive environment
- Give information: display leaflets, put up posters.
- Be aware of signs of domestic abuse
- Know how to ask

For women who disclose

- Validate and support
- Prioritise her safety as the foundation of treatment. Help her with a safety plan, or refer her to someone who can
- Make a record - write down what she tells you; document the evidence
- Refer her to sources of information and support, with her consent
- Ensure confidentiality and information sharing protocols are followed
- Look after your own safety and well-being

Remember: Health professionals are not responsible for solving the problems immediately or on their own.
Why don’t women tell us they are experiencing domestic violence?

Only 1 in 9 assaults are reported to the police (Mirlees-Black, 1999)

On average, a woman is beaten 35 times before her first call to the police (Jaffe & Burns, 1982)

80% women had seen their GPs but nearly half concealed the domestic violence because

- they were afraid their partner would find out
- the hurried, unsympathetic or hostile attitude of the GP
- they were ashamed

There is a perception that health professionals are there for physical problems only (Roberts et al, 2005)

The process of labelling the experiences and disclosing domestic violence is an almost insurmountable challenge to a victim in the context of:

- intimidation by the perpetrator,
- her suffering consequent on the abuse, and
- social processes (denial, stigma, pressure to remain at home from the community)

(Home Office, 1995)

Used with permission

Module One

Domestic Abuse as a Health Issue

Handouts
Handout 2.A

Case study 1
Alisha is a 35-year-old Asian woman. She has been married to Karim for 12 years. They have three children, aged ten, six, and two years old. Alisha was a secretary, but has not worked since her first child was born. Karim is a computer programmer. Alisha has experienced abuse from Karim throughout their marriage. He is a domineering man, and likes to be in charge of family matters. As the sole breadwinner, he has always controlled the family finances, restricting the amount of money available to Alisha for household shopping and items for the children. Alisha has always thought she would like to return to work, but she now lacks confidence in her skills. This has been aggravated by Karim’s negative attitude towards her, saying that no one would employ her, she is useless, and that it is anyway her job to stay at home and look after the house and the children. Karim can be very moody, and unpredictable in his behaviour towards Alisha. She constantly feels anxious about pleasing him, and feels that she is ‘walking on eggshells’ all the time. Karim is always criticising Alisha, but can also be very sexually demanding.

Consider: The impact of the abuse upon her emotional health.

The impact of the abuse upon her physical health.

The impact of the abuse upon her sexual health.

Identify points of contact with healthcare workers.

Case study 2
Angela is having her first baby. She is 22, and is now eight months pregnant. She has lived with her partner, Neville, for two years. Angela and Neville are both Afro-Caribbean; they have extended family in the city where they live, and several friends. Their relationship had always been shaky, with a few arguments, but they always made it up again. Since Angela got pregnant, Neville has started being abusive towards her. This has involved two major incidents of physical violence: Neville kicked Angela in the stomach when she was 22 weeks pregnant, and caused vaginal bleeding. Last night he pushed Angela down the stairs. She feels bruised and dizzy.

Angela has missed many appointments for antenatal care, as Neville does not like her attending.
Angela is very frightened of what will happen next and is concerned for her unborn baby.

Consider:
The impact of the abuse upon her emotional health.
The impact of the abuse upon her physical health.
The impact of the abuse upon her sexual health.
Identify points of contact with healthcare workers.

Case study 3
Diane is 39, and has been married to Kevin for 20 years. They have three children, aged 20, 18 and 15 years old. Diane has experienced serious violence throughout her marriage; she has been admitted to hospital twice because of physical injuries.

On one occasion she said she had been decorating the flat, and fallen off a ladder; she had broken two ribs, dislocated a shoulder, and had extensive bruising.

On another occasion, Kevin banged her head against a wall, causing her to lose consciousness. She was admitted to hospital with a head injury.

Last year, she took an overdose of anti-depressants, which her GP had prescribed for her depression. She has now been referred to a Community Psychiatric Nurse for counselling.

Consider:
The impact of the abuse upon her emotional health.
The impact of the abuse upon her physical health.
The impact of the abuse upon her sexual health.
Identify points of contact with healthcare workers.
Handout 2B
Domestic Violence – Fact Sheet

- Domestic violence accounts for 16% of all violent crimes (Dodd, Nicholas, Povey & Walker, 2004)

- Women are far more likely to say they have experienced domestic violence at some time in their lives, 26% of women and 16.5% men aged 16 to 59 report having been physically assaulted by a current or former partner. (McVeigh et al, 2005).

- A number of local surveys in the UK show between 1 in 3 and 1 in 4 women report having suffered domestic violence at some time in their adult lives.

- A household survey of 430 women in a London borough found that 1 in 3 women had experienced domestic violence at some time in their lives, 12% had been victims of domestic violence in the past year (Mooney, 1994).

- A survey of 484 women in Surrey shopping centres found that 1 in 4 defined themselves as having suffered domestic violence from male partner/ex-partner since the age of 18 years (Dominy & Radford, 1996)

- A survey of 129 women attending GPs surgeries in North London found 1 in 9 reported experiences of domestic violence serious enough to require medical attention in the past 12 months (Stanko, Crisp, Hale and Luraft, 1997)

- A survey of 1,207 women attending GP surgeries in London in 1999 found 41% (425) of the women had experienced domestic violence, 17% (61) had been abused by more than one partner, 8% (79) had been raped (Coid et al, 2003).

- Similar findings are reported from research overseas. A telephone survey of over 11,000 women in Canada found one in three reported violence from their partners (Johnson & Sacco, 1995).

- A survey of 1000 women in city centres in North England found that 1 in 8 women reported having been raped by their husbands or partners (Painter, 1991).

- As many as 1 in 3 marriages that end in divorce involve domestic violence (Borkowski, Murch & Walker, 1983).

- British Crime Survey findings show 6% of females and 4% males reported having experienced non-sexual ‘intimate partner’ violence since the age 16 (Walby and Allen, 2004). Social science surveys (that use different methods
and definitions of abuse) show higher prevalence rates with between 1 in 8 and 1 in 10 women report domestic violence in the past year (Mooney, 2000).

- Domestic violence occurs at similar prevalence among people at all income levels, and among people from all white, black and minority ethnic backgrounds (British Medical Association, 1998) although women from professional backgrounds may be less likely to report violence to the police or to other authorities (Mooney, 2000). Financial strain and poverty may exacerbate the abuse (Mirlees-Black, 1999).

- 57% of people who experience domestic violence experience repeat victimisation. No other crime has a rate of repeat victimisation as high as that for domestic violence (British Crime Survey, 2000) Women are much more likely to report experiencing repeat victimisation than are men (Mirlees-Black, 1999).

- Domestic violence often continues and may escalate in severity after separation. As many as one third of women who leave refuges experience continued abuse and harassment from their ex-partners (Binney, Harkell & Nixon, 1988). 22% of women recently separated from a partner report experiencing domestic violence in the past year (Mirlees-Black, 1999). Younger women with children who have recently separated from partners are at greatest risk of domestic violence.

- Research suggests that children’s contact with the violent parent can put both mothers and children at risk of continued violence and harassment (Hester and Radford, 1996: Radford, Sayer and AMICA, 1999: Aris, Harrison & Humphreys, 2002).

- Each year, 45% of female homicide victims are killed by present or former male partners, compared to 8% of male victims. On average, 2 women per week are killed in England and Wales by their partners/ex-partners (Povey, 2004).

- Women are at greatest risk of homicide at the point of separation or after leaving a violent partner (Daly & Wilson, 1988).

- Weapons are less likely to be used in assaults but victims of domestic violence are more likely to be injured. Only 7% of domestic assaults involve use of a weapon but 70% of domestic incidents result in injuries (British Crime Survey, 2000).
Women report more frequent assaults, more severe injuries and are more likely to report fear as a result of domestic violence (Walby & Allen, 2004).

Bruising is the most frequently reported injury (35% of incidents, followed by scratches (18%) and cuts (9%). 2% of assaults result in broken bones (Mirlees-Black, 1999).

1 in 4 incidents result in substantial physical injuries. 10% of 129 women surveyed in North London GP surgeries reported being knocked unconscious by their partners. 5% had sustained broken bones as a result of domestic violence. (Stanko, Crisp, Hale and Lucraft, 1997).

Women who are physically abused report physical injuries resulted in, on average, four occasions during a twelve month period (Mooney, 1994).

Women assaulted by a partner or ex-partner are thirteen times more likely to be injured in the breast, chest and abdomen (British Medical Association, 1998).

60% of 127 women resident in refuges in Northern Ireland experienced violence during pregnancy. 13% lost their babies as a result (McWilliams & McKiernan, 1993).

Victims of domestic violence account for 25% of all female emergency psychiatric in patient admissions. 64% of female psychiatric inpatients have a history of abuse (Stevens, 2002, quoted in McVeigh et al, 2005).

Psychologists in the USA have found parallels between the effects of domestic violence on women and the impact of torture and imprisonment on hostages (Graham, Rawlings, & Rimini, 1988).

Research has shown that these effects include low self esteem, dependence upon the perpetrator, feelings of hopelessness about ending the violence, a tendency to minimise or deny the violence (Kirkwood, 1993).

Victims of marital rape suffer many of the same reactions as other victims of rape, including very severe depression and suicidal tendencies. Feelings of shame and degradation prevent women from talking about this form of abuse (American Medical Association, 1992).

Domestic violence is a factor in 1 in 4 suicide attempts by women (Stark, Flitcraft, & Frazier, 1979).

Rates of drug and alcohol abuse seem to rise after the first episode of violence has presented and may be a consequence of this. Stark and Flitcraft (1996) found that women who were abused were 15 times more
likely to abuse alcohol, 9 times more likely to abuse drugs, 3 times more likely to be diagnosed depressed or psychotic and 5 times more likely to attempt suicide.

- Women who suffer domestic violence are likely to under report incidents of abuse. In a study of 484 women’s experiences of violence in Surrey, 2 out of 3 women who defined themselves as victims of domestic violence said they had not told family, friends or agencies about the abuse (Dominy & Radford, 1996). Half of the victims of domestic assault interviewed for the British Crime Survey said they had not told anyone about the last attack (Mirlees-Black, 1999).

- Domestic violence is the least likely violent crime to be reported to the police. Only 21% of women report the violence they experience to the police (McVeigh et al, 2005).

- On average, a woman will be assaulted by her partner or ex-partner 35 times before reporting it to the police (Yearnshire, 1997).

- Just under 3% of ALL calls for police assistance are due to domestic violence (Stanko, 2000).

References


McWilliams, M. & McKiernan, J. (1993) *Bringing it out into the open*, Belfast : HMSO


Mooney, J. (1994) *The Hidden Figure : Domestic Violence in North London*, Middlesex University Centre for Criminology


Handout 2C

Quiz: The Extent and Severity of Domestic Abuse

This quiz is for your own interest. It is not a test. Please circle the correct answer.

1. Almost one in four women has been physically assaulted by a partner or ex-partner at some time in their lives

   True / False

2. How many incidents reported by women to the 1996 British Crime Survey were domestic violence incidents?

   a) 20%    b) 44%    c) 75%

3. Domestic abuse rarely occurs in professional or middle class families

   True / False

4. Which of the following statements are true?

   a) There is more domestic abuse in Asian communities due to male dominated religions

   b) Black men are more violent to women because of their own experience of violence and oppression

   c) Domestic abuse occurs within all races and ethnicities in similar numbers

5. Women are most at risk of fatal violence if they

   a) remain in the violent situation

   b) attempt to leave the violent relationship

   c) have recently left the violent partner

6. On average, how often are women killed by their partners or ex-partners?

   a) 2 women each year

   b) 2 women each month

   c) 2 women each week.

7. There is no overlap between domestic abuse and child abuse.

   True / False
8. In what percentage of domestic violence incidents are children in the same or next room?
   a) 35%  b) 75%  c) 90%

9. Women are safer while pregnant
   True/False

10. What percentage of physical domestic violence results in injury?
    a) 49%  b) 69%  c) 89%
The extent and severity of domestic violence: Answers to the quiz

1. True (Home Office, 1999a; McGibbon et al, 1989; Dominy and Radford, 1996). A household survey of 430 women in north London found that one in three women had experienced domestic violence from a partner or ex-partner at some time in their lives, and 12% had suffered domestic violence in the past year (Mooney, 1994).

2. 44% of all incidents reported by women were domestic violence (Home Office 1999a). Of all reported violent crime, domestic violence accounts for 25% (British Crime Survey, 1996).

3. False. Women of all socioeconomic groupings experience domestic violence to similar degrees.

4. c). Domestic violence occurs within all races and ethnicities in similar numbers. Domestic violence occurs at similar rates across all social classes, religions, ethnic groups and geographical areas, although the number of cases known may be skewed by various factors including the woman’s financial circumstances, dependency on statutory bodies for help, language difficulties and cultural pressures (WHO, 2002; BMA, 1998; Camden Police Statistics, 1997).

5. b) or c). Women are at increased risk of death or serious injury at the point of separation or after leaving a violent partner (WHO, 2002; Harris, 2000; Schornstein, 1997; Daly & Wilson, 1988). Domestic violence often continues and may escalate in severity after separation. One-third of women who leave refuges experience continued abuse and harassment from their ex-partners (Binney et al, 1988). The British Crime Survey (BCS, 1996) found that 29% of separated women had experienced threats or domestic assault from a previous partner in the past year.

6. Each year 45% of female homicide victims are killed by present or former male partners compared to 8% of male victims (British Crime Survey, 1996). On average, two women per week are killed in England and Wales by their partners / ex-partners (British Crime Survey, 1996; Home Office, 1999a).

7. The overlap between domestic violence and child abuse is now well established (Kelly, 1997). A UK study found that domestic violence featured in 52% of cases where children were registered in need of child protection (Farmer and Owen, 1995). The NSPCC (1997) report that in over 50% of known domestic violence
cases, children were also directly abused. Children may be in danger when they try to minimise the violence or protect their mother (Mirrless-Black 1999). Even if children are not the direct target of violence, by being exposed to abuse they may suffer from the profound effects of emotional abuse, causing age-related emotional, cognitive, and behavioural difficulties including withdrawal, depression, fear, anxiety, aggression and PTSD (BMA, 1998).

8. In 90% of incidents of domestic violence, children are in the same or the next room (Home Office Violence Update, 1992; BMA, 1998)

9. Usually false. Pregnancy is a high risk period during which violence may begin or escalate, harming the unborn child as well as the mother (Williamson, 2000, p.14; ESRC, 2002, p.21; Bewley et al, 1997). 25% of women experiencing domestic violence are assaulted for the first time during pregnancy (Royal College of Midwives, 1997). 40-60% of women experiencing DV are abused while pregnant (BMA, 1998).

10. b). Domestic violence is more likely to result in injury than any other violent crime: 69% of incidents result in injury; 13% result in broken bones, compared with 4% of muggings (BMA, 1998). 29% of women over their lifetime and 1 in 9 women over a 12 month period is so severely beaten she needs medical attention following domestic violence (Stanko et al, 1997: Mooney, 1994).
Handout 2D
Domestic Violence Quiz

1. For crimes in general, what proportion of convicted offenders are male?
   a) 58%  b) 77%  c) 81%

2. The people most at risk of being victims of any violent crime are:
   a) Women aged 65+
   b) Women up to age 45
   c) Men under 25

3. What percentage of violent crime reported to the British Crime Survey is domestic violence?
   a) 10%  b) 16%  c) 45%

4. What proportion of women report experiencing domestic violence at some time in their adult lives?
   a) 1 in 3  b) 1 in 4  c) 1 in 20

5. In the BCS, what proportion of men report having been physically assaulted by a current or former partner at some time in their lives?
   a) 1 in 6  b) 1 in 20  c) 1 in 40

6. What percentage of women reported to the 1999 BCS being physically assaulted by a current or former partner in the past 12 months?
   a) 4.2%  b) 5.8%  c) 10%

7. On average, how many assaults does a woman endure before calling the police?
   a) 15  b) 25  c) 35

8. What percentage of domestic violence incidents result in injuries?
   a) 30%  b) 70%  c) 95%
9. How many women on average are killed by partners in England and Wales?
   a) 1 per month
   b) 1 per week
   c) 2 per week

10. What is the percentage of domestic violence incidents where children are in the same or the next room?
    a) 20%  b) 50%  c) 90%

11. What percentage of men who are violent to their partners also abuse their children?
    a) 10%  b) 30%  c) 70%
Answers
1. 81%
2. Men under 25
3. 16%
4. 1 in 4 for BCS, 1 in 3 for Mooney, 2000
5. 1 in 6 BCS
6. 4.2%
7. 35, Yearnshire, 1997
8. 70% BCS, domestic violence results in more serious injuries than muggings or pub brawls
9. 2 per week, Criminal Statistics
10. 90%, Hanmer 1999
11. Between 30% to 70%
Beliefs that blame the victim

It must be something about her, or her previous experiences

The biggest risk factor for being subjected to domestic violence is being a woman. The ‘just world hypothesis’ implies that good things happen to good people and bad things to bad people (Schornstein, 1997). The world is not just: domestic abuse does not just happen to bad people. Being good does not stop a woman being victimised. There is no correlation between a woman’s background and the chances of her being abused (Horley, 2000).

She must have asked for it. She must have provoked him

Domestic violence is a crime; she is a victim, not a criminal. The abuser will often claim he has been provoked, but no provocation justifies physical attack (just as being poor is not an acceptable justification for burglary). Victim of any other crime (such as mugging or bombing) are not told they deserved it. What abusive men count as ‘provocation’ is abnormal: women are assaulted for not having a meal ready, or asking for money, or are attacked in their sleep. Provocation is often an excuse offenders use to avoid responsibility for their behaviour. No woman ever deserves to be beaten, no matter what she has said or done. The idea that provocation leads to violence does not universally apply -if an abuser feels provoked by his boss or bank manager, it is unlikely that he would punch them in the face or kick them to the ground. Often, no provocation is apparent: women asleep are assaulted or dragged out of bed.

If domestic abuse is that bad, why wouldn’t they speak up?

Assault victims remain silent for several valid reasons. In the early stages, women hope that the abuser will change or stop the violence (Barnett & LaViolette, 1993). When it doesn’t stop, a woman remains silent primarily because of fear: she may be frightened of the abuser’s threats to kill her, to stalk her, to take her children away, to hurt others she loves, to kill her pet, to kill himself. It takes great courage to tell someone if a woman knows she will be at greater risk (often a valid assumption, based on past experience). Many women are prevented from talking, because their abuser locked them in the house, took the phone to work or always
accompanied her to the GP. Other women may hesitate to get help because they feel ashamed, because the perpetrator has convinced them the abuse was their fault, and that they are failures. Most often, women have tried to do something and tried to get help … but no-one listened. Those women courageous enough to disclose have often met a refusal to listen, disbelief or blame by family or friends.

She stays because she loves him or she is co-dependent

Loving the ‘charmer’ at the beginning (Horley, 2002) is not the same as loving the reality: that the same person is capable of love and abuse. His intermittent reinforcement is powerful method of behavioural control; his behaviour alternates between kind, loving and remorseful and insulting, threatening and violent but this can increase the degree of traumatic bonding, or dependency forged through fear rather than affection (BMA, 1998). Following recognition of the Stockholm Syndrome, it is clear that attachment to or identification with the perpetrator is a natural survival strategy, when hostages are dependent on their captors for basic rights, including food, water and toilet privileges (all can be controlled by abusers within a domestic situation). The captives become indebted to their captors for awarding privileges: the right to eat, or sleep. In over 30 years, those working with domestic violence services have never encountered a woman who did not want the violence to stop. Women try many strategies to prevent abuse, and always hope it will never happen again. Women feel horror, terror, and disgust – and never talk of any positive features about being attacked. If a woman returns to a relationship, it is not to the abuse that she is returning but to the hope that it has stopped.

Why don’t they leave? Why do they stay?

These questions imply it is the woman’s responsibility to end abuse and that there is something wrong with her that she puts up with it. In fact, a woman can unwittingly find herself trapped by an abusive man in the same way as passengers can be held hostages by terrorists on an aircraft. Few people would ask ‘Why don’t they get off the plane?’ Women often do try to leave, but abusers continue to stalk, harass, threaten, and/or assault them: 22% of separated women were assaulted in the previous year by their partners or ex-partners (BCS, 1999). Between a quarter and a half of divorced or separated women are still abused by their husbands (Davies, 1998). It is not just the abuser who doesn’t let the woman go; our society and the law can pressure them to maintain contact; for instance, the courts under
the Children Act (1989) can order contact between children and their fathers, and thereby increase the risk of ongoing abuse. Housing officers often suggest she returns to her own home, without understanding the danger. Many women do not know about refuges and even if they do, refuges are overcrowded and find it difficult or impossible to provide a space. Many face money problems, having left everything they possess behind, and perhaps having to leave paid jobs, without the hope of financial help from the abuser. Some women may have had their earning potential removed or reduced because their abusers prevented their taking employment or attending college or training. Some women may face particularly difficult obstacles to coping alone, including migrant women (who may have insecure resident status and no recourse to public funds), women with mental health needs or physical disability, very young women or elderly women. It is more astonishing that so many women leave rather than that they stay.

Some women just say they’ve been abused to get re-housed

Leaving an abusive relationship can often mean leaving belongings, homes, jobs, family, friends and pets behind, taking children away from their father, friends and schools; living in overcrowded refuges or hostel accommodation while waiting for up to two years to be re-housed. Moving away from familiar surroundings, family, friends and community networks is something few women would choose to put herself and her children through without good reason.

Women are violent too.

The possibility that a health professional may meet a male victim of domestic abuse should not be overlooked. Any person who has been abused needs to be safe and to be given advice and support. However, research clearly shows that women are most likely to be victims of domestic abuse because:

1) The inequalities of physical power between men and women will have a profound effect on any violent encounter. Men are usually larger and stronger than women, so the same acts (e.g. shoving) have different consequences. Men use more dangerous forms of violence, make more frightening threats, do more damage and are almost always the perpetrators in sexual assaults (Walby & Allen, 2004).

2) Men and women usually have different motives when they are violent (Browne, 1987; BMA, 1998; Barnett & LaViolette, 1993). Men most frequently abuse women
because they want to ‘show who is boss’ or gain more control. Women who are violent act mostly in self-defence, to stop an on-going or threatened attack. Taken to the most extreme, studies by Walker (1989) and Browne (1987) identified abused women who killed in self-defence, using violence as a last resort to protect their own lives and/or the lives of their children. At least 60% of men who were killed initiated the violence episode leading to the homicide (see the review of studies in Mechanic, 1996). In a review of empirical studies of dating violence, men reported that the primary purpose of their violence was to ‘intimidate’, ‘frighten’ or ‘force the other person to do something’ (e.g. to obtain sex ). In contrast, women most frequently gave self-defence or retaliation as the reason for their aggression (Sugarman & Hotaling, 1989). Gender neutrality minimises the disproportionate amount of male violence perpetrated against women and overlooks the self-defence aspect of much female violence.

**Beliefs that excuse violence**

*Men who assault their wives are mentally ill.*

Domestic abuse is too common to be explained as being the result of mental illness. Most men with mental health problems do not abuse, and most abusers would not be diagnosed as mentally ill. It has been estimated that only 3% of men who abuse their wives show signs of organic brain damage (EWA, 1984). The proportion of abusers who are mentally ill is no higher than in society as a whole (Horley, 2002). If mental illness is a factor, why doesn’t the abuser also attack their employer, or strangers? Trying to understand him or his intent will not diminish the effects or impact of the violence on the victim, and her children.

*He has poor impulse control; a problem in anger management*

Many people feel angry but do not assault another person. Anger is a healthy feeling; violence is a criminal behaviour. Most men who assault their partners do so in the privacy of their own home, not outside in public view, suggesting that his assaults are not subject to his current emotion or poor impulse control; he can wait to beat her when they get home, in a planned way. Some women are hauled out of bed, asleep, and beaten. The abuse is often directed to parts of the body that will not be visible if bruised. Most violent men would not attack their boss, bank manager or a stranger when frustrated. His assault is often ‘in cold blood’ with no sign of ‘loss of temper’. The assault may stop immediately if there is an
interruption such as a phone call, or a ring at the door. These behaviours do not indicate poor impulse control or rage, but cold, planned use of violence.

*It's intergenerational; he had a bad childhood*

While it may be true that he experienced abuse, not all men who grow up in a violent home become abusive. Each man has a choice. Domestic abuse is no different than any other crime, and it would not mitigate the sentence of a burglar if he said he grew up in a poor home. An abuser can coerce women into believing he cannot manage without her, that it is her fault if she leaves him, and that she should therefore feel guilty and ashamed. Women come to recognise that they left because of their abuser's violent behaviour, not because they don't care. The recognition that the danger has forced her out can be crucial for a woman; it is the domestic abuse that caused the separation, not her lack of care. If her partner cannot manage alone, there will be other people who may help him: family, friends or professionals – and whether or not he chooses to access them is not her responsibility.

*Treatment of his substance misuse will stop the violence*

Alcohol is present in many domestic assaults, and a quarter of all facial injuries to women happen during alcohol-related domestic assaults (ESRC, 2002). 21-25% of women subjected to domestic violence are severely abused by perpetrators who use drugs and alcohol frequently (e.g. Roberts, 1996). Although research indicates a higher rate of domestic violence among heavy drinkers than among non-drinkers, the majority of abusers are not alcoholics and the majority of men classified as high level or binge drinkers do not abuse their wives (BMA, 1998; Schornstein, 1997). Many people who get drunk sing, fall asleep, or get sick, but do not assault their partner. The majority (76%) of physically abusive incidents occur in the absence of alcohol. Marlatt & Rohsenow (1980) found the most significant predictor of behaviour immediately after drinking was not the physiological effect of alcohol per se, but the expectations or meaning the individuals place on the drinking experience. The majority (76%) of physically abusive incidents occur in the absence of alcohol (Kantor & Straus, 1987). It’s a socially acceptable reason for loss of control (Horley, 2002).

**Beliefs about the role of society**

*What goes on at home is private and we should not interfere*
Violence is a crime. In the case of a burglary or a mugging, we expect the victim or bystanders to report the crime, and the criminal to be charged. No one would ask customers held hostage in a bank if they wanted to charge the terrorists. After being abused, a woman may not feel able to fight for her rights as a human being. To ignore her experiences can be to collude with domestic violence and keep women and children trapped.

It is very tempting to take the side of the perpetrator. All the perpetrator asks is that the bystander do nothing. He appeals to the universal desire to see, hear, and speak no evil. Herman, 1992

Every family has a row once in a while. They have a marital problem

As the prevalence statistics indicate, domestic violence of any kind is serious, causes significant injury and can be life-threatening. Many women have been killed ‘accidentally’ when their throat has been squeezed ‘too hard’ or when their head bounces off a wall for the last time. A ‘row’ in normal parlance does not mean injury or bodily harm. Domestic abuse is purposeful and systematic behaviour that occurs without a two-sided argument, since victims learn not to answer back. Women are no more responsible than the victim of any other crime. Focussing on the relationship clouds the issues and excuses the perpetrator. (Akin to child abuse survivors, women experiencing domestic violence very rarely exaggerate; indeed, the majority minimise and under-report the extent of the abuse; Dutton, 1992).

Women abuse is rife on council estates or minority ethnic communities

Domestic abuse transcends any societal grouping: geographical, cultural, religious, socio-economic, and age – the incidence and prevalence remain similar. Reports may seem more common in lower economic groups because women with few resources have to rely on statutory services and become visible as a result; women with more means may afford private alternatives. Domestic violence services support the wives of headmasters, social workers, solicitors and doctors.

Myths that minimise the violence

It was a one-off. He’s learned a lesson. He was really sorry.

Domestic abuse is not a single incident, or even a series of them. It is a systematic pattern of control and intimidation. Apologies may be another form of coercion, without evidence that he has taken responsibility for his abuse and means to keep
his promise. On the whole, studies show that abuse tends to recur and become more frequent and severe over time (Schornstein, 1997). Violence rarely stops without intervention.

At least he’s a good dad/He’d never hurt the children

In 45-77% of homes where men assault women, children are abused as well (Davies, 1998; BMA, 1998). Half the men who abuse their wives assault their children more than twice a year (Gelles & Straus, 1988). Witnessing domestic violence can cause a variety of physical, cognitive and emotional problems for children, including headaches, tummy-aches, enuresis and insomnia (Schornstein, 1997) and mental health difficulties in adult life (Kolbo et al., 1996; Morley and Mullender, 1994; Hester et al., 2000). Children in a violent home may suffer separation anxiety, difficulties in school, behavioural problems and identity issues (including confusion about guilt and responsibility for the abuse; BMA, 1998). Their beliefs about conflict, control and gender will be affected by witnessing their father abuse their mother; What ‘good dad’, for instance, would teach their children to use violence to effect power and that it is acceptable to beat women or within a family? What parent would use their children to relay threat or undermine their relationship with their mother? What sort of father sanctions violence as stress management or the fault of others (Jaffe et al, 1998)? Apart from physical risk (intentional and accidental), children may be at risk of neglect, since their mother may not feel safe enough to offer the parenting she might want to: either because she restricts their behaviour to minimise the risk of violence, or because her degree of trauma impacts on her availability.

Unborn children are especially at risk. Women are often abused for the first time in pregnancy, and miscarry, or the violence escalates in severity and frequency. Pregnant women can become more dependent on their partners and further trapped by practical and emotional pressures e.g. less income, bigger pressure to remain from her priest, along with her own hopes and dreams for a loving family.
Handout 2F
Domestic Violence and Health: A Quiz.

1. Women are more likely to experience domestic violence during pregnancy than gestational diabetes or pregnancy-induced hypertension
   True / False

2. Women who experience marital rape suffer less severe reactions than victims rape by a stranger.
   True / False

3. Domestic violence injures more women each year than car accidents and muggings combined.
   True / False

4. Domestic violence is a significant cause of disability and death for women world-wide.
   True / False

5. Domestic violence is a factor in one in four suicide attempts by women.
   True / False

6. Women who seek help about domestic violence are likely to turn to their GP.
   True / False

7. Psychologists have found parallels between the effects of domestic violence on women and the impact of torture and imprisonment on hostages.
   True / False

8. What percentage of women experiencing domestic violence are abused during pregnancy?
   a) 8%  b) 26%  c) Over 40%

9. What were the estimated costs of providing treatment for injuries and psychological harm arising from domestic violence in Greater London in 1996?
   a) £5m  b) £50m  c) £150m
Domestic violence and health: Answers to the quiz.

1. Women are more likely to experience domestic violence during pregnancy than gestational diabetes or pregnancy-induced hypertension.
   
   **True.** Domestic violence during pregnancy is more common than gestational diabetes or pregnancy-induced hypertension (Bewley et al, 1997).

2. Women who experience marital rape suffer less severe reactions than victims of rape by a stranger.
   
   **False.** Victims of marital rape suffer many of the same reactions as other victims of rape, including very severe depression and suicidal tendencies.

3. Domestic violence injures more women each year than car accidents and muggings combined.
   
   **True.**

4. Domestic violence is a significant cause of disability and death for women world-wide.
   
   **True.** Domestic violence has a major impact upon the health and welfare of women and children world-wide. The 1995 World Development Report by the United Nations shows that on a world scale, it is a significant cause of disability and death: 5% of health years of life are lost world-wide by women because of domestic violence (BMA, 1998).

5. Domestic violence is a factor in one in four suicide attempts by women.
   
   **True.** Domestic violence is a factor in one in four suicide attempts by women (Stark et al, 1979).

6. Women who seek help about domestic violence are likely to turn to their GP.
   
   **True.** Community-based studies have illustrated that when women seek help from statutory agencies, the GP is likely to be high up the list of those approached (Mooney 1994; Dominy and Radford, 1996). However, the number of women seeking help from their GP is not clear and the helpfulness of the GP is variable (British Medical Association 1998; 39).

7. Psychologists have found parallels between the effects of domestic violence on women and the impact of torture and imprisonment on hostages.
   
   **True.** Psychologists in the US have found parallels between the effects of domestic violence on women and the impact of torture and imprisonment on hostages (Graham et al, 1988). These effects include low self-esteem, dependence upon the perpetrator, feelings of hopelessness about ending the violence and a tendency to minimise or deny the violence (Kirkwood, 1993).
8. What percentage of women experiencing domestic violence are abused during pregnancy? a) 8%, b) 26%, c) Over 40%.

40 – 60% of women experiencing domestic violence are abused during pregnancy (McFarlane et al 1992). 60% of 127 women resident in refuges in Northern Ireland experienced violence during pregnancy. 13% lost their babies as a result (McWilliams and McKiernan, 1993).

9. What are the estimated costs of providing treatment for injuries and psychological harm arising from domestic violence in Greater London in 1996? a) £5m, b) £50m, c) £150m

The estimated cost of providing for injuries and psychological harm arising from domestic violence in Greater London in 1996 is estimated to be £189 million. (Stanko et al, 1997).
Handout 2.G

Domestic Violence Is a Public Health Problem
It is a significant cause of death & disability (BMA, 1998). The World Bank (1993) also recognized that domestic violence ‘is as serious a cause of death and incapacity among women of reproductive age as cancer, and a greater cause of ill-health than traffic accidents and malaria combined’.

Domestic violence causes physical and psychological harm, as follows:
Physical injuries caused by domestic violence include the following:
Abrasions, lacerations, contusions, fractures, dislocations, sprains, miscarriage, early labour, facial injuries (particularly to the lips, eyes, teeth, jaw, hair loss and perforated eardrum), abdominal or pelvic pain, headaches, gastrointestinal disorders, low birth rate, bruising, inflammation, penetrating puncture wounds and haemorrhages (Williamson, 2000).

In a survey within a London GP practice (Crisp & Stanko, 2001), on average there had been (at the time of the survey) 4.2 injuries per person experiencing domestic violence: most commonly cuts, bruises, black eyes, split lips, broken teeth. 10% of women were knocked unconscious, 5% sustained a broken nose, jaw or cheekbone and 2% had broken arms, legs or ribs.

Sexual violence has a profound impact on the physical and mental health of victims, in the short- and long-term, and at worst results in death through suicide, HIV infection, murder or ‘honour killings’ in which women are murdered to preserve the honour of her family in the eyes of the community (WHO, 2002).

Unlike other injuries, acute injuries caused by domestic violence are often bilateral and common sites include the head, neck and trunk (particularly the breasts, chest, abdomen and genital area (BMA, 1998)).

The client may have multiple injuries at various stages of healing, or untreated injuries that cause chronic pain or somatic symptoms.

Permanent or longer term damage caused by domestic violence includes scars, deafness, impaired vision, epilepsy, impaired mobility, loss of motor coordination for poorly healed fractures, dental problems and HIV or STD infections.
Women need medical treatment
Domestic violence is more likely to result in injury than any other violent crime: 69% of domestic violence incidents cause injury & 13% result in broken bones, compared with 4% of muggings (BMA, 1998).

29% of women over their lifetime and 1 in 9 women the previous year is so severely beaten she needs medical attention following domestic violence (Stanko et al, 1997: Mooney, 1993).

20-30% of injuries that send women to A & E departments are caused by physical abuse by husbands or boyfriends (Schornstein, 1997)

1 in 9 women with a current male partner attending Accident & Emergency was there because of acute domestic violence (Abbott et al, 1995)

Abuse victims attend A&E not just with injuries but with a wide range of other illnesses such as chest pains and irritable bowel syndrome (Stevens, 2000)

Many women are prevented by the perpetrator from seeking the medical help that they need.

Women and the unborn child are at risk during pregnancy
Pregnancy is a high risk period during which violence may begin or escalate, harming the unborn child and the mother Occasionally it has been associated with a reduction in violence (Williamson, 2000, p.14; ESRC, 2002, p.21; Mezey et al, 2000; Campbell et al., 1992: Purwar et al., 1999; Stewart & Cecutti, 1993; Webster et al., 1994).

40-60% of women experiencing domestic violence are abused while pregnant (BMA, 1998; Parker & McFarlane, 1991).

25-40% of women experiencing domestic violence are assaulted for the first time during pregnancy (Royal College of Midwives, 1997; Coid, 2000)

13% of women in refuges in Northern Ireland lost babies as a result of violence during pregnancy (McWilliams & McKieran, 1993)

Domestic violence in pregnancy is more common than other pregnancy complications, such as pre-eclampsia and gestational diabetes (Friend, 1998; Mezey, Bacchus & Bewley, 2000).

Domestic violence is associated with obstetric complications such as: genitourinary infections, non-induced premature labour, premature rupture of
membranes, abdominal pain, bleeding before 37 weeks, false labour, and significant headache, backache or hyperemesis (severe vomiting) (Bacchus, Mezey & Bewley, 2004)

**Harm to mental health**

Metanlyses show that the greater a person’s exposure to domestic violence, the more adverse the effects on their mental health (Golding, 1999).

56% of women experiencing domestic violence will be diagnosed with a psychiatric disorder (Danielson et al, 1998)

46% of abused women have an anxiety disorder (Gelles & Harrop, 1989)

37% - 48% exhibit symptoms of depression (Houskamp & Foy, 1991; Golding, 1999).

25% of women who attempt suicide are experiencing domestic violence (AMA, 1992)

Abused women are 8 times more likely to attempt suicide (Stark & Flitcraft, 1996)

Up to 44% of abused women have tried suicide as a means to escape violence (Humphreys, 2003).

More than 50% of women in contact with mental health services have experienced abuse and/or violence (Naz, 2003; DoH, 2002; Jordan et al, 2004).

Across settings (psychiatric wards, primary care practices and voluntary sector) the rates of depression for women experiencing domestic violence is at least twice as high as the rates for non-abused women, and can range from 32% to 83% (Humphreys, 2003; Stark & Flitcraft, 1996).

Three studies of women in USA shelters or self-help groups found PTSD rates ranging from 45% to 84% (Astin et al, 1990; Houskamp & Foy, 1991; Kemp, Rawlings & Green, 1991), in contrast to women in the general population with prevalence rates of less than 26% (Humphreys, 2003). These studies found a significant association between the extent and severity of assaults and the severity of PTSD symptoms. They also found that continued contact with the abuser (through court cases, for instance) made symptoms worse.

60% of women across England who had separated from their partners due to domestic violence said they left because of ‘fears for their mental health’ (Humphreys, 2003). After separation, women most often stress the impact of
domestic violence on their mental health, self-esteem, self-worth and security (BMA, 1998). Many women say the ‘mind-games’ were worse than the beatings.

Women suffering abuse are most commonly diagnosed as suffering from depression, trauma and anxiety disorders; others are given diagnoses such as eating disorders, obsessive-compulsive disorder and personality disorders (Davies, 1996).

For most women, experiencing domestic violence and mental distress is doubly stigmatising. Survivors feel most positive when the domestic violence, not they, are seen as the problem. Many would prefer ‘talking therapies’ rather than medication (DoH, 2002).

**Domestic violence impacts on behaviour**

Women who are experiencing domestic violence, with no prior history of substance use (BMA, 1998) are 15 times more likely to abuse alcohol, 6 times more likely to abuse drugs (Stark & Flitcraft, 1996).

Research shows that domestic violence results in alcohol abuse, rather than vice versa; women are more likely to drink after an attack, rather than prior or during it (Downs & Miler, 1994).

40% of abused women have difficulty sleeping (Mooney, 1994).
Handout 2H

Jason, aged 4

Last night, I heard Mummy and Daddy fighting downstairs. I wish they wouldn’t fight. It makes me scared and gives me nightmares. Sometimes when I have a bad dream I would like to get in bed with Mummy, but Daddy always makes me go back to bed. He gets very cross in the morning if my bed is wet.

Roxanne, aged 10

I got my own breakfast this morning. I could see Mum had been crying, but I didn’t ask her why. She had a bad bruise on her face though. I wanted to stay home with her, but in the end I went to school. I was late. As usual. My friends often ask me why I’m always late; I don’t know what to say. Sometimes, I just want to cry.

Lucy, aged 7

My Mum shouts a lot when we come home from school because she says we make a mess and usually we have to be very good when Daddy comes home and very quiet. Sometimes, he comes upstairs to say goodnight and brings me a present. But sometimes I don’t like it when he says goodnight because he hurts me.

Jon, aged 13

I have to go to court next week. I have to tell them about what my Dad did to my Mum. Sometimes, I really hate him for the way he comes and goes out of our house, gets really drunk and pushes Mum about. I wish he would just stay away. I think it’s the shouting and the names that he calls her that I hate as much as the hitting. I’m really frightened, but if I try to help her he just lashes out at me too. I hope they put him away so we can all feel safe again.
Handout 21
Children and Domestic Abuse

Some children lose their mother as a result of domestic violence – 2 women per week are killed by a partner or ex-partner (Home Office, 1999a)

Over 30,000 children spend at least one night in a refuge in England in a year (Stanko, 2000)

Sometimes adults blame children for the violence by saying that the children's behaviour provoked them (Women's Aid Federation of England, 1996)

Children may miss school because they stay at home to take care of their mother (Women's Aid Federation of England, 1996)

Children may become involved in criminal or civil legal proceedings as a result of witnessing domestic violence (Saunders 1995)

A child's education may suffer as a result of having to live in temporary accommodation (Clark, 1993)

In half of families where the mother is abused as least one child is also abused (Jaffe et al, 1990)

Children of all ages who witness violence against their mother will try some form of passive or active support to protect her (Dobash and Dobash, 1984; Smith, 1989, Hanmer, 1990; Hester & Radford, 1996)

Sometimes children feel guilty if they do not come to their mother’s aid, and/ or blame themselves because they believe they have in some way ‘caused’ their father to be violent (Saunders, 1995)

Children may feel angry toward their mother for not protecting herself or them from violence, and/or blame her for causing the violence. Others may be so concerned about their mother’s distress that they hide their own (Saunders, 1995)

Common ‘adjustment difficulties’ in child witnesses of domestic violence:

Increase levels of anxiety, psychosomatic illness including headaches, abdominal complaints, asthma, peptic ulcers, rheumatoid arthritis, stuttering, enuresis, sadness, withdrawal, fear, lowered social competence (particularly boys) and a reduction in understanding social situations including thoughts and feelings of people involved (Jaffe et al, 1990)
Behavioural effects include aggressive behaviour (Holden & Ritchie, 1991), running away from home (Jaffe et al, 1990)

Girls in particular seek to protect younger siblings during violent episodes and offer support or reassurance in the aftermath (Jaffe et al, 1990)

Children are not merely passive by-standers to the violence occurring around them but will act and make choices and many children develop a wide range of complex strategies of survival in order to deal with the stress and adversity they experience (Hester et al, 1999).

**Children suffer many of the same losses as women experiencing domestic violence, and additional ones. The following are inclusive but not exhaustive**

**Physical**
- Death
- Physical injury e.g. broken bones, bruises
- Brain damage
- Stress-related illness e.g. asthma, bronchitis
- Failure to thrive or weight loss
- Bed-wetting
- Sleep disturbance including nightmares
- Eating difficulties
- Self-harm

**Educational**
- Developmental delay
- Disrupted schooling and/or truanting
- Difficulties concentrating
- Memory problems

**Emotional**
- Fear and anxiety
- Introversion
- Anger
- Guilt
- Blame and self-blame
- Confusion
- Depression
- Low self-esteem
- Post-traumatic stress
- Tension
**Behavioural**  
Hyperactivity  
Withdrawal  
Alcohol or drug misuse  
Aggressive behaviour  
Running away  

**Relational**  
Advanced maturity and sense of responsibility  
Secretive and quiet (withholding information, protecting others, afraid to tell)  
Protective of mother and siblings by getting help  
Lack of experience of intimacy  
Isolation  
Confusion about whom to trust and who to turn to for help  
Poor or, conversely, highly developed social skills  
Confusion about gender roles  
Confusion about the appropriate use of power and violence  
Vulnerability  
Development of a range of complex strategies of survival and safety planning

The impact varies according to the stage of development:

**Examples of harm to unborn and infants, 0-2 years**  
Miscarriage; Stillbirth; Premature birth; Low birth weight; Brain damage leading to disability; Fretfulness; Flinching; Sleeplessness; Failure to thrive; Eating problems

**Examples of harm, 3 years - 7 years**  
Bed wetting and soiling; Withdrawn; Aggressive; Attention seeking behaviour; Nightmares; Crying, sadness, anxiety; Confusion, anger and fear; Can't concentrate at school or nursery; Play and social skills affected.

**Examples of harm, 8 years - 12 years**  
Performs poorly at school; Over-achieves at school to help build self esteem; Poor school attendance because at home looking out for mother; Self harms by cutting, scratching, burning, biting nails; Eating disorders; Bullies at school or is bullied; Tries to intervene to protect mother.
Examples of harm, Teenage years

Runs away from home; Early pregnancy to escape from home; Start offending; May join in the abuse or be forced to join in the abuse; May attack perpetrator; Drug or alcohol use

LCCEWA Children’s Sub-Committee (1994) Make a Difference

Handout 2J

Case Study: Yvonne and Nigel

Yvonne is a black British woman who is 35 years old. Her parents came to England from Jamaica before she was born, but returned to Jamaica seven years ago.

Yvonne has been married to Nigel for eight years. They have two children, Alex aged five years old, and Natasha aged six months. Yvonne is a secretary, and Nigel is a white British computer programmer. Throughout their relationship Nigel has become increasingly controlling of Yvonne, often preventing her from seeing friends, putting her down in front of others etc.

Occasionally he has hit her during an argument. He raped Yvonne quite violently after their second child was born.

She then decided to leave Nigel, taking the children with her. She went to stay with a friend who had almost lost her patience with Yvonne because she remained in the relationship.

After a week she approached the local authority for accommodation and was placed in bed and breakfast where she has been staying for a month. She has taken sickness absence from her job and is finding it hard to cope.

She is now considering going back to Nigel.
Handout 2.K

Identities: Equality and diversity exercise

1. You are a 41-year-old white woman. You are a successful businesswoman and in addition have a private income. You have one daughter, aged 14. You and your husband jointly own two houses that are paid for.

2. You have been in the UK for six months, after coming from Thailand to marry your British husband. You do not yet have indefinite leave to remain in the UK. You do not speak much English.

3. You are a white Australian woman, on a work permit for a further six months. You work as a teacher. You are renting a property from your boyfriend’s parents.

4. You are a white woman with learning disabilities. You have a council property in your sole name. You are in rent arrears through not paying your heating charge because your boyfriend wanted money.

5. You are a 34-year-old white woman. You have one child, aged three years old. You are a wheelchair user. You have a joint tenancy on a council property, which has wheelchair use.

6. You are a black woman, married to a police officer and live in police accommodation. You have three children aged one, three, and six.

7. You are a 70-year-old white woman, married for 50 years. You have lived with domestic violence all your married life. You have one son who gets on with his father.

8. You are a 30-year-old black woman who is profoundly deaf. You can lip read and use sign language. You live with your (hearing) husband in a jointly owner-occupied house. You work and have an independent income. You have no children.

9. You are a 50-year-old white woman with a severe visual impairment, using a guide dog. You live with your (sighted) husband and three teenage children in a council property.

10. You are a 40 year old Asian lesbian, trapped in an abusive heterosexual marriage. You and your husband have two children aged 3 and 6 years old. You jointly own your home but wish to leave with the children to set up home with a new (female) partner.
11. You are a white woman, 16 years old who has recently moved in with your boyfriend. He is the father of your three-month-old baby.

12. You are a 25-year-old white woman and have six children, all less than 10 years old. You are a travelling woman. You have difficulty with reading and writing.

13. You are an Asian woman, living over the shop that you and your husband run. Your mother lives with you and she speaks no English. You have some other properties and savings in joint names.

14. You are a 20-year-old white woman and have spent most of your childhood in care. You have a one-year-old daughter whose father has never lived with you but he calls around sometimes and is very threatening.

15. You are a 26-year-old Vietnamese woman. You are pregnant. You cannot speak English. Your husband claims Income Support for you both.

16. You are a 21-year-old Asian woman with three children under five years old. You live with your husband and children in his parent’s house.

17. You are a 62-year-old white woman, with a flat in your own name. Your son, whom you help out with money, is physically abusing you.

18. You are a 19-year-old white lesbian with one child, aged two. You work as a live-in nanny to your partner’s children. Neither of you is ‘out’ about your sexuality.

19. You are a white woman aged 32. You have two children, aged seven and ten years old. You live on Income Support. You are not in a relationship, but an ex-boyfriend is harassing you badly.

20. You are an African-Caribbean woman with a hearing impairment. You have three children, aged two, four and five years old. Your husband works.

21. You are a Turkish woman, aged 39 years old. You have three sons aged less than 10 years. You and your husband live on Income Support. The council flat you live in is in your husband’s name only.
Handout 2.L
Asian Women

Why might an Asian woman experiencing domestic abuse not approach agencies for help?

- Might not know where to go for help
- Fear of racism in mixed/mainstream refuges.
- Agencies are predominantly white-led; lack of specialist support services and may lack understanding of BME women's experiences of domestic abuse
- There is a low level of awareness among BME women about the existence of refuge services
- Agency workers may not be able to speak Asian community languages
- Even if Asian, workers might not speak right language, agency may not be able to access interpreters
- Interpreters may be male or may be from the same community and may not be properly qualified
- She may fear that her confidentiality would be broken by interpreter
- Agencies may be racist
- May be lack of cultural awareness in agencies
- May fear religious and cultural stereotyping by individuals and agencies
- May believe it is not acceptable to talk about her business outside of the family/community
- May fear being reported to Home Office if has unsettled immigration status

What might stop her from leaving an abusive relationship?

- May not have access to information about support services
- May have no recourse to public funds, unsettled/insecure immigration status and fear being deported
- Abuser may have essential documents such as passport, marriage certificate, correspondence from Home Office
- May be under pressure from family/community/elders/religious leaders not to leave
- May fear loss of community support and social networks – being ostracized or isolated
- May believe that wherever she goes, he will find her through community networks by word of mouth or because ethnic minority women more visible in different communities
- She may be being abused by in-laws and kept isolated
- May believe that she will be a burden on her family if she leaves
- Betraying the family honour (izzat) and shame (sharam)
- To leave will affect the honour of other family members who are already married and those who are not
- Lack of awareness of British systems
- Abuser interprets religious teachings to suit his own ends

What stereotypes and discrimination might she face?
- Certain religions say it's okay to chastise your wife
- Seen as foreigners and therefore don't have same rights as British citizens
- Asian women are submissive/tied to the home
- The Asian community polices itself
- They should keep it in the community
- Black men are more violent/aggressive
- What do you expect from arranged marriages

What specialist services are available to Asian women locally/nationally?
- Muslim Women's Helpline Tel: 0208 904 8193
- Southall Black Sisters Tel: 0208 571 9595
- Newham Asian Women’s Project Tel: 0208 552 5524

Read: Circle of Light by Kiranjit Alhuwalia: on issues for Asian women facing violence

African Caribbean Women and Domestic Abuse

Why might an African-Caribbean woman experiencing domestic abuse not want to approach agencies for help?
- Fear of racism, based on experience e.g. of discriminatory work practices, harassment
- Racist treatment by agencies: inadequate housing, inaccessible protection
- Fear of cultural stereotyping
- Most agencies are white-led; lack of specialist support services
- Language may not have a term for domestic violence (eg French) impedes asking for help
May fear that agencies won’t be aware of cultural issues
May fear being judged
Only a small number of Black-led agencies
May fear betraying partner if goes outside family/community
May believe it's not acceptable to talk about family business outside the family
May fear children being removed

What might stop her from leaving an abusive relationship?
Might not know where to go for help
Abuser might threaten to tell family/community/church that it's her fault if she leaves
Fear that is betraying partner, family, community
If partner is Black, fear that he might be more severely dealt with than if he were white
Fear of losing support of partner, family and community especially in dealing with effects of living in racist society
Feeling responsible for protecting a community already subject to racism
Being classed as mentally ill
Fear of deportation, the slow asylum-seeking process, curtailed right to claim benefits

What stereotypes and discrimination might she face?
African Caribbean women are strong and feisty
African Caribbean women give as good as they get
The African Caribbean family is matriarchal
African Caribbean men are violent and aggressive so what do you expect
It's normal in those communities - let them get on with it
Disproportionate number of black people sentenced to prison

(also see overlap with check-list for Asian women)

Specialist help
Southall Black Sisters 0208 571 9595
Akina Mama Wa Afrika 0207 713 5166
Domestic Abuse and Issues for Women who use Drugs or Alcohol

Why might women who use drugs or alcohol not want to approach agencies for help?

- Fear that she won't be taken seriously
- Fear that she won't be believed
- Fear that she will be seen only in terms of her drug or alcohol use
- Treated by agency only in terms of her drug or alcohol use
- Fear that she will be labelled
- Fear that nobody will help her
- Believes that she doesn't deserve to be helped
- Abuser might make counter-allegations against her
- Agencies believe that she is as bad as him and don't help
- Believes agencies won't take women in who use drugs/alcohol and are in chaos or don't have support for drug/alcohol use

What might stop her from leaving an abusive relationship?

- Her abuser may be her supplier
- Fear that she may lose her supply and have to face withdrawal
- Fear that the children will be removed
- Fear that once the agency get to know about her drugs/alcohol use, they will withdraw their support
- She believes or is told that there is nowhere to go that can help her
- Fear of leaving support and social networks
- Unable to transfer to a drug or alcohol programme in a different area
- Abuser forces her to take drugs/alcohol to get her addicted and more dependent on him
- Abuser threatens to tell other people about her drug/alcohol use
- Abuser controls her by controlling her drug/alcohol use
- May be so out of it on drugs/alcohol that can't seek help
- Scoring drugs/alcohol may feel more important than getting help
What stereotypes and discrimination might she face?

- She's low life
- She's disgusting
- She's a bad mother
- It's her fault
- It's only men who use alcohol or take drugs and her use is invisible
- She's irresponsible

Help:
Alcohol Concern  0207 928 7377
Drugscope  0207 928 1211
Issues for Lesbians Living with Domestic Abuse

Why might a lesbian experiencing domestic abuse not want to approach agencies for help?

- Homophobia and fear of homophobia
- Belief that agency will assume she's heterosexual
- Fear that agency won't believe that domestic violence occurs in lesbian relationships
- Fear that the agency will judge her
- Not wanting to reinforce prejudice against lesbians – e.g. that all lesbians are violent, or “masculine”
- Fear that she might lose her children, that courts will give residence to father/husband
- Might be faced with agency assumptions and stereotypes about lesbians, e.g. that they are white, hate men, wear trousers and have short hair etc
- May not know which agencies to approach
- May not know which agencies to approach
- Fear of AIDS might be heightened within bisexual relationships (Letellier, 1996)

What might stop her from leaving an abusive relationship?

- Partner might threaten to ‘out’ her to family, friends, children, community and workplace
- Female partner might accuse her of being abusive too
- Taboo of domestic violence in lesbian community so might not receive support
- Shared circle of friends means escape from violence equates with loss of community
- Female partner might approach same agency for help
- May fear that the family courts will judge her ability as a mother based on their stereotypes of her as a lesbian (Mullender, 1996)
- Fear of being easily found / tracked by mixing in lesbian/gay communities
- Fear of not being taken seriously if she approaches agencies
- No specialist refuges for lesbians
- Internalized social homophobia, perhaps adding to a sense of shame, guilt or powerlessness
Sense of duty to protect the community by keeping silent about domestic violence

**What stereotypes and discrimination might lesbians face?**

- Lesbians don't abuse each other
- It's just a cat fight (downgrade the severity)
- She's just being hysterical
- She brought it on herself
- Don't rock the boat in the community
- They're both as bad as each other
- If she has previously had a male partner, Look at what he's had to put up with
- She just needs a good ****
- Lesbians are bad mothers and will pervert their children
- Children need fathers
- Pressures to deny sexuality
- Experience of emotional abuse and humiliation

Survivors of Lesbian Abuse          Tel: 020 7328 7389
London Lesbian & Gay Switchboard   Tel: 0207 837 7324
Broken Rainbow                    Tel: 07812 644 914
Hold tight tight hold             Tel: 0207 928 1211
Domestic Abuse and Mental Health

How might domestic abuse affect a woman's mental health?

- May become depressed or anxious
- May feel worthless and have low self-esteem
- May feel or become suicidal
- May self-harm
- May become more isolated
- May develop an eating disorder

How could an abuser use a woman's mental health issues to further abuse her?

- Might tell her nobody will believe her
- Might tell her (and others) that she is mad
- Tell her she could not cope on her own
- Refuse to let her go anywhere on her own, and say it's for her own good
- Might threaten to have her sectioned
- Might threaten to tell Social Services she can't look after the children
- Might withhold her medication
- Might give her an overdose of her medication

Why might a woman with mental health issues not want to approach agencies for help?

- Fear of not being believed
- Lack of confidence: maybe she IS the one with the problem?
- May have panic attacks when she goes out
- May fear that she will be seen only as a 'mad' woman
- May fear that children will be removed
- May fear that she'll be made to see a psychiatrist or even sectioned
- May fear that things will be taken out of her control once she has told people
- May fear that people will be sympathetic to abuser and see her as the cause of the problem

What might stop her from leaving an abusive relationship?

- Fear
- May not know where to go
- May not be unable to find a suitable refuge place
- May believe no refuge will take her
- May believe that she is the problem and that the abuse is her fault
- May feel dependent on abuser
- Fear of repercussions
- Fear of being found
- Fear of losing children

**What prejudice might she face?**
- 'She's the problem'
- 'She's a nutter'
- 'She's hysterical'
- 'You can't blame him. Look at what he has to put up with'
- 'He's better off without her'

24 hour National Domestic Violence Helpline 0808 2000 24 7
Young Women and Domestic Abuse

Why might young women find it difficult to approach agencies for help?

- Lack of trust in an adult dominated society
- Fear they may not be believed
- Don't know where/who agencies are
- No transport
- No money
- Lack of entitlement to benefits and tenancies (16-18 year olds)
- They may feel intimidated by agencies or their GP
- Fear of being 'caught' asking for help
- Peer pressure to have boyfriend
- Passing the problem between agencies; lack of specialist support

What attitudes, stereotypes and discrimination might young women face?

- The relationship/problem is not serious as they are just kids
- They are making it up as a form of attention seeking
- Go home to your parents
- There are 'plenty of fish in the sea'
- There may be a high regard for the perpetrator in the community
- She deserved it because she is a slag, flirt etc
- Financial discrimination imposed by government restrictions on benefits
- Age discrimination involved with being homeless
- He is only young and may grow out of it, 'phase'
- My son would never do a thing like that
- It is only domestic violence if you are living together, married.
- Friend dismissive or 'I told you so' attitude
- Feeling that police will not assist because of age

What other issues might young women face?

- Abuser may be older and better able to manipulate and exert power
- Health, contraception, and parents etc. knowing GP or that GP might tell
- Trying to complete education
- Housing
- Money
- Job or training
- Lack of awareness about the issue in school, youth clubs, etc.
- Immigration status may be dependent on perpetrator
- It doesn't happen to my friends, therefore it must be me
- Fear of parents finding out and imposing restrictions, or shame, especially if they disapproved of the relationship
- Abuser offered an escape route from family or isolation in care system

**Specialist services**

- Child-line Tel: 0800 1111
- Careline Tel: 0208 514 1177
- NSPCC Tel: 0808 800 5000

24 hr. freephone for children+young people 24 hr. freephone
Older Women and Domestic Abuse

Why might an older woman experiencing domestic abuse not want to approach agencies for help?

- Lack of knowledge about welfare benefits and support services
- Most service providers are younger
- Most services users are younger
- Feel embarrassed about disclosing to much younger women
- Lack of specialist support services
- May feel the pressure to offer stability to those around her

What might stop her from leaving an abusive relationship?

- May feel there is no point in trying to leave now
- May feel she cannot leave after having built up home and possessions over so many years
- Pressure by others including grown up children
- Harder to imagine the possibility of ‘future’ relationships
- May feel the pressure to conform to traditional stereotypes of passivity
- May feel she won’t fit in within a refuge, and/or will find it harder to cope with lack of privacy, noise, and other women and children
- Her abuser may also be her carer
- May lose pension rights if has to give up job
- May have no independent pension provision of her own and fears loss of share in partner’s pension
- Belief that marriage is for life
- Harder to imagine the possibility of ‘future’ relationships

What stereotypes and discrimination might she face?

- Disbelief by others that older men can be abusive
- Disbelief by others because violence has been hidden for so long
- Marries/remarries late in life and may feel foolish at “not choosing more wisely” at her age
- Disbelief that a parent would not have control over her children
- The hidden nature of institutional abuse

24 hour National Domestic Violence Helpline Tel: 0808 2000 24 7
Women with Disabilities and Domestic Abuse

Why might a disabled woman experiencing domestic violence not want to approach agencies for help?

- Lack of accessible services
- Agency may not be able to locate accessible accommodation suitable to woman's needs
- Fear that agency will place her in residential care
- Fear of bureaucracy and delays around applying for funding from Social Services if she wants to live independently
- May need to recruit personal assistants if wanting to live independently
- Agency may not be accessible
- Agency may collude with abuser
- Agency may not believe her
- Fear of children being removed
- Specialist disability services may not be aware on domestic violence
- Domestic violence services may not be aware on disability issues

What might stop her from leaving an abusive relationship?

- May not know where to go for help
- May fear that she won't be believed or treated as credible
- He may have total power and control over her access to outside world
- May not be able to get help because agencies are inaccessible
- May believe it's her own fault
- Loss of employment or community group (e.g. deaf community) geared to meet her needs, particularly if partner is part of community
- If abuser is her carer, she may be totally dependent on him for care
- Fear of not being able to look after children if abuser also her carer and father of children
- Her home has been specially adapted to meet her needs
- Refuges and other safe accommodation that have accessible accommodation may not be right for her needs

What stereotypes and discrimination might she face?

- She's always falling over; She bruises easily
- What a saint he is looking after her like he does
- You can't blame him if he gets a bit frustrated at times
- Prejudice/disbelief, especially if abuser also has disability
- Being labeled as asexual or tragic or burden to society
- Disability is some kind of punishment for evil behaviour
- Disability is an impairment the individual should overcome by effort, or be seen as ‘apathetic’
- It is the individual who is at fault, not society

**Specialist services for women with disabilities**

Social Services Adult Care Team  For contact details, see local directories

Powerhouse (advice and information for women with learning difficulties) Tel: 020 7366 6336

Beverly Lewis House (London refuge for women with learning difficulties) Tel: 020 8522 0675
Class and Domestic Abuse

Working class Women

Why might a working class woman experiencing domestic abuse not want to approach agencies for help?

- Previous experience of class discrimination
- May feel daunted about approaching professionals
- May feel frustrated or patronized in the past
- May feel inferior, unworthy or self-doubt reinforced by negative attitudes from professionals

What might stop her from leaving an abusive relationship?

- Less access to employment prospects
- Less educational opportunities
- Further financial challenges for single parent
- Day to day struggles of dealing with poverty, childcare, bad health, bad housing take precedence

What stereotypes and discrimination might she face?

- The effects of living on a low income
- Forced or encouraged to lower aspirations
- Attitudes can be patronizing and judgmental
- Lower expectations for her quality of life
- Lower expectations of her capacity to make informed decisions
- Stereotyped as inarticulate, aggressive, unable to cope, unwilling to change

Middle class Women

Why might a middle class woman experiencing domestic abuse not want to approach agencies for help?

- Reluctance herself to believe ‘I am that type of woman’ (her belief in a stereotype that violence is a working class phenomenon)
- She may fear she will not be believed by others – particularly if her abuser is a respected member of the community, e.g. minister of religion, G.P. or surgeon, M.P., etc.
- Lack of knowledge of support services, welfare services and benefits available
- (More likely to approach health suffering from depression than refuge providers asking about domestic violence)
- Embarrassment and shame
What might stop her from leaving an abusive relationship?
- Home and standard of living dependent on abuser’s income
- Private schooling for children dependent on abuser maintaining payment
- Used to staying at home; employment prospects daunting or curtailed
- Reluctance to get caught in the poverty trap

What stereotypes and discrimination might she face?
- Disbelief by others including service providers that upper/middle class men can be violent
  - (due to their ‘respectability’ or profession e.g. teacher, policeman, doctor, priest, lawyer)
- Pressure to be grateful for expensive holidays, ‘being so well off’

Traveller Women and Domestic Abuse
Why might a woman experiencing domestic abuse not want to approach agencies for help?
- Her community’s previous experience of the police
- Fear of the way police would treat the perpetrator
- Civil remedies inappropriate
- On-going treatment by society e.g. that place her community on municipal sites alongside industrial units, factories and waste tips; poor facilities in a brutalized environment

What might stop her from leaving an abusive relationship?
- She would have to leave her community
- She may lose the protection of her extended family
- Loss of her status as a married woman
- Difficulty in attending social occasions (dances, weddings, christenings)
- She would have to adapt to a ‘settled’ lifestyle
- Loss of her way of life and security
- ‘Marriage is for life’ prevalent belief in travelling community
- It is rare for women to live as a single parent in a travelling community

What stereotypes and discrimination might she face?
- Insults, lack of respect
- Objections to her presence in a refuge from other residents
- Prejudice and hostility from the settled population
• Difficulty adhering to her high standards of cleanliness in a communal kitchen

Women Working in the Sex Industry and Domestic Abuse

Why might a woman experiencing domestic abuse not want to approach agencies for help?
• Previous lack of support, history of abuse
• Isolation
• Disrespect from authorities, e.g. being addressed by a court as ‘Mary Smith, common prostitute of (address)’ – the only defendants in the British Justice System to be addressed and treated in such a way
• Forced drug addiction

What might stop her from leaving an abusive relationship?
• Financial pressures
• Fear of the perpetrator who has immense power over a number of women
• Fear of her children being removed
• Fear that she would suffer discrimination both in a refuge or elsewhere
• Difficulty in obtaining employment: lack of references, educational qualifications and training
• Addiction to drugs and difficulty in obtaining effective treatment
• May be unable to find place in a refuge – or may fear that refuge will not take her because of her sex work and/or drug use.

What stereotypes and discrimination might she face?
• Inappropriate advice from professionals who do not understand her living circumstances
• Judgment and condemnation for her ‘life-style’
• Women in the sex industry should expect assault and rape
• Women in the sex industry do not experience the effects of violence to the same extent

For Women Whose First Language is not English

National Interpreting Service Tel: 0800 169 5996

Interpreting by phone can be achieved from any telephone, but not mobiles. No special equipment is needed. You must be registered and have an ID number

Steps in the process
• Dial 0800 028 0073 or 0207 626 2929
- Operator: What language do you require?
- Answer: State language needs and request a female interpreter
- Operator: What is your client I.D.? Answer: ****
- Operator: What organization are you calling from? Answer: ****
- Operator: What is your personal code? Answer: ****
- Operator: Please hold for an interpreter

After about a minute, the operator will tell you that the interpreter is ‘now on line’. The interpreter will introduce themselves with their first name and interpreter number. This information will be entered onto the record. If you wish, make a note of their ID, so you can ask for them in a follow-up call.
- Introduce yourself to the interpreter. Explain the problem and what you want to achieve
- Speak to the client, not the interpreter e.g. What is your name? How can I help you?
- When you have finished the interview, thank the interpreter and say ‘end of call’

N.B. The interpreter will interpret what each of you say, but it is not her job to advise you or the client. The only time she might intervene is to seek clarification, or make you aware of a cultural implication that might cause offence. The interpreters are professional and bound by a strict code of confidentiality.

If you wish to speak to a client while they are in their own home and you are at work, then you need a 3-way conference and your switchboard must have a 3-way calling facility. Call the interpreter as usual and when the interpreter is on line, put the interpreter on ‘hold’ and call the client. The interpreter will answer first and introduce you. Proceed with your questions.
If you do not have a 3-way facility, ask the operator to set up a phone conference for you. Give the operator the full telephone number of the client, including the international dialling code.

**Women Who Have Come From Abroad**

Women who enter the UK to join a spouse or fiancé will have leave to remain depending on their marriage to that man, and are usually granted a 12 month stay in the UK. After 12 months, before the expiry of their visa, they need to apply for...
indefinite leave to remain on the basis that their marriage is continuing. However, some women experience domestic violence and are forced to leave their partner before the 12 months are up. It used to be that separation made her right to remain precarious. However, a Government concession now means that she can apply in her own right for indefinite leave to remain if she can produce:

- An injunction, non-molestation or other protection order (but not an ex-parte or interim order)
- A relevant court conviction of her husband, or
- Full details of a relevant police caution issued or pending prosecution against her husband.

It is therefore essential that women are advised to seek legal advice as soon as possible, so that an application can be made for a court order or to file a police report. At a later date, it may be harder to convince the court that a threat of immediate violence remains. Women are often afraid to seek police or legal support because their partners have threatened that they will be destitute and deported straight away.

A woman who does not have police evidence may find it more difficult to apply under the concession but can apply if she has more than one of the following:

- A hospital medical report that her injuries are consistent with domestic violence
- A letter from a GP that her injuries are consistent with domestic violence
- A court undertaking that the perpetrator will not approach her
- A police report that they were called to her home because of domestic violence
- A letter from Social Services confirming involvement due to domestic violence
- A letter of support from a women’s refuge

She may also be entitled to benefits. A specialist can advise her about the European Convention of Human Rights (Articles 8 & 12). Any woman is subject to immigration control if she is not a British citizen or an European Economic Area (EEA) national, and:

- she needs leave to be in the UK but does not have it,
- she does not have recourse to public funds
- support from another person or sponsor was a condition of her entry, or
- she is appealing a decision about her immigration status

A trustworthy and competent advisor to help on immigration issues is essential. Women may be entitled to legal advice whatever their immigration status. It is now against the law (under Part V of the Immigration and Asylum Act, 1999) for immigration advice or services to be provided unless the person has registered with or have been exempted by the Office of the Immigration Services Commissioner (OISC), or they are members of a specific professional body (such as a solicitor). Relevant law includes the Immigration and Asylum Act (1999), the National Assistance Act (1948) and the Children Act (1989). The Home Office agency called the National Asylum Support Service (NASS) can offer support arrangements for people seeking asylum. Some asylum seekers may access welfare benefits directly; others receive assistance from local authorities (Social Services).

A woman admitted as a wife who could maintain and accommodate herself may look for a paid job and ask Social Services for help, until granted indefinite leave to remain. An asylum seeker without money can access support through NASS. She can apply through the Refugee Council for vouchers that can be exchanged for cash. Pregnant women or women with a baby can claim a maternity payment and extra payments for milk. Women who arrived in the UK before April, 2000 may be entitled to claim for benefits such as Income Support and Housing Benefit, at least until a final decision is made. Women who are pregnant, have children or special needs may get help from local authority Social Services. Any allowance made may be available until the application for indefinite leave to remain has been decided, abandoned or until the appeal is determined.

If local authorities refuse to help, women can apply for short-term funding from the ‘Last Resort Fund’ administered by Women’s Aid, telephone number 0117 944 4411.

NB. The legal information is correct at time of writing – but benefits and immigration law both change frequently and trainers need to check current position.
Help create an environment in which women feel comfortable talking about abuse.

Be aware of signs that could indicate domestic abuse is taking place.

Know how to ask the right questions to let a woman know she can talk to you about abuse. Explain the limits of confidentiality.

Validate and support women who do reveal abuse.

Pass on information about relevant support agencies, whether or not a woman discloses abuse.

Keep detailed, accurate records about a woman’s injuries and what she reveals to you – but never in hand held records.

Ensure confidentiality. If you need to share information with other agencies, follow guidelines.

Carry out your usual health duties.
Handout 2N
Barriers to women seeking and receiving help

There are many reasons why women do not disclose domestic abuse:

- They may feel embarrassed to talk about domestic abuse.
- They may be afraid of the consequences of telling the truth about their injuries or illness.
- They may not trust the health professional to keep what they say confidential, especially if their partner has the same GP as them.
- Differences in social class between a woman and the health professional can make a woman less willing to broach a personal subject like abuse.
- They may find it difficult to disclose personal information about abuse to male staff.
- They may not define their experience as domestic abuse.
- They may feel that no one can do anything that will change the situation.
- They may not be enough time available to being to talk about the abuse.
- They may fear their children will be taken away.
- If you suspect that the woman you are treating may be abused, it is important to make it clear to her that she can confide in you. Also give her the option of talking to someone else, whom she might feel more comfortable with, such as a nurse or health visitor.
- When a woman discloses about abuse she may need to talk for quite some time. If you can't offer this amount of time, let her know this and refer her onto someone who can give her plenty of time to talk.
- Be aware that domestic abuse frequently starts or increases when a woman becomes pregnant.
- Offer a woman a quiet room to sit in after she has spoken to you as she may feel vulnerable and not ready to leave. If possible offer her a drink and provide tissues. If a woman who is testing the ground sees you as warm and listening she is more likely to return, and more likely to entrust information to you.
- If a woman denies, or will not speak about abuse it does not mean she has not been/is not being abused. She may not trust you enough to expose her personal life at that point. If she denies it, but you are still unsure, record this in your notes - she may tell you at a later date and need you to provide medical evidence to support her in relation to legal procedures.


Communicate that it is OK for the woman to talk to you again. If you have
suspicions that domestic abuse is an issue, asking the patient to return for a
relatively minor reason to check their blood pressure, that may signal your
interest and allow a further opportunity for disclosure.



Be alert to the possibility of current or past abuse when a woman patient
returns a number of times to the surgery with a set of vague and changing
complaints. This may be her way of trying to make you aware that these
legitimate health problems are not her main concerns.



Liaise with other members of the primary health care team so that the most
appropriate support can be achieved. Know of outside agencies who can
offer support and information.



Publicity, such as posters and booklets, sends out two messages: to
women that it is OK to speak about it, and to men that the surgery team
disapproves of domestic abuse.

166


Module Two

Positive Identification

Training Guide
3. POSITIVE IDENTIFICATION

3.1 Introduction

_Responding to Domestic Abuse_ advises health professionals to create a supportive environment that will make it easier for women patients to talk about domestic abuse, to be aware of possible signs of abuse, to ask patients directly about abuse and to respond to their needs appropriately. Trainers must be aware of the context in which a particular group of professionals work and provide training that is relevant to their specific working environment. For example, the opportunities to see patients alone and to ask them about domestic abuse may vary across the different contexts of a trauma injury case in a busy accident and emergency department, a new patient giving her history in primary care, a check up appointment in antenatal care and an outpatient appointment in a community mental health team setting. The materials in this section of the manual may need to be adapted by training facilitators to suit the specific training needs and context in which a group of professionals work.

The Positive Identification module contains materials to be used in training sessions that aim to:

- equip professionals with the skills to identify possible indicators of domestic abuse;
- increase their confidence and willingness to directly ask women patients about domestic abuse;
- help them to provide an appropriate response, whether or not domestic abuse is disclosed.

3.2 Indicators of abuse

Some women experiencing domestic abuse approach health services but do not disclose the violence as the source of their problems. Many seeking medical help are not asked how their injuries were inflicted and by whom. If the opportunity for intervention is lost, the abuse may continue and/or the woman remain isolated and unaware of her options for help. Whenever a woman seeks help, professionals must be alert to the possibility that she may have been assaulted and that she may need guidance to get help and support.
The British Association for Accident and Emergency Medicine (Academic Committee, 1993) suggested a number of indicators of domestic violence. None of these is proof that abuse has definitely occurred and they should not be treated as such. Rather they are signs that further questions should be asked carefully and tactfully.

**Indicators of abuse short exercise (10 mins)**

**Aim:** to raise participants’ awareness of physical, psychological and behavioural factors that might indicate domestic abuse.

**Materials:** flip chart paper divided into 2 columns with the headings ‘patient’ and ‘perpetrator’; pens, overhead projector/slide show equipment, Slides 3.A & 3.B.

**Method:** In small groups of 3-5 participants, ask groups to list possible signs in a woman and her partner that might alert the health professional to suspect domestic abuse.

Feedback, sum up and review responses drawing upon trainer’s notes (below) and using Slides 3.A & 3.B.

**Indicators of abuse case studies exercise (10-15 mins)**

**Aim:** to raise participants’ awareness of physical, psychological and behavioural factors that might indicate domestic abuse.

**Materials:** Case studies (Handout 3.A) overhead projector/slide show equipment, Slides 3.A & 3.B.

**Method:** In small groups of 3-5 participants, using case studies, ask groups to identify possible behaviours by a woman patient and her partner/perpetrator that might alert the health professional to suspect domestic abuse.

Feedback, sum up and review responses drawing upon trainer’s notes (below) and using Slides 3.A & 3.B.

**Trainer’s notes**

Trainers may want to:

- Address the needs of patients whose first language is not English (use professional interpreters rather than relatives or friends);
- Ask specifically about indicators of abuse in older adults;
• Ask about indicators for patients with disability;
• Ask about children;
• Note that a patient being accompanied by someone of the same sex may be gay or lesbian and being ‘supervised’ by their abuser;
• Address the different opportunities of being alert to possible indicators – in the waiting room, on interview, during examination, behaviour on the ward, attendance over time.

3.3 Asking About Domestic Abuse
Domestic abuse is a common experience for women patients but the majority of women do not disclose their experiences to a health professional. Lifetime disclosure rates, according to research, range from 18% to 37% of abused women disclosing the experience to a member of the health professions (Roberts et al, 2005). Only 13% to 20% of patients who experience abuse are ever asked about it (Roberts et al, 2005). Yet, evidence from practice suggests the majority of women do not mind being asked when it is explained that the same inquiry is being made of all women because domestic violence is widespread and often hidden (ESRC, 2002, p.21; Harris, 2002). 99% of women in Guys & St Thomas’ research found it acceptable for a midwife to enquire about domestic violence as part of their care (Bacchus, Mezey & Bewley, 2002).

Talking about domestic abuse needs to become part of the health professional’s daily work.

However training and support is needed to ensure that health professionals feel confident to ask women patients directly about domestic abuse, whether this is done selectively (asking some patients when abuse is suspected or seems likely) or routinely (asking all women patients whether or not there are indicators of abuse).

Asking women about domestic abuse can:
• Raise awareness about the issue of domestic abuse among women patients and health professionals;
• Identify more women at risk;
• Provide an opportunity for frightened patients to disclose and decrease their feelings of isolation;
• Whether abuse is disclosed or not, provide an opportunity to give women information about local and national services for people affected by domestic abuse;
• By preventative intervention, save the health service money and time;
• Help women to get access to services (as shown by increased referrals made to services);
• Help children live safely;
• Play a part in holding abuse perpetrators to be accountable.

It is not easy to ask, or be asked about, domestic abuse. Privacy is important and health professionals should never ask a woman about domestic abuse when somebody else is present (unless this is an interpreter). Questions need to be carefully framed and sensitively asked to minimise patient discomfort. There is no one set list of questions that are best used when asking about domestic abuse (Roberts et al, 2005). Initial comments or questions should attempt to put the patient at ease and help them to feel sufficiently safe and comfortable to talk if they wish to, now or in the future. Trainers should ensure that professionals understand that they should avoid trying to push women patients into revealing abuse. **The aim is to have a supportive conversation rather than to obtain a disclosure.** Women should be given information on or be able to see information about support services, regardless of their replies to questions about domestic abuse.

**What helps women to talk about domestic abuse? - 30 minute exercise:**

**Aims:** To consider the factors which may influence a woman’s decision to talk about experiences of domestic abuse.

**Materials:** Case study (Handout 3.B), pen and paper, flip chart and pens.

**Method:** Small group discussion. Divide into small groups and provide each group with a copy of the case study. Ask each group to imagine being Aimee sitting in the waiting room of the baby clinic, and to plan what they might say to the health visitor. Allow about 15 – 20 minutes for the small group discussion, to be followed by feedback and discussion in the large group.
Trainer’s notes

Women experiencing domestic abuse are often uncertain where to seek help and who they should talk to about their situation: Aimee may not be sure that it is appropriate to tell the health visitor.

Requests for help increase over time, with a gradual shift towards formal sources of help. Aimee may decide to talk to family or a friend instead of the health visitor. Women with children worry that telling about the domestic abuse will lead to them losing their children (NCH, 1994). Aimee may worry that by telling about the domestic violence, she may lose her baby. Aimee may have been threatened by Mark so she may fear that he will punish her if he finds out she has talked to somebody about the abuse. Women often feel embarrassed about their experiences of domestic abuse. Aimee may be reluctant to talk because she feels ashamed, embarrassed and guilty. She may have been disbelieved or criticised by a member of her family, or a friend, or professional she previously approached. Is it possible to speak in private? Will there be time, or will the discussion feel hurried? Is there a shared language or other difficulties in communication to overcome?

Barriers to asking: exercise 15-30 minutes

Aims: To give professionals an opportunity to air and to review their concerns about talking to patients about abuse

To build professionals’ confidence and increase their willingness to directly ask.

Materials: Post-it notes, pens distributed to participants. Flip-chart and marker, overhead projector/slide show equipment, Slide 3.C.

Method: Ask participants in three minutes to write down three concerns they or colleagues might have about talking to women about domestic abuse. Ask them to share aloud or put into a basket; trainer to read out and record issues on flip-chart.

Trainer’s notes

Responses might include:

- What is the point of asking?
- Lack of time
- Lack of confidence
- Fear of opening a can of worms
- Not knowing what to do next
- Lack of privacy
- Not wishing to offend
- Not knowing how to ask
- Lack of policies and guidelines
- Language barrier
- Remembering own experiences

The training facilitator then offers a response to address each concern, or helps the group generate solutions.

**What is the point of asking?** Reinforce the reasons for asking set out in the introduction above using SLIDE 3.C. *Why Mothers Die* (1997-99) shows that 12% (45) of the 378 women who died had voluntarily reported violence to a health care professional during their pregnancy. None had been asked about violence as part of their social history. 8 women were murdered by their partners or close relatives. 80% of under 18 year olds had suffered violence in the home. Research shows that direct questioning about domestic violence leads to a higher rate of disclosure (Norton et al, 1995; Hamberger et al, 1992; Taket et al, 2003). Routine enquiry within an emergency department increased the detection of domestic violence experienced by women during their life-time from 5.6% to 30% (McLeer & Anwar, 1989). However, 8 years later, the protocol had lapsed and the detection rate fallen to 7.7%, highlighting the need for consistency.

**Lack of time** – Time may be a real concern for health professionals who may have other appointments waiting. It is important that a woman does not feel rushed and is able to talk about the abuse at a pace that suits her. Dealing with other agencies to refer can be time consuming and frustrating. Professionals should be advised to arrange another appointment to see a woman if concerned. Research shows that asking about abuse can be incorporated into everyday clinical practice (such as taking the clinical history for a new patient) and can take just a few minutes.

**Lack of confidence, not knowing what to do next** – training and support for staff are essential. Professionals should not be made to feel that they carry sole responsibility to ‘rescue’ women from abusive partners. Staff need to be supported with training that clearly explains what their role should be and covers specialist
help available. Good links need to be established with specialist services. Staff should be made aware of policies and support available if they themselves have experienced domestic abuse.

**Fear of opening a can of worms** – health service staff should not take on a case worker role with respect to domestic abuse. They should be aware of specialist agencies to whom they can refer.

**Lack of privacy** – This can be a problem in some settings where facilities may be limited or where patients are encouraged to attend with their partners. Members of the group may well be able to share examples of how they previously coped with facilities where privacy was difficult. Possible strategies for seeing an accompanied woman alone include –

- involving partners in the appointment but setting aside time alone at the end of the appointment so he is less likely to feel excluded;
- saying you need to do some physical checks;
- saying you need to take the woman with you to do a urine sample;
- asking the partner to help fill in documents while you speak to the woman;
- suggesting the partner phone home / goes for food / drink as you may be a while. The woman’s safety must be a priority.

**Not wishing to offend** – research suggests that most women do not mind being asked, if this is done sensitively (Bacchus, Mezey & Bewley, 2002).

**Not knowing how to ask** – reinforce the point that there is no ready package of set questions for talking to women about abuse. Training will help professionals practice asking and build their skills and confidence. Conversations with patients about abuse may not be one off events but rather the start of a process where she considers and tests out her options. Professionals should aim to try to make the patient feel comfortable about coming back to see them again.

**Lack of policies and guidelines** – refer participants to the Department of Health handbook *Responding to Domestic Abuse* and to their Trust policy or guidance.

**Language barriers** – professional interpreters should always be used NOT partners, children, family members, friends or colleagues. Arrange for an interpreter in advance. Ideally interpreters should have domestic abuse training. They must sign a confidentiality agreement. Specialist organisations may also be able to help by providing an advocate.
**Own experience** – staff should be made aware of the workplace policy, national and local sources of help for themselves or colleagues.

**How to ask**

**Introduction**

The Department of Health handbook *Responding to Domestic Abuse* advises:

*In response to the evidence provided by the University of the West of England and North Bristol NHS Trust project (…), all Trusts should be working towards routine enquiry and providing all women with information on domestic abuse support services. (p.40)*

Routine enquiry involves asking all women, whether or not they show signs of abuse, if they are experiencing domestic abuse. The 1998 Health Services Circular, following an enquiry into maternal deaths, underlined the need for *routine questioning in antenatal care, and sensitive enquiry about domestic violence, being included in taking a social history*. An appropriate time to do so would occur when taking a social history or when asking about other factors that have a negative impact on a woman’s health. Asking all women helps avoid stigma and inappropriate judgements. Routine enquiry is not a ‘cure’ but it can help women get the support they need.

**It is vital to recognise that routine questioning about domestic violence must be accompanied by appropriate protocols, training and support for all staff involved**, along with local strategies for referral to advocacy services (*Why mothers die*, Dept. of Health, 1998, p.166). This needs careful planning and preparation. All health professionals must be given training before changing from selective to routine enquiry. Professionals who have already been trained in their role and the limits of their responsibilities quickly become confident in the new approach to questioning.

Trainers should be familiar with their Trust’s position on routine enquiry as well as the guidance given to managers and policy-makers in Part 3 of the Department of Health handbook *Responding to Domestic Abuse*. 
Asking about domestic abuse: 25 – 45 minute exercise

**Aims:**
To build health professionals confidence in asking direct questions about domestic abuse;
To improve interviewing skills by giving health professionals the opportunity to rehearse asking questions about domestic abuse.

**Materials:** Photocopies of Handout 3.C Sample Questions to distribute to members of the group.

**Method:** Ask participants to divide themselves into small groups of 4 or 5 people. Give each participant a copy of Handout 3.C. and tell them to practice asking each other the questions, putting themselves into the roles of both patient and practitioner relevant to their practice. (For a shorter workshop give each group of participants just two of the questions to practice and to discuss). Ask each group to identify problems or issues that might arise in asking patients and then to work together to generate means to resolve them. Note: The exercise is designed to equip professionals to develop confidence in asking about domestic abuse, **not to put pressures on members of staff to disclose their own experiences.** It may be useful to suggest clearly that the person being asked should role play a recent patient.

Feedback to the larger group, drawing upon the trainer’s notes below.

**Trainer’s notes:**
There may be some overlap with the issues raised in the exercise above on barriers to asking so you should refer to the above trainer’s notes as well and be prepared to reinforce the key points.

In addition you should note:
- Opportunities for asking woman about abuse include - taking a routine health history with new patients; at an initial visit for a new complaint; at a periodic health review e.g. well woman clinic, family planning, post-natal check up; when reviewing repeat prescriptions; when there are presenting signs or symptoms of abuse.
The importance of making safety a priority (ask the group how they might ensure this e.g. unaccompanied woman, arranging to see her alone, privacy in a room they cannot be overheard, care of case notes etc).

That it is important to take time to put a woman at ease before asking questions about domestic abuse but not to ask in such a way that it seems unusual or alarming.

Flexibility – the need for different questions relevant to specific situations. Encourage participants to reflect on this with reference to their own practice experiences.

Asking goes hand in hand with giving information about specialist services, preferably in credit card sized leaflets.

A woman who you suspect is being abused may well deny it if directly asked. Accept ‘no’ as her answer but offer her information on services, telling her it may be useful in the future for family or friends.

Asking is not necessarily a ‘one-off’ event. It may take a while for a woman who has experienced domestic abuse to feel confident enough to respond to questions, if indeed she responds directly at all. She may use the information provided without telling you.

Confidentiality is vital for the woman's safety as an abuser could become more violent if he thinks his partner has told someone. Confidentiality is a woman's right and should not be breached unless it is in the public interest to do so - for example: where there are Child Protection issues, or where a woman's life is imminently in danger, or where a perpetrator is likely to put the lives of others in danger. The role of the health practitioner will come under scrutiny in homicide reviews that will examine whether the professional has acted in a way that offered a duty of care.

Professional female interpreters are particularly important for women whose first language is not English due to the extra difficulties they face in seeking help. They may fear discrimination and fear they may be ostracised by their families, communities or social group if they disclose. Using family or friends to interpret inhibits the woman's opportunity to talk and jeopardises confidentiality.

Considering the welfare of any children. Professionals should be aware of potential risks to children, and that child witnesses of domestic violence may need an immediate response to address their own needs.
• Routine questions will mean that practitioners become aware of more women in their case loads that will need support. They need to plan how to deal with this.

• Establishing a support network within the team and links between clinical and local advocacy services.

**How to Ask - Case exercise (20 minutes)**

**Aims:** to identify helpful and unhelpful responses to disclosure of domestic violence.

**Materials:** case study (Handout 3.D) and copies of scripts (Handouts 3E & 3F), Handouts 3.H and 3.I, flipchart, marker pen.

**Method:** Facilitator and/or volunteers from group read first the case study and then the two scripts in Handouts 3E & 3F. Participants discuss what was helpful and unhelpful about the health professional's responses in the two scripts. The trainer records the group's thoughts on a flip chart, and using trainer's notes on the scripts for Handouts 3.E and 3.F (below) and Handouts 3.H and 3.I summarise aspects of a good response.
Scene 1: Aimee with Health Visitor

Health Visitor: We ask all our patients about their experience of domestic violence because we know that domestic violence is very common and that it can get worse in pregnancy. We do maintain strict confidence at all times and the only exception to that is if you choose to tell us that a child is being hurt. So can I ask you … Would you say that you feel afraid of or experience violence from anyone close to you?

Aimee: Pause … Well Mark has been rather bad tempered lately.

Health Visitor: I suppose everyone gets grumpy sometimes. Has he been under a lot of strain at work? (Doesn't pick up cues, changes focus from Aimee to Mark, makes assumption and minimizes problem.)

Aimee: He probably has got a lot on his plate but sometimes it feels a bit much.

Health Visitor: Really? So he's started to be violent; that's bad (Another assumption, jumped to conclusion without finding out what is actually going on, failed to ask an open question; judgmental in a way Aimee may interpret as her being bad.)

Aimee: Well, it's not too bad. I'm just feeling confused and unsure … (Aimee is beginning to retreat)

Health Visitor: How often does he hit you? It's really worrying if Samantha's nearby. She could be in danger (Multiple questions, not listening to Aimee. Reframing domestic violence as child protection issue.)

Aimee: Oh, no. It's never been when Sam has been around and it only happened once anyway. (Aimee is retreating and getting defensive, worried about social services removing Samantha)

Health Visitor: Even so, domestic violence often gets worse. You should get out when you can. I'll call the refuge for you and make an appointment for you with the counsellor (Telling her what to
do, taking over, disempowering. Aimee ends up feeling isolated and unsupported.)
Case study
Scene 2: Aimee with Health Visitor

Health Visitor  We ask all our patients about their experience of domestic violence because we know that domestic violence is very common and that it can get worse in pregnancy. We do maintain strict confidence at all times and the only exception to that is if you choose to tell us that a child is being hurt. So can I ask you … Would you say that you feel afraid of or experience violence from anyone close to you?

Aimee  Pause … Well, I think Mark has been under a lot of strain at work recently but it is getting to be a bit much.

Health Visitor  It sounds as though you’re feeling under strain too. How has he been behaving at home?  (Reflecting feelings, drawing out with open question, refocusing on Aimee)

Aimee  Well, I thought we’d sorted it out. After Sam was born Mark started to get aggressive and he hit me a few times. It hasn’t happened for nearly a year and I honestly thought he wasn’t going to get like that again. But last week, he got furious because I’d been out with a friend all day and I hadn’t got the food ready. He punched my stomach. I was terrified.

Health Visitor  That sounds so frightening. What happened after that?

Aimee  He left and I started to wonder if I should go to stay with my mum. I was going over later to pick up Samantha anyway and I was afraid of what he might do next. But I didn’t stay and when he got back he was very apologetic. He’s been a lot better since then as if he’s got something out of his system. Nothing bad seemed to happen so I left it.

Health Visitor  And what are you feeling about it now?  (Open question)

Aimee  I’m just so confused. I kept pretending it wasn't happening but now I’m wondering what I'm doing wrong to provoke him.
Health Visitor: You're wondering if it's your fault but you're really not to blame. Nobody deserves to be hit or to have to live in fear. *(Acknowledging her feeling of self-blame but following it with the message that it's not her fault)*

Aimee: But I really love him and we used to get on so well before. I wish it would be like that still.

Health Visitor: It seems that you're feeling a strong conflict inside. On the one hand you feel frightened and have wanted to leave at times, and on the other, you want to stay and for things to go back to how they were before. *(Staying with how Aimee is feeling and the conflict she's in - this helps Aimee take her thoughts one step further)*

Aimee: I wonder if things can ever be the same as before?

Health Visitor: Would you like me to give you some information about what help is available to you? *(Health Visitor hasn't got much time so has to move onto information giving)*

Aimee: Yes, it might be good to know. I guess so.

Health Visitor: Well, sometimes it can help to talk about how you're feeling and we have a counsellor you can see who can spend more time with you. She can help you look at all the confusing feelings and support you, whatever you decide to do. Then if your partner gets violent again there are several options. You can always call the police to help you in that situation because you know it's illegal for him to hit you. *(Information giving, empowerment, reinforcing that she is in charge)*

Aimee: I don't think I could ever do that to him.

Health Visitor: There is also Women's Aid and Refuge if you want to speak to someone on the phone at any time, or if you ever need to leave in a hurry and you need somewhere to stay. You can contact them even if you aren't thinking of leaving straight away, just to be in touch for them to support you. There are some numbers here on this leaflet. Would it be safe for you to
take a leaflet or would you rather write the numbers down? *(Information giving, concern for safety)*

**Aimee**  
I’ll write them down in code as I don’t want Mark to know I’ve spoken about this.

**Health Visitor**  
Sometimes it’s good to have things ready too, in case you ever need to leave in a hurry. Things like important documents, medicines, toys for Samantha etc. *(Information for preparing for a crisis and leaving)*

**Aimee**  
Yes, that sounds like a good idea.

**Health Visitor**  
Also Aimee, I need to ask you about Samantha. Do you think she may be at risk of harm from Mark? Was she ever present when he hit you? *(clear and direct question about the child’s safety)*

**Aimee**  
No luckily she wasn’t around and didn’t see what happened. I’m pretty sure that he wouldn’t harm her. You know, I think I would like to see the counsellor as I can’t believe this is happening to me.

**Health Visitor**  
Would you like to use the phone to make an appointment? (Aimee does so). Aimee, would you give me permission to record what you’ve told me in your case notes?

**Aimee**  
I don’t want anyone else to know about it. I feel too ashamed. I don’t want you to record it.

**Health Visitor**  
Yes I understand that you don’t want people to know now but we know from experience that it could be important in the future to have a record especially if you ever decide to take legal action or need to apply for housing. And your notes are completely confidential. I feel that it is best for you if we record it, but I would like you to agree to it. *(explains the reasons for recording and reassures her about confidentiality)*

**Aimee**  
Oh I see, well I suppose if you’re sure that no-one will find out and if it could help me, then maybe you should.
Health Visitor does so, getting a detailed description of what happened last week in Aimee’s own words. She also records previous incidents that Aimee recalls. She asks Aimee to check what she has written and then dates and signs it.

**Health Visitor**

This happens to a lot of women and it’s not their fault. The important thing is for us to support you in what feels right to you. Call me or come and see me at any time.

**Trainer’s notes**

Trainers might support delegates to adopt the following elements of good practice, or include them in a handout:

1. Let a woman know that she is not to blame or responsible for what is happening and that no one deserves to be treated that way. Tell her that she does not have to deal with the problem alone and that there are many organisations that have years of expertise in supporting women experiencing violence in relationships eg. Women’s Aid (WAFE) and Refuge. Both have a joint national help line. They and local organisations provide practical and emotional support, and refuge space if a woman wishes to leave and has nowhere to stay. They can advise on legal matters and housing needs. Useful telephone numbers are included in the Contacts section.

Note: A woman does not have to want to leave home to be referred on to these organisations. Sometimes making contact or visiting the organisations on an outreach basis gives women the support they want – or the familiarity to make leaving possible the next time violence occurs.

2. If possible, offer the use of a telephone in a private room where she will not be overheard. Give the referral numbers and let her ring them and do the talking and planning. Keep popping back to check she is okay, but let her decide what to do.

3. Provide ongoing support and keep the lines of communication open. Ask her how things are going at subsequent appointments and whether there is anything she is concerned about that she wishes to discuss. If possible, make arrangements so that you see her for the remainder of her care. This will facilitate ongoing support and communication. You will also be able to keep track of any changes occurring, e.g. if the violence gets worse.
The woman must lead the process of change. All staff have a responsibility to act in the woman’s interest, but not for her. She is the only person who knows what is best for her. She is the only person who has all the information about her situation. If a woman decides to stay with her violent partner, you have not failed. By remembering that our intervention is only part of the process, we hopefully reduce the pressure on staff and prevent anyone feeling that they must try and immediately solve the situation.

If she discloses and her partner is waiting outside room:

- Do not discuss the violence in depth. The partner may become suspicious and walk in mid conversation.
- It is safer to limit the conversation, without making the woman feel as though you are not interested. Offer the woman referral information and arrange another appointment to discuss it fully, when it is safer. Try to arrange the next appointment at a time when her partner cannot make it.
- Find out how to reach her safely to discuss things further at another time. Perhaps there is a trusted friend or family member that could take a message for her. You could arrange to meet her at their home if she feels it is safer.
- Make sure the woman feels OK before inviting her partner into the room. Women who experience domestic violence often say that they fear that their partner will find out they have told someone, provoking further violence.
- Help her to prepare an answer in case her partner questions her about what was discussed during the confidential time. It is fine to make up a story with her - perhaps reference to a previous miscarriage, benefits etc. The important point is that the woman feels safe and prepared to carry on with the appointment.

DO NOT:

- Give her direct advice, or tell her to leave him.
- Tell her to defend herself or hit him back.
- Take action without her consent - or discuss what she has said with other colleagues without her permission (except if child protection issues mean you need to contact a social worker; and then you can still inform her).
- Ask her why she puts up with it or what she has done to make him hit her.
- Trivialise the abuse or minimise the danger (by not taking her seriously or telling her she should not put up with it).
- Expect immediate results.
- Try to solve the woman's problem for her.
- Let the abuser know that your patient has disclosed abuse.

Leaving a violent relationship requires planning and preparation in order for the woman to be safe. You may place the woman at risk of further violence if you coerce or pressure her to leave her partner before she is ready.

**How to respond – 30 minute group exercise**

**Aim:** To increase health professionals' knowledge about what to do if domestic abuse is suspected but not admitted or if domestic abuse is disclosed.


**Method:** Give participants copies of case studies in Handout 3.A. Divide the group into pairs asking each pair to consider a different case study.

Display the following questions on the flipchart:

*What would you do if a woman does not admit abuse yet you suspect that it has happened?*

*What would you do if a woman disclosed abuse?*

What should you NOT do?

Ask each pair to consider the questions (10 minutes) and make a list of the things they would do to feed back to the group (10 minutes feedback time).

Discussion of feedback drawing upon trainer's notes below, 10 minutes. After facilitating discussion of the feedback, give participants copies of Handouts 3.G, 3.H and 3.I.
**Trainer's notes**

How to respond if abuse is not disclosed:

If the client answers ‘no’, respect her response and choice. However, note any signs of injury; non-verbal signs of hesitation or inconsistency; signs of fear, or a partner’s behaviour which seems overly protective or controlling.

Whether or not there are signs of abuse, give information on specialist services by saying something like:

‘Because domestic abuse happens to one in four women at some point, I let every woman know there is information and help available (specify where, such as in the waiting area or Ladies) and that women who are at risk can call a free national domestic violence help-line. I also have a card that you can take, for yourself or someone else.’

Try to put her at ease so that she feels comfortable about coming to see you again.

**How to respond if a woman discloses abuse:**

Sum up the key points using SLIDE 3.D

Validate her experience: Let the woman know that you believe her and make it clear that the abuse is not her fault and in no way does she ‘deserve it’. Tell her that abuse is unacceptable and she has the right to safety. Let her know that she is not alone, 1 in 4 women will have experienced abuse at some time in their lives. She also has the right to feel the way she does and to talk about it.

Give emotional support and encourage her to see that there is life after abuse and that she deserves to be safe. Other women have created safer lives for themselves – so can she. Domestic violence is a crime and she has the right to report it if she wants to.

Emphasise and explain confidentiality – but be clear about its limits, such as if a child is involved. Be clear that you will not talk to the alleged perpetrator about what she has told you.

Ask her what she wants you to do. Be clear about what’s possible, but explain that other agencies might be able to help in areas where you can’t.

Do not act as a caseworker on domestic abuse – refer to specialist domestic abuse agencies.
Never be tempted to act as a go-between. This includes never helping her partner locate her if she has left him. Don’t pass on letters messages or facilitate contact – you could put yourself and your patient in danger.

Give her information on local and national support agencies and helpline 0808 2000 247.

Know what’s going on locally - It’s important that you know what services are offered locally to women experiencing domestic abuse. It's a good idea to keep a chart of contact details, so that you can easily refer to them in an emergency. See Handout 3.G.

Perform your usual health duties. The woman may have injuries that need treating, chronic ill health and/or psychological symptoms. A referral to Social Services or mental health services may be appropriate.

Don’t try to make decisions for her. It's crucial that she decides herself what it is she wants to do next. Do not for instance tell her that she must leave her partner. She may not feel ready nor safe nor want to do this. Telling her what to do might alienate her and compound her isolation and fears about approaching ‘outsiders’ for help in the future. You might like to talk through different options with her, but it would be better for her to speak to a specialist domestic violence agency about what support is currently available. Allow the woman to do things for herself. If she wants to phone a helpline, allow her to use your phone rather than make the call for her – unless she feels unable to do so. If she does not speak English, ask the help line to set up a call through Language Line.

Discuss options – these might include seeking advice from a helpline; getting support from domestic violence agencies; contacting the police; getting legal advice about obtaining a civil injunction or a restraining order; taking additional safety measures (such as changing locks) to make her home more secure after the abuser has left; seeking emergency refuge accommodation; returning to her abuser after making a safety plan.

Support the woman in whatever decision she makes. You might not understand her decision. She might decide to stay with or return to an abuser – and not just because she is afraid to leave him. Sometimes women still love their abuser, believe he can change or want their children to grow up with their father.
Don’t judge her or make assumptions. For example, if your patient is from a minority ethnic background, don’t assume that she will only accept help from culturally-specific agencies. This might limit her options, as specialist agencies might not have the capacity to respond immediately.

If you have ongoing contact with the woman, continue to provide support each time you see her.

Participants might ask whether we know enough about what are helpful responses to domestic abuse in a health care context. There have been five systematic reviews on this topic. Summing up findings from the literature Feder, Ramsay and Zachary concluded that there was a need for further research. However they maintain:

Despite the relative weakness of research evidence it is possible to articulate an appropriate response to clinicians when faced with disclosure of IPA\(^1\): immediate validation and emotional support, strict confidentiality, documentation, checking the safety of the woman and her children, ongoing support, and referral to expert services/advocacy. This core response needs to be supported by system change within the clinical setting and integrated within a coordinated community response to IPA.

Feder, Ramsay and Zachary, 2005, p.108

Health professionals are rightly concerned about the evidence base that supports their practice. However, it has to be acknowledged that it is more complex to evaluate the effectiveness of interventions that might prevent or ‘remedy’ abusive behaviour than it is to evaluate the effectiveness and curative capacity of a new drug treatment or clinical procedure. The need for further research should not be used as a justification for doing nothing.

Responses that could be dangerous

- discussion when anyone else is present or could overhear e.g. behind curtains;
- confronting the partner;
- suggesting couples counselling or suggesting that the woman leaves;
- failure to offer information;

\(^1\) IPA = Intimate Partner Abuse
- asking what she did to cause the violence or acting as if she should be ashamed;
- failing to move the patient into safe area or failing to alert reception when necessary.

**Examples of other unhelpful responses**
- Telling the woman what to do and taking control of decision making;
- Breaching confidentiality so that she is embarrassed or at risk;
- Not listening to what she says;
- Being judgemental and presumptive;
- Pushing her into disclosure;
- Showing shock or embarrassment;
- Letting your own personal issues about domestic abuse to get in the way;
- Rushing her;
- Giving out incorrect information;
- Asking a family member to translate (if English is not her main language) or to speak on her behalf (if disabled).

Health professionals may find it helpful to use a ‘prompt card’ or sheet to help guide them through the process of responding appropriately to women who disclose domestic abuse (refer to Handout 3.I). Handout 3.H sums up the Department of Health guidance on how to respond.
3.4 Risk Assessment

Introduction
Safety is a priority if abuse is disclosed. In most cases domestic abuse occurs repeatedly so it is important that a woman who discloses abuse has a safety plan for what to do next. In order to help her to develop a safety plan, the health professional needs to work with the woman to assess the nature and level of risks of further abuse. Although many perpetrators of domestic abuse are only violent to their partners and may frequently present a ‘charming’ disposition towards people outside the relationship, the possibility that he may present a risk to professionals should also be considered. This is especially important for health professionals who may be in contact with him in the family home (e.g. health visitors, midwives, district nurses, CPNs and general practitioners).

The Department of Health Guidance Responding to Domestic Abuse identifies three stages of risk assessment that are relevant to health professionals:

1. an immediate risk assessment between the professional and the patient when domestic abuse has been disclosed;
2. an organisational assessment, which is an approach or procedure based upon a Trust’s or Health Authorities protocol and policy;
3. a broader multi-agency risk assessment that brings together a range of professionals working with a woman and her children to assess and monitor the level of risk and to help to improve safety through multi-agency collaboration. An example is the Cardiff police MARACs (multi agency risk assessment conferences).

There is also a fourth form of specialised risk assessment relevant to health professionals’ practice where a specialist or expert medical or mental health professional prepares a detailed or forensic risk assessment report, usually for the courts.

The training materials in this manual are limited to stage one risk assessments that are only the preliminary assessments made when a woman discloses domestic abuse. There is a clear need for further accredited training for professionals wanting to provide more specialised risk assessments.
A preliminary risk assessment does not necessarily have to be a written assessment. A professional might be in a situation where s/he needs to make an emergency decision about whether or not a woman or her children or they themselves or colleagues may be at risk of immediate harm. This will be more obvious in cases where a woman has serious injuries and where the perpetrator is present and is agitated but a professional should be advised to try to determine the extent of risk in every domestic abuse case. Often the issues are complex. A full risk assessment takes time and trust and rapport usually needs to be developed between the woman and the assessor for her to feel she can really say what has been happening. Professionals should be advised to encourage women to contact a specialist domestic violence service for more comprehensive assessments of risk, detailed safety planning and ongoing support.

Preliminary risk assessment – 30 minute workshop exercise

Aim: To increase professionals’ understanding of the purpose of risk assessment and its limitations;

To introduce professionals to basic questions that can be asked to assess the level of risk;

To give them the opportunity to practice preliminary risk assessment skills.


Method: Begin with a presentation to the group to raise awareness about risk assessment, its purpose and factors to take into account. Present Slides 3.E, 3.F, and 3.G. drawing upon trainer’s notes below. Ask the group to divide into smaller groups of 4 to 5 people. Distribute copies of the case studies (Handout 3.J) to the groups. Ask the groups to identify the risk factors they would want to explore in the case studies. Facilitate the feedback and discussion drawing upon trainer’s notes.

Note that the next part of the training will cover safety planning. Give participants Handout 3.K.
Why do risk assessments? A risk assessment is a probability calculation that a harmful behaviour or event will occur. This involves an assessment of the frequency of the behaviour/event, its likely impact and who it will affect (Kemshall, 2003). The purpose of a risk (safety) assessment is to provide knowledge that will assist in safety planning with the victim and children. Understanding the victim’s fears and experiences of living with the violence is a crucial step in getting her better protection.

They cannot predict: Risk assessment can never be wholly accurate nor infallible and cannot be used to predict whether or not an event will happen. Research on homicides and child deaths has shown that assessments cannot be used to predict even the worst outcomes (Sinclair & Bullock, 2002). Searching for ‘lethality indicators’ can throw up a large number of ‘false positives’ because indicators of lethality are found in many relationships that do not result in homicide (Kemshall, 2003).

At the other end of the risk scale, defining a perpetrator of abuse as ‘low risk’ is not an excuse for complacency. A central pattern in domestic violence is the escalation of abuse. What may be considered ‘low risk’ initially may change very rapidly – for example, on separation.

Not all the assessments that are used have a firm evidential foundation. The evidence base for domestic violence risk assessment is growing but still rather limited. Factors commonly linked with a risk of further domestic violence in the research literature include:

- Previous physical or sexual assaults (Walby & Myhill, 2002);
- An escalation in the frequency and severity of violence (Websdale, 1999);
- Recent separation (Walby & Myhill, 2002);
- Either partner’s threats and attempts to kill or to commit suicide (Websdale, 1999);
- Violence in pregnancy (Campbell et al, 1998);
- The perpetrator’s possessiveness, jealousy, stalking and psychological abuse of the victim;
- Previous criminality or breach of court orders;
- The degree of isolation and vulnerability of the victim. Women aged 16 to 24 years report more domestic violence (Walby & Myhill, 2002);
- Child abuse and previous contact with a child protection agency.

This list is by no means exhaustive but many of these risk indicators can be found in the various domestic violence risk assessment tools and checklists that now exist (see for example the SARA, Spousal Assault Risk Assessment, Kropps et al, 1999 or Campbell’s Danger Assessment Checklist, Campbell et al, 1998).

The possibility of change should be considered within any assessment. Risk assessments often combine static and dynamic risk factors. Static risk factors focus on the history and past behaviour of the perpetrator and the nature of the past abuse. Dynamic factors consider the changeable characteristics of the perpetrator (such as attitudes) and of the context (such as separation) that can either raise or decrease the risk of further harm. These risk factors need to be understood as being associated with an increased likelihood of further violence rather than as being definitely linked or casual factors.

**Assessments can help to put the abuse in context and validate experiences.**

**Harm to children** women are often unaware of the extent to which children have witnessed or overheard the abuse (McGee, 2000). Doing what is best for the children is often a major reason why women say they stay with an abuser and if they think children are being harmed it is often a major factor influencing their decision to leave. Women living with abuse may not be able to protect their children. A risk assessment that considers the impact of the abuse on the children can inform the children’s safety plan.

**Examples of risk assessments developed in the UK** include the Metropolitan Police Risk Assessment guidance, based on a review of homicides and of domestic violence police records. Risk factors are shown in Slide 3.E. Key risk factors based on Metropolitan Police guidelines, 2004 are ‘SPECCS’.

**Separation:** Women are at more risk at or just after separation (particularly in the first two months)

Forced participation in court-ordered child contact arrangements is a significant risk to abused women and children.

**Pregnancy** : Abusive men may see pregnancy as:

- Competition for the woman’s time and attention;
- Something which is outside their control;
- A signal of a new role – which they are unhappy about;
• The opportunity for the woman to receive more interest and attention from family & friends, which the man resents or does not want to permit;
• The opportunity for medical intervention – which they may resent or see as a threat to their control.

Bewley, 1998

**Escalation**: increases in the frequency and severity of abuse indicate greater risk.

**Stalking**: obsessive controlling behaviour such as watching, following, constant telephoning is linked to increased likelihood on continued violence.

**Social isolation**: social/cultural isolation and reduced access to services can combine to increase lethal risks.

Women who are sexually assaulted are subject to more serious injury and perpetrators are more dangerous (Metropolitan Police, 2004).

**Questions about risk**
A trainer may present the questions below or facilitate the group top generate them on the basis of risk factors identified above.

How worrying is the abuse history? Is there an incident of severe abuse or a pattern of violence?

What type of physical, emotional or sexual abuse has there been to the woman? Has the abuser caused injuries that required medical attention now or in the past? What is the impact upon health?

Is the abuse becoming more frequent, intense or severe? Research on domestic violence fatalities has found that often (although not always) there has been a pattern of escalating domestic violence in the relationship (Browne, 1987; Websdale, 1999)

Is the abuser using or threatening to use a weapon?

Has the abuser threatened to kill her or anyone else?

Is the woman pregnant or has she recently had a child?

Are the children being harmed (directly or by witnessing)? If it is believed that children are at risk, child protection guidelines must be adhered to, and the need to follow these procedures must be discussed with the patient, and their consent
obtained, if possible. However, the interests of the child are paramount, and initiating procedures is not conditional on obtaining consent.

Is the woman about to leave her partner or has she recently separated?

Is the abuser stalking or harassing her?

Is there emotional abuse?

Is the woman socially isolated? To what extent? Have there been any previous attempts to get help (e.g. from police, courts, refuges etc) during the past 12 months? What happened? Does she have access to a car or a phone? What level of social support is available from family and friends?

Is there sexual abuse?

Has there been any threat of suicide or any self harm by either party?

Does either party have a mental health problem?

Does the abuser misuse drugs or alcohol? Does the woman? Does the woman have a disability? Women with disabilities may have experienced discrimination and oppression. Their abuser may also be their carer. They may feel obliged to be grateful and more vulnerable to feeling shamed or to blame. Their homes may have been specially adapted for their disability. They may be less aware of their rights associated with independent living – a social worker might advise them of their rights under the Chronically Sick and Disabled Persons Act (1970) and the Community Care Act (1990).

Does the abuser have a criminal history or record of breaching court orders?

How much does the woman feel at risk? What are her current fears of the situation and threats, and her beliefs about the immediate danger?

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

An abuser has a negative influence over the parameters of a woman’s life. Other mediating factors might compound her reactions to domestic violence (Dutton, 1992). There are no specific or attitudinal characteristics that make some women more vulnerable than others to the occurrence of domestic violence in the first
place (BMA, 1998). However, the following individual factors can impede a woman's escape or compromise her safety:

- Institutional responses e.g. attitudes of professionals;
- Informal responses e.g. being ostracised by the neighbours, or others;
- Tangible resources and social support, including access to crisis support, cognitive support, ongoing emotional support, intimacy and practical support;
- Prior abusive experiences that might increase her vulnerability to self-blame;
- Dependents with special needs;
- Additional life stressors e.g. risk of social exclusion; language barriers; insecure immigration status with the threat of deportation and no recourse to public funds (and/or ostracism or harm, even murder, if they were returned). A woman’s ethnic or religious group may not accept divorce or separation. Young Asian women may be at particular risk of significant harm following disclosure, and special care should be given to their safety if they plan to return home (Forced marriage, 2004).
- Risk factors more recently outlined with respect to forced marriage (see Forced Marriage, 2004). These include educational performance (e.g. truancy); employment variables (e.g. permission to work, confiscation of wages); family history (restrictions, house arrest); health (eating disorders, self-harm, depression, suicide attempts);
- Risk factors associated with dowry abuse and dowry-related violence, including the risk of honour killing;
- A woman may be afraid of being rejected by her family or the wider community if she leaves.
- Lesbian and bisexual women may fear discrimination, loss of support or loss of their children if their sexuality becomes apparent.
3.5 Where there are children in the household

There are well established links between domestic violence and child protection. Under the Adoption and Children Act 2002, living with and witnessing domestic violence is identified as a source of ‘significant harm’ for children. Safeguarding children guidelines must be followed if there are children in the family. The initial approach should never be to blame a woman for failing to protect her children because it is the abuser’s violence that puts them at risk. Supporting the non-abusive parent to be safe and supporting her in her parenting can be effective child protection. The health professional should make an initial assessment to determine the impact of the abuse upon the child. If the woman says that this isn’t the first assault, and she has children, the health professional should discuss the situation with her/his manager and/or senior colleagues. If there are still concerns, local child protection guidelines should be followed.

Assessing the impact of domestic abuse on the child – case study exercise, 25 minutes:

Aim: To increase professionals’ knowledge of potential risks to children from witnessing and living with domestic violence.


Method: Ask participants to divide into three groups. Give copies of Handout 3.L. Ask each group to focus on just one of the case examples each and to draw up a list of potential risk factors and issues they would need to explore when making an initial assessment (15 minutes). Facilitate the feedback and discussion drawing upon the trainer’s notes below.

Trainer's notes

Assessment might explore:

- The level of risk to children
- The level of care provided
- The child’s emotional health
- The child’s physical health
- The child’s development
- The adult’s ability to protect
Assessment might also include liaison with other members of the PCT for information and to ensure on-going support and follow-up.

The Child Protection Policy and Procedures for the local area should be followed if child abuse is suspected.

**Responding to disclosure by children See Slide 3.H**

**Risk assessment**

When a child discloses they are witnessing woman abuse at home, it is important to assess their level of risk/safety.

Ask questions or find out about issues such as –

- How recently the abuse occurred;
- What happened;
- How often the abuse happens;
- Is the child scared?
- Has the child ever been hurt?
- What the child is doing when the abuse occurs?
- Is the child (and any siblings) in a safe place?
- Could they easily get help?
- Were weapons involved?
- Where was their mother?
- Were they and their mother prevented from leaving the house?
- Did the police come to the house? What happened?
- Did the child try to stop the violence? What happened?
- Do they know how to keep themselves safe in future?

**Issues about contact**

Domestic abuse does not stop after separation. Child contact negotiations and contact ordered by the courts provide further opportunities for perpetrators to continue to abuse mothers and children. The Children Act 1989 does not currently provide enough protection for children who may be forced to have continued contact with an abusive father. Children are especially vulnerable to abuse or manipulation by the perpetrator during poorly supervised contact meetings after the parents have separated (Barron & Saunders, 2004; Radford, Sayer & AMICA, 1999).
Supporting children
As well as following safeguarding children procedures, health professionals can support children by working in partnership with agencies such as Sure Start, Early Years and schools, which can as part of their usual service:

- make early interventions with pregnant women, new mothers and children who have educational and behavioural problems resulting from domestic abuse;
- teach children about healthy relationships, the law and the family (see Leeds Inter-agency Project resources for schools);
- follow guidance for safeguarding children;
- use Local Education Authority child protection coordinators to help protect children; and
- provide education and support for children who are affected by domestic abuse.
- Refer children to specialists or to resources such as www.thehideout.org or Childline 0800 1111.

Where possible, health professionals can also help by being a proactive member of multi-agency initiatives such as:

- Children’s Boards – all authorities must have Local Safeguarding Children Boards (LSCBs) by April 2006. They provide health professionals with the opportunity to help safeguard and promote the welfare of children; and

- Children’s Trusts – introduced following Lord Laming’s Inquiry into the death of Victoria Climbié. Children’s Trusts will bring together health, social care and educational organisations in the interest of vulnerable children.

3.6 Professional Safety Issues

Introduction
This section addresses issues of physical safety and psychological reactions that staff may encounter when working with domestic abuse. Dangerous and violent perpetrators can present a threat to everyone. When faced with an aggressive patient or relative, many professionals are reluctant to discuss fears for their own safety and ask for help. To work effectively with women experiencing domestic violence, health professionals need adequate support, regular supervision, ongoing training and local policy.
Professional Safety Issues  (15-30 minute exercise)

Aim: To help healthcare workers to identify and acknowledge their own needs in order to work effectively with women experiencing domestic abuse.

Materials: Flipchart, marker pen, overhead projector/slide show equipment, Slide 3.I.

Method: Case study, small group discussion; feedback to larger group recorded on flip-chart.

Ask a participant to volunteer to describe to the group (anonymised details of) a woman patient experiencing domestic abuse with whom they previously worked. Briefly describe the case and contact with the member of staff. Trainer to record key points on flipchart. The group is asked to identify issues for the professional such as

- Were there safety concerns created by the presentation of the case?
- Was the professional physically safe or likely to be in danger at any point?
- Would they as professionals know what to do to protect themselves?
- What was their emotional reaction?
- Did they know how to get support?

Sum up drawing on trainer’s notes below. Show Slide 3.I.

Trainer’s notes:

Safety

Points for the trainer to emphasise include:

- Staff should always follow safeguards to their own safety as a priority.
- Staff should not engage with enquiries from others about services, assessment, or treatment offered to patients. Partners and family members do not ‘have a right to know’;
- Always have another member of staff accompany you when dealing with a violent (or suspected violent) person;
- Contact the police or security if at risk.

Personal reactions

The personal reaction of a professional working with domestic violence is neither a character flaw nor a personal weakness. Secondary reactions in professionals
supporting women experiencing domestic violence are natural consequences of the work. This is not intended to deter, but to equip professionals, on the grounds that forewarning and preparation achieve protection and prevention.

To be effective in working with women who have experienced domestic violence, staff must be actively involved in an emotionally supportive environment, which follows under supervision, training and policy, and take responsibility for self-care, to maintain a healthy perspective and diffuse any signs of vicarious traumatisation.

**Indicators already identified in helpers of trauma survivors include:**

- Physiological and physical reactions: arousal, agitation, sleep problems, anxiety & fear reactions, bad dreams;
- Emotional reactions: uncontrolled & unintended displays of emotion; irritability; depression; sadness; anger; detachment or denial; horror, dread; hopelessness; confusion; grief; feeling overwhelmed; guilt about being spared from trauma; shame about own limitations or witnessing the patient’s degradation; embarrassment.
- Cognitive reactions: shifts toward erroneous thinking in areas such as
  - Trust (all men abuse their partners)
  - Safety (there is no safe place in the world)
  - Power (I am helpless or I am the only one who can help)
- Frame of reference (We should understand the abuser)
- Psychological reactions: detachment by rationalisation, isolation, denial
- Behaviour within or about sessions: forgetting, lapse of attention, loss of empathy, hostility; relief when the patient fails to attend; denial of feelings &/or need for supervision; excessive concern/identification with patient; numbing or emotional constriction and self-medication.

**Dealing with aggression**

The training programme is not designed to include dealing with aggression and violence; this is a topic in itself. However, the following is meant to provide some ideas if a question or issue arose about dealing with perpetrators of domestic violence who are behaving aggressively.

Fear is healthy information designed to alert people to a threat or danger. If frightened, ask:
- Is this person’s hostility directed at me or the organisation? Is it a form of distress?
- Am I in danger? (If so, leave if it is safe to do so and get help immediately);
- Am I the best person to deal with this situation? (This is a positive step to resolution, not a cop-out);
- Never underestimate a threat, but do not respond aggressively, which might increase the chance of confrontation. Instead:
  - Tell the person who you are, ask who they are, and ask what they want to happen/say what you want them to do;
  - Speak gently, slowly and clearly;
  - Do not be enticed into an argument
  - Do not hide behind your authority, status or jargon;
  - Try to talk as if discussing with a reasonable adult;
  - Avoid an aggressive stance: hands on hips, crossed arms or a wagging finger will challenge;
  - Keep your distance, preferably between the aggressor and door or close to potential escape route;
  - Never turn your back or put your hand on someone who is angry;
  - Try to avoid looking down at them;
  - Encourage them to take action: to go and see a colleague, to write down a complaint.
Module Two

Positive Identification

Training Resources
### Behaviour that may alert you to domestic violence

<table>
<thead>
<tr>
<th>Patient</th>
<th>Partner/perpetrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>May cover body with clothing to hide injuries</td>
<td>May encourage patient in hiding marks/injuries</td>
</tr>
<tr>
<td>Attends late or cancels misses appointments</td>
<td>Partner cancels on her behalf</td>
</tr>
<tr>
<td>Fails to complete treatment</td>
<td></td>
</tr>
<tr>
<td>Patient attends frequently with vague symptoms</td>
<td>Partner always attends with her and never leaves her side</td>
</tr>
<tr>
<td>Seems frightened of partner</td>
<td>Seems bullying</td>
</tr>
<tr>
<td>Seems passive</td>
<td>Seems over-protective</td>
</tr>
<tr>
<td>Evasive or embarrassed about any injuries Inconsistent explanations</td>
<td>Similarly evasive</td>
</tr>
<tr>
<td>Evades discussion of home situation</td>
<td>Adamant about cause of injury</td>
</tr>
<tr>
<td>Over-vehement denial or minimisation of violence</td>
<td>Over-vehement denial or minimisation of violence</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td></td>
</tr>
<tr>
<td>Repeated depression, anxiety or self harm</td>
<td></td>
</tr>
</tbody>
</table>
On Examination:

Physical signs of domestic violence

- Unexplained burns or bruises
- Bruising patterns indicative of abuse
- Area of erythema consistent with slaps
- Multiple injuries in various stages of healing
- Repeated or chronic injuries
- Injuries in areas of the body inconsistent with falls or other explanation offered
- Injuries to the breast, chest and abdomen – abused women are 13 times more likely to be injured here
- Injuries to face, head or neck
- Perforated eardrums, detached retinas
- Evidence of sexual abuse or frequent gynaecological problems
- High incidence of miscarriage, terminations, preterm labour
- Frequent visits with vague complaints or symptoms
- Frequent use of pain medication or tranquillisers
- Damage to sutures following operation or delivery

Emotional signs including

- Panic attacks, symptoms of anxiety
- Depression
- Feelings of isolation

Behavioural signs

- Alcohol or drug use
- Suicide attempt
- Self harm
Asking women about domestic abuse can:

- Raise awareness
- Identify more women at risk
- Provide an opportunity for women to talk/disclose
- Decrease their feelings of isolation
- Provide an opportunity to give women information on relevant services
- Potentially save the health service money and time
- Help women to get access to services
- Help children live safely
- Play a part in getting abuse perpetrators to be accountable
How to respond to a disclosure of domestic abuse:

- Validate
- Support and encourage
- Confidentiality
- Ask her what she wants you to do
- Do NOT act as a caseworker
- Do NOT act as a go-between
- Give information
- Know about services
- Perform your usual health duties
- Don’t make decisions for her
- Don’t judge or make assumptions
- Discuss options
- Give follow up support
**Slide 3E**

**Why should we do a risk assessment?**

It cannot be used to predict, even homicides

It can only indicate probability but note false positives and false negatives

A high degree of lethality indicators should inform decisions about whether to involve others

It can help the woman ‘name’ the behaviour as abuse or violence

It can help to put the abuse in perspective, validate her experiences and feelings

It can highlight the harm to her and to the children

It can inform her safety plan and help manage the risk

It can help identify additional support options

Identifying risk to professionals
Slide 3F

Risk factors: SPECSS Plus

Separation (Child contact)

Pregnancy/new birth

Escalation of violence in frequency or severity

Cultural Issues/ isolation

Stalking/harassment

Sexual assault

Plus Other Factors e.g.
  abuse of children, abuse of pets
  weapons, threats to kill,
  suicidal behaviour,
  alcohol/drug misuse,
  mental illness,
  acute jealousy,
  forced marriage,
  disability

Based on Metropolitan Police Guidelines, 2004
Risk assessment questions:

How worrying is the abuse history?

Is the abuse becoming more frequent, intense or severe?

Is the abuser using or threatening to use a weapon?

Has the abuser threatened to kill her or anyone else?

Is the woman pregnant or has she recently had a child?

Are the children being harmed (directly or witnessing)?

Is the woman about to leave her partner or has she recently separated?

Is the abuser stalking or harassing her?

Is there emotional abuse?

Is the woman socially isolated? To what extent?

Is there sexual abuse?

Has there been any threat of suicide or any self harm by either party?

Does either party have a mental health problem?

Does the abuser misuse drugs or alcohol?

Does the woman have a disability?

Does the abuser have a criminal history or record of breaching court orders?

How much does the woman feel at risk?
Handling disclosures from children

Do:
- listen to children if they want to talk
- take the information seriously
- reassure the child that they are not to blame and that they are not alone
- be supportive
- be alert to the possibility that the child may also be abused – try to create an atmosphere of acceptance and trust where such a disclosure could be made
- involve appropriate agency staff e.g. named person in your organisation or Child protection Worker
- consult with local community agencies with experience in working with survivors of domestic violence
- take appropriate action, including necessary referrals

Don’t:
- show shock, horror or distress about their stories
- minimise the situation or assume the crisis has passed
- guarantee confidentiality, quick fixes or promises that cannot be kept
Working safely

- practice within professional rules and codes
- prioritise your own safety
- adhere to policy guidelines on safety
- report violent or aggressive incidents or risks to the person in charge
- complete an incident form
Module Two

Positive Identification

Handouts
Handout 3A
Indicators of Domestic Abuse – Case Studies

Mrs Patel is 32 years old. She attends ante natal clinic wearing trousers and a long sleeved top. She has a cut on her lip and some bruising around it. She avoids eye contact and you are concerned that she is not telling you what has actually happened. She is six months pregnant.

Miss Reed is 19 years old and 16 weeks pregnant with her second child. Her two year old son accompanies her to the surgery. You notice that she has bruising on her abdomen. When you ask her about the bruises she says her friend’s toddler clambered on to her lap and was very boisterous and the bruising is a result of those kicks.

Mrs Williams is 69 years old. She suffers from severe arthritis. She lives alone with her adult son who helps with her personal care. You see Mrs Williams in A & E, where she is accompanied by her son. There is a severe burn on her forearm. You notice that Mrs Williams has attended A & E previously but for an unrelated reason (abdominal pain).

Mrs Chang is 22 years old and is suffering from depression following a miscarriage last year. She lives with her husband and his parents. She has been complaining about difficulty in sleeping and feeling dizzy. She missed two of her previous appointments. You see her at the surgery today with her mother in law. She has lost a lot of weight and admits that she has not been eating properly.

You go to visit Mrs Woods and her newborn baby. The baby is thriving but Mrs Woods is grimacing in pain when she lifts the baby. When you ask her what is wrong she says that she tripped and twisted her back. Mrs Woods’ husband suddenly appears from the kitchen and Mrs Woods looks nervous and says that she is tired and if that is all, she would like to be left to have a rest.

1. What are the possible indicators of domestic abuse?
2. What issues would you want to explore further?
3. What would you say and what would you do?
Handout 3B

Aimee is 28 years old, and lives with Mark. The couple met when they were at university, and have been together for seven years. They are both teachers. Their first child, Samantha, is now two months old. Aimee is breast-feeding.

During her pregnancy, Mark started being abusive towards Aimee. At first he was verbally abusive, but after one argument he hit her, on her face and abdomen. This caused bad bruising, and a cut lip, but she hid the injuries and did not see a doctor. Mark was apologetic and said it would not happen again. Things had been going okay until last night. Mark was tired when he came in from work, and annoyed that Aimee had been busy with the baby, and had not prepared the evening meal. Mark got really angry. He pulled Aimee by the hair across the kitchen, and punched her breasts. She was really frightened. Last night Aimee slept in the spare room, and lay awake worrying about the future.

Aimee is really unhappy, and wants to talk about her situation. She has come to see the health visitor at the weekly baby clinic.

Imagine that you are Aimee.

What will make it more likely that you will tell the health visitor about the abuse?

What will make it less likely that you will tell her about the abuse?

What do you hope will happen?

Describe your feelings.
Handout 3C

Asking About Domestic Abuse

Sample questions

Initial Questions

‘Has your partner ever physically threatened or hurt you?’

‘Has your partner ever hit you?’

‘Are you afraid of your partner?’

‘Have you ever been afraid of your partner?’

‘Sometimes partners react strongly in arguments and use physical force. Is this happening to you?’

‘Were these injuries caused by someone you know?’

‘Have you been forced to do anything sexually that you did not want to do?’

‘Is there a lot of tension in your relationship?’

‘Violence is very common in the home. I ask a lot of my patients about abuse because no one should have to live in fear of their partners. Has your partner ever hurt or frightened you?’

‘We know that 1 in 4 women have been abused by their partners at some time in their lives and as many as 1 in 9 have been hurt in the last 12 months. Has your partner or anyone else ever hurt or frightened you?’

‘We have started to ask all women about domestic violence as a routine because we know it is common and it can sometimes increase during pregnancy. As in all nursing care we maintain strictest confidence at all times; the only exception is if you tell us that a child is being hurt. Has your partner ever hurt or frightened you?’

Prompt questions

If the client hesitates, you might say

‘I’m asking because I am concerned about your safety and to find out if you need information or support. I will not tell your family or partner about what you say.’

If the client says she has been abused you may need to ask further more direct questions:

‘Have you ever been slapped, kicked or punched by your partner?’
‘Has your partner ever: destroyed or broken things you care about? threatened or hurt your children? forced sex on you, or made you have sex in a way you did not want?’

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

**Questions for group discussion:**

How easy or difficult would it be to ask these questions in your clinical practice?

What are the key challenges and how could these be overcome?

What do you see as being the possible advantages or disadvantages of asking patients about domestic abuse?

What stages of your clinical practice would present the best opportunities to ask women about abuse?

Handout 3D
Case study: Aimee – How to Ask
Aimee is 28 years old and lives with Mark. The couple met when they were at university and have been together for seven years. They are both teachers, although Aimee has not worked outside the house since the birth of her first child, Samantha, two years ago. Aimee is now pregnant again and is at her antenatal booking appointment.

Mark first started being abusive towards Aimee during her first pregnancy. It started with verbal abuse but after Samantha was born he became violent and hit Aimee on the face and breasts. There were several episodes of violence but she felt so ashamed that she hid her injuries and did not see a doctor. Mark had been very apologetic and promised it would not happen again and things had been going OK until she found out she was pregnant again. Last week Mark had got home from work very tired and had been annoyed that Aimee hadn't prepared the supper. He got really angry and punched Aimee in the abdomen and threw her across the kitchen. She was very frightened and hasn't really slept properly since. She is worrying about the future for herself, Samantha and the baby. She is very unhappy and is amazed that someone is concerned enough to ask her directly if domestic violence is a problem.
Handout 3E

Scene 1: Aimee with Health Visitor

Health Visitor  We ask all our patients about their experience of domestic violence because we know that domestic violence is very common and that it can get worse in pregnancy. We do maintain strict confidence at all times and the only exception to that is if you choose to tell us that a child is being hurt. So can I ask you ... Would you say that you feel afraid of or experience violence from anyone close to you?

Aimee  Pause ... Well Mark has been rather bad tempered lately.

Health Visitor  I suppose everyone gets grumpy sometimes. Has he been under a lot of strain at work?

Aimee  He probably has got a lot on his plate but sometimes it feels a bit much.

Health Visitor  Really? So he's started to be violent; that's bad.

Aimee  Well, it's not too bad. I'm just feeling confused and unsure ...

Health Visitor  How often does he hit you? It's really worrying if Samantha's nearby. She could be in danger.

Aimee  Oh, no. It's never been when Sam has been around and it only happened once anyway.

Health Visitor  Even so, domestic violence often gets worse. You should get out when you can. I'll call the refuge for you and make an appointment for you with the counsellor.
Handout 3F
Case study
Scene 2: Aimee with Health Visitor

Health Visitor: We ask all our patients about their experience of domestic violence because we know that domestic violence is very common and that it can get worse in pregnancy. We do maintain strict confidence at all times and the only exception to that is if you choose to tell us that a child is being hurt. So can I ask you … Would you say that you feel afraid of or experience violence from anyone close to you?

Aimee: Pause … Well, I think Mark has been under a lot of strain at work recently but it is getting to be a bit much.

Health Visitor: It sounds as though you’re feeling under strain too. How has he been behaving at home?

Aimee: Well, I thought we’d sorted it out. After Sam was born Mark started to get aggressive and he hit me a few times. It hasn’t happened for nearly a year and I honestly thought he wasn’t going to get like that again. But last week, he got furious because I’d been out with a friend all day and I hadn’t got the food ready. He punched my stomach. I was terrified.

Health Visitor: That sounds so frightening. What happened after that?

Aimee: He left and I started to wonder if I should go to stay with my mum. I was going over later to pick up Samantha anyway and I was afraid of what he might do next. But I didn’t stay and when he got back he was very apologetic. He’s been a lot better since then as if he’s got something out of his system. Nothing bad seemed to happen so I left it.

Health Visitor: And what are you feeling about it now?

Aimee: I’m just so confused. I kept pretending it wasn’t happening but now I’m wondering what I’m doing wrong to provoke him.
You're wondering if it's your fault but you're really not to blame. Nobody deserves to be hit or to have to live in fear.

But I really love him and we used to get on so well before. I wish it would be like that still.

It seems that you're feeling a strong conflict inside. On the one hand you feel frightened and have wanted to leave at times, and on the other, you want to stay and for things to go back to how they were before.

I wonder if things can ever be the same as before?

Would you like me to give you some information about what help is available to you?

Yes, it might be good to know. I guess so.

Well, sometimes it can help to talk about how you're feeling and we have a counsellor you can see who can spend more time with you. She can help you look at all the confusing feelings and support you, whatever you decide to do. Then if your partner gets violent again there are several options. You can always call the police to help you in that situation because you know it's illegal for him to hit you.

I don't think I could ever do that to him.

There is also Women's Aid and Refuge if you want to speak to someone on the phone at any time, or if you ever need to leave in a hurry and you need somewhere to stay. You can contact them even if you aren't thinking of leaving straight away, just to be in touch for them to support you. There are some numbers here on this leaflet. Would it be safe for you to take a leaflet or would you rather write the numbers down?

I'll write them down in code as I don't want Mark to know I've spoken about this.
Health Visitor  Sometimes it's good to have things ready too, in case you ever need to leave in a hurry. Things like important documents, medicines, toys for Samantha etc.

Aimee  Yes, that sounds like a good idea

Health Visitor  Also Aimee, I need to ask you about Samantha. Do you think she may be at risk of harm from Mark? Was she ever present when he hit you?

Aimee  No luckily she wasn’t around and didn’t see what happened. I’m pretty sure that he wouldn’t harm her. You know, I think I would like to see the counsellor as I can’t believe this is happening to me.

Health Visitor  Would you like to use the phone to make an appointment? (Aimee does so). Aimee, would you give me permission to record what you’ve told me in your case notes?

Aimee  I don't want anyone else to know about it. I feel too ashamed. I don't want you to record it.

Health Visitor  Yes I understand that you don’t want people to know now but we know from experience that it could be important in the future to have a record especially if you ever decide to take legal action or need to apply for housing. And your notes are completely confidential. I feel that it is best for you if we record it, but I would like you to agree to it.

Aimee  Oh I see, well I suppose if you’re sure that no-one will find out and if it could help me, then maybe you should.

Health Visitor does so, getting a detailed description of what happened last week in Aimee’s own words. She also records previous incidents that Aimee recalls. She asks Aimee to check what she has written and then dates and signs it.

Health Visitor  This happens to a lot of women and it’s not their fault. The important thing is for us to support you in what feels right to you. Call me or come and see me at any time.
Handout 3G
How to Respond – Know what is going on locally
Keep a contact list of local services. Enter up to date contact details for services in your area.

The National Domestic Violence Helpline:
Freephone 24 hours 0808 2000 247
Domestic Violence Refuge services

Domestic Violence Outreach services

Domestic Violence advocacy services

Projects working with Domestic Abuse Perpetrators (members of Respect – see www.respect.org)

Rape crisis/sexual assault referral centre/rape and sexual abuse services

1 public contact numbers are listed in the Gold Book, available from Women’s Aid or online at www.womensaid.org.uk
Counselling services

Local police station domestic abuse unit or community safety unit

Local authority homelessness office

Social Services contact

The Children’s Service Director

Legal services

Crown Prosecution Service Domestic Violence Officer
Drug and alcohol treatment services

Victim Support

Other relevant support services
Handout 3H
What to do following a disclosure

If there is a danger to physical or mental health or to life

Discuss with manager. Police involvement or hospital involvement necessary?

Refer to social services

Child protection measures in place

For all cases, record accurately (see guidance)

Is it the first incident?

Is a referral to social services needed?

Take action against perpetrator? (consider safety issues)

Assess the risk to the woman and her children

Are there children in the household?

Outline the need for safety and discuss safety plan

Woman reveals she is experiencing domestic abuse

Reassure, support and give national helpline numbers and information on local specialist domestic violence services

Yes

No
### Handout 3I

**Sample prompt card to issue to staff**

<table>
<thead>
<tr>
<th>Step 1: Ask</th>
<th>Step 5: Record</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask</strong> unaccompanied female patients over 16 talk in private when she is alone get an interpreter if need be</td>
<td>Document and record information Obtain patient’s consent Complete standard screening form Explain a record may help her access her housing or legal rights in future</td>
</tr>
</tbody>
</table>

1.a. **Frame the question**
As violence from partners or ex-partners is so common and seriously damages health, we now ask all women patients routinely

1.b. **Ask directly**
Are you in a relationship with someone who hurts you or threatens you?
Did someone cause these injuries to you?
Have you ever felt scared or unsafe at home?

**Step 2: Give key message**
There is help available
You are not alone: 1 in 4 women experience domestic violence in their lifetime
You do not deserve to be treated like that
Domestic violence is a crime and you have the right to be safe

**Step 3: Assess**
Assess patient’s immediate safety
Is your partner here with you?
Where are the children?
Do you have any immediate fear or concerns?
Do you have somewhere safe to go? (consider admission if not)

**Step 4: Refer**
Refer to freephone 24 hour National Domestic Violence Helpline run by Refuge and Women’s Aid in partnership

**Step 6: Follow up**
Offer continued support if possible
Discuss safety as a priority
If not, refer her to someone who can e.g. GP, HV, midwife, counsellor

**Staff safety**
*Every health professional should ensure their own safety and has the right to withdraw from any situation where they feel their personal safety is compromised*

**What women want**
For you to be aware that domestic violence is a possibility
For you to recognise signs and symptoms of domestic violence
For you to initiate the discussion
For you to listen and make time
For you to give information on sources of help

**What can every health professional do?**
Provide a quiet private space
Ensure confidentiality
Ask the woman without her partner being present
Provide an interpreter if needed
Ask the question directly
Validate her experience
Provide information about sources of help and contact numbers
Handout 3J  
Risk Assessment – Case Studies  

Jenny is 18 years old. She is training as a children’s nurse in a large city, and is enjoying her course very much. Although her family live only a few miles away, she has moved to a small bed sit to be nearer college and her new friends. Jenny has recently ended the relationship with her current boyfriend, whom she has known for three months. Mark is 23 years old and lives nearby. At first they got on well together, but Jenny wanted to get on with her own life, and felt that Mark was taking over. On one occasion they had an argument, and he hit her. Jenny never told anyone about this incident, but shortly afterwards decided not to see Mark again. It has now been two weeks since Jenny told Mark she did not want to see him again. However, Jenny has seen Mark near her flat on quite a few occasions. Once he parked his van outside her kitchen window and sat there for about two hours. On another occasion, he walked past her front door. Last night the phone rang at 2am, but when she answered it there was no reply.

Iris is 59 years old and has recently remarried to a man six years her elder. She has sold up everything to move into his house. Her first marriage was very happy and secure but her husband died. She has known her new husband, John, all her life as a family friend and as the village policeman. On their honeymoon he beat her up so severely that she has to go to casualty at the hospital. He says he’s sorry, that it will never happen again and to never ever tell anyone.

Rosie has experienced verbal and psychological abuse throughout her married life. The verbal abuse has got progressively worse. Her husband frequently hurl insults at Rosie in front of their three children and often publicly humiliates her. He controlled her appearance and activity and she had no financial independence. Rosie lost confidence and self esteem and gradually lost contact with family and friends, becoming socially isolated. As the children grew older they tried to avoid confrontation and spend as much time away from home as possible. Rosie suffered numerous anxieties about her health and made frequent visits to her GP. She was given medication to help her sleep and was treated for anxiety and depression at different stages. She also experienced problems with her digestive system and was referred for further investigation. Rosie has two daughters and a son. Her son wet the bed until he was 16. Her elder daughter suffered from migraine and saw the GP regularly who prescribed medication. Her younger child,
Jane, has asthma and eczema, is prone to coughs and colds, and has missed a lot of school. The GP asked Rosie to bring Jane to the asthma clinic as she was not responding well to treatment. The practice nurse was worried that Jane was small for her age and seemed very withdrawn.

Mrs. Woods brings her baby to the clinic to be weighed and measured. Her husband isn't with her on this occasion. Once again the baby is fine but Mrs. Woods has a black eye. When you ask her how this happened she breaks down and tells you that her husband did it and that he has been increasingly violent towards her since she had the baby. She tells you he thinks she is paying the baby too much attention and neglecting him. She says that he ‘insisted on having sex’ before her stitches had healed sand that her post-childbirth sutures have become infected and sore. She is afraid to return home and fears he may attack her while she is holding the baby.
Handout 3K

Risk assessment questions:

How worrying is the abuse history?
Is the abuse becoming more frequent, intense or severe?
Is the abuser using or threatening to use a weapon?
Has the abuser threatened to kill her or anyone else?
Is the woman pregnant or has she recently had a child?
Are the children being harmed (directly or witnessing)?
Is the woman about to leave her partner or has she recently separated?
Is the abuser stalking or harassing her?
Is there emotional abuse?
Is the woman socially isolated? To what extent?
Is there sexual abuse?
Has there been any threat of suicide or any self-harm by either party?
Does either party have a mental health problem?
Does the abuser misuse drugs or alcohol?
Does the woman have a disability?
Does the abuser have a criminal history or record of breaching court orders?
How much does the woman feel at risk?
Handout 3L
Risks to Children – Case Studies

**Myra Jones** is 34 and has two children; Jane aged 6 and Peter aged 8. They have just left their home to come into a refuge. Myra is 6 months pregnant. Last night Myra’s husband came home in a bad mood and an argument developed because he kicked the dog. Myra said she wanted a divorce. Mr Jones assaulted Myra by slapping her around the face, pulling her hair, kicking her in the abdomen and throwing her against the kitchen table. He told Myra that if she left he would find her and kill her. He had been violent before and Myra was very frightened. She tried to run out of the house but he caught hold of her. Peter and Jane had heard and partly seen the violence. Peter climbed out of the kitchen window and went to the neighbour’s house and asked her to call the police. The Police arrived quickly, arrested Mr Jones and helped Myra to pack some clothes and come to the refuge. You see her and the children at her antenatal check up.

**Janet** is 22 and has two children, Kelly aged 4 and Brad aged 8 months. Janet has brought Brad in for routine inoculation. You notice that Janet seems very upset and when asked she tells you that she has been having difficulties in her marriage since her husband lost his job three months ago. He has been drinking heavily and has been increasingly violent. Last week he began yelling at her saying she was a ‘waste of space’, grabbed her while she was holding the baby and twisted her wrist sharply causing painful bruising. Brad appears to be quiet and rather small for his age.

**Parvinder** is 8 years old and lives with her divorced mother, Nasreen. Nasreen has brought her to the surgery because Parvinder has been having nightmares, complaining of tummy ache and has recently started bedwetting. Nasreen separated from her husband last year because of domestic violence. He is still harassing her and he has issued threats on many occasions, usually when Nasreen takes Parvinder over to his house for contact visits.

What are the possible risk factors to the children that you need to explore?
Module Three

Positive Response

Training Guide
4.1 POSITIVE RESPONSE

Introduction
Important aspects of the health response were covered in Module One, when the overview of the health professional's role was presented, and in Module Two, especially in the section on what to do when a woman discloses, and in the last section on risk assessment. This module on Positive Response aims to further develop health professionals' knowledge on what to do following a disclosure to cover safety planning, documentation and record keeping, confidentiality and information sharing and working with perpetrators.

As with the other core modules the training needs of professionals will vary. Trainers are advised to adapt the materials to suit the needs of a particular group of health professionals.

4.2 Safety Planning

Introduction
It is important that a woman who discloses abuse has a safety plan. Patients do not need to write a safety plan. Indeed it may be safer not to. Health professionals can help them by prompting them to think about what they can do to reduce the risks of further abuse. It is important that the plan is the woman’s own plan so professionals should not create any plan on the woman’s behalf. Specialist domestic abuse services may also be able to help create a safety plan.

Safety Strategies for Women: 10 to 25 minute exercise

Aims: To help health professionals identify safety strategies with women: planning to stay with the partner, leaving in an emergency and after separation.


Method: Presentation (10 minutes for administrative and policy staff) or small group work with feedback (25 minutes for staff who have contact with patients likely to disclose abuse).

25 minute exercise - Ask participants to divide into three groups, A, B & C. Give each group some flip chart paper and a marker pen.

**Group A instruction:** Safety strategies for women who stay - Make a list of the possible risks a woman may face if she decides to stay with her abuser. Make a list of the safety strategies she could use (what would she need to do or prepare in advance) to reduce these risks.

**Group B instruction:** Safety strategies for women who may have to leave in the future if violence re-occurs - Make a list of the possible risks a woman may face if she has to leave her partner in emergency circumstances following an assault. Make a list of the things she could do and prepare in advance to improve her safety.

**Group C instruction:** Safety strategies after separation - Make a list of the possible risks a woman may face after she has separated due to domestic abuse. Make a list of the safety strategies she could use (what would she need to do over the longer term) to reduce these risks.

After 15 minutes. ask groups to feed back to each other. The trainer facilitates discussion drawing on trainer’s notes below.


**Trainer’s notes:**
Remind participants of some options to consider if a woman discloses domestic abuse (as discussed in Module 2) – to seek advice from a helpline; getting support from domestic violence agencies; contacting the police; getting legal advice about a civil injunction or restraining order; taking additional safety measures to make her home secure such as changing locks etc; seeking emergency accommodation; returning to the abuser and making a safety plan.

Safety planning can cover her staying as well as her leaving the abuser.
Stress the importance of listening to a woman’s beliefs about her immediate danger.

What are the risks if women stay (or return)?

- **Physical**
  - Might the injuries get worse?
  - Is she thinking about hurting herself or him?
  - Is she turning to drink/ drugs to ease the pain?
  - Might she die or be killed?

- **Psychological**
  - What about his emotional and mental abuse?
  - What about his threats to her? To the children?
  - Increased dependency?
  - What are the psychological threats of his physical or sexual abuse?

- **To the children**
  - Are they going to get hurt?
  - How is what they see and hear affecting them?
  - Might she lose them through his behaviour?
  - Risks to unborn child?

- **Money**
  - What about her standard of living?
  - Does she have control over money?
  - What about the bills?
  - Culpability for debts?
  - What about the damage to her things?

- **Support**
  - Is he turning family and friends away?
  - Is he trying to separate her from people?
  - Is she losing support and blaming herself?
  - Is she being rejected by the community?

- **Relationship**
  - Is he affecting who she is as a person?
  - Is he undermining her relationship with the children?
Loss of self-esteem?

• The law
  Is she or others covering for him breaking the law?
  Has he been coercing/encouraging her into illegal activities?
  Does she know her legal rights?

What are the risks if she leaves (and does not return)?

• Physical
  Violence after separation
  Increased risk of being killed for separating women
  His threatened suicide or self-harm
  Substance abuse
  Stalking
  Abduction and being forced to return

• Psychological
  Verbal and emotional abuse
  How can she recover from threats and the abuse?
  How will she get help to grieve?
  Stalking
  Fear and loneliness
  Feeling that she cannot cope
  Pressures from the children or family to go back

• Children
  Risk of harm to children from violence or abduction etc
  Impact of a change of school?
  How will they manage to make new friends?
  Fears about single parenting
  Loss of children (residency or child protection)
  Being blamed for disrupting children’s lives

• Money
  Nowhere to go
  Lower standard of living
Knowing or finding out about benefits and her rights
Loss of job or income
Loss of home
Loss of possessions
Debts

- **Support**
  - Threats to family or friends
  - Loss of support (moving, letting family or community down)
  - Fear of loneliness

- **Relationship**
  - Loss of hope for change
  - Loss of source of support
  - Grief for partnership & loss of status
  - Can she separate her needs from staying with him?

- **The law**
  - Consequences of his arrest
  - Loss of residency status
  - Loss of children
  - Fear of legal proceedings
  - Is she breaking the law?
  - His threats if she were to go through with proceedings
  - Use of contact with children to harass and control her

**Safety strategies used by women experiencing domestic abuse**
The trainer might present this list to enable participants to respect, explore and acknowledge women's attempts to manage their safety and to challenge any beliefs that a victim of domestic abuse is ‘passive’.

<table>
<thead>
<tr>
<th>Type of strategy</th>
<th>Examples of action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Legal strategies</strong></td>
<td>calls police, contacts solicitor, seeks injunctions</td>
</tr>
<tr>
<td><strong>Formal help seeking</strong></td>
<td>approaches statutory (health, social services, housing) or voluntary agency (refuge, help-line, advice centre)</td>
</tr>
</tbody>
</table>
Informal help seeking  
- talks to friends, family; asks neighbour to call police; asks someone to intervene directly (to speak to abuser) or indirectly (just to be present)

Escape behaviours  
- walks away, barricades a room; flees house; goes to public place with CCTV; runs to relative’s house

Separation  
- moves out; applies for divorce, residency order

Hiding  
- tries to keep address of home, work or school secret; disguises appearance, changes name

Appeals to abuser  
- talks to ‘calm him down’; asks him to promise to stop; asks him to explain; tries to distract or divert

Compliance  
- anticipates abuser’s demands: does things to please partner or stops doing things she believes might trigger violence; complies with demands e.g. submits to sexual abuse to reduce physical injury and end episode more quickly

Resistance  
- answers back, threatens action e.g. to call police, attempts suicide

Self defence  
- passive (blocking, resisting) and active (striking)

Uses children  
- teaches children to call police, to seek help, to leave
- asks children to comply to protect against abuse
- asks children to help fight back
- asks school to apply injunction, prevent abduction

Personal  
- dissociates, numbing; relies on faith

Note:

a) there is no single best strategy for all women

b) some strategies that seem useful in theory (e.g. calling police) may not work in practice: e.g. their partner will not be deterred; police cannot keep a 24 hour watch;
c) some strategies may result in an increase in violence or negative consequences in the wider social setting (e.g. a woman is ostracized for running away);

d) the same strategy is not guaranteed consistent success e.g. fighting back may have worked once, but another time mean more violence.

No strategy is used in isolation; women typically use a combination, which vary across time.

**Safety strategies for children and young people: 15-minute exercise**

**Aim:** To help health professionals identify safety strategies used by children and young people living with domestic abuse.

**Materials:** Flipchart, marker pens.

**Method:** Group work brainstorming exercise. Working in groups of 4 to 5 people ask participants to draw up a list of safety strategies used by children and young people living with mothers who have experienced domestic abuse. Strategies should be relevant to children aged up to 9 years, from 10 to 13, and for teens aged 13 to 18.

**Trainer’s notes:**

Many young people feel they should be able to protect their mother and put themselves at risk by such actions.

- Ensure that the child/adolescent is aware that responsibility for stopping the violence rests with the abuser and with the community.
- Hiding is a protective strategy.
- Inform the child/adolescent about support options for them e.g. Child-line, the NSPCC website, local support centres, domestic violence help-lines, the hideout
- Are there any other adults able to give the child emotional support and protection?
- Even very young children take protective action, eg young child crying or coming into the room to stop an assault, shouting.

Many children and young people can (with the agreement of their mother) learn how to get help using the telephone.
They can go to a room out of the sight of the abuser and call 999 or the number of a relative or friend.

A simple message stating their name address and that ‘someone is hurting my mother’ is enough.

Older children especially may try to intervene and can be hurt themselves as a result. Children often try to do very courageous things however health professionals should not advocate that they physically intervene and put themselves at risk.

4.3 Documentation and record keeping

Introduction
Health records play an important role in responding to domestic abuse – and not just in a health setting. The records kept can be used in:

- criminal proceedings if a perpetrator faces charges;
- obtaining an injunction or court order against a perpetrator;
- immigration and deportation cases;
- housing provision; and
- civil procedures in family courts to assess the risks associated with granting an abusive parent contact with children.

Health professionals in contact with patients who disclose domestic abuse should keep detailed, accurate and clear notes to indicate the harm that the abuse has caused. This can ultimately assist women to live a safer life and in the longer term, is likely to bring about better physical and mental health. Perpetrators will be more likely to be charged and sentenced and may be less likely to be able to continue to deny the abuse.

Why document injuries? 5-minute presentation

Aim: To increase health professionals’ knowledge about the Department of Health guidance on record keeping and documentation in Responding to Domestic Abuse (2005).

Materials: Slide 4.C., overhead projector/slide show equipment.

Documentation and record keeping – 30 – 45 minute exercise

**Aim:**

To practice documentation following a disclosure of domestic abuse.

**Materials:**

4 copies of Handout 4.E (disclosure interview script – this can be replaced by video material, see video resources section); paper; pens; copies of Handouts 4.F, 4.G and 4.H (supplement or substitute with local Trust or Health Authority documentation guidance); flipchart, marker pen.

**Method:**

Observation of role play/video extract, working in pairs to document disclosure details. Ask 3 participants to volunteer to read/role play the disclosure interview script (Handout 4.E). The trainer should keep a copy herself to help with any script reading questions if necessary. Ask the group to listen carefully to what is said and make some notes if they wish. Collect in Handout 4.E after the role play. Ask the participants, working in pairs, to document the disclosure. As guidance, give out Handout 4.F (or copies of documentation forms and any local protocols that outline procedures for recording experiences related to domestic abuse). The trainer should circulate among the groups to answer any questions about what was said during the interview.

At the end of the session ask one or two pairs of participants to read their patient notes completed in the exercise. Facilitate a discussion from the group about the exercise, any issues that arose and learning outcomes.

Give out Handouts 4.G and 4.H

**Trainers' notes**

Emphasise key points in Handout 4.F, especially:

- Always make records during an interview with the woman alone;
- Explain the benefits of keeping records to the woman;
- Include name, date of birth, ethnicity, number of children, pregnancy, friend or kin (not perpetrator);
- Include response to routine questions about abuse and whether disclosure or denial, record suspicions based on physical, emotional and/or behavioural indicators;
- Use the woman’s own words, rather than your own, using quotation marks e.g. ‘Patient reports.’ or ‘Ms. Smith said that…’
- (avoid "she claims" or "alleges", which suggests you doubt it);
- Briefly describe the types and nature of abuse and if physical or sexual, injuries sustained;
- Include a detailed physical record, with sketches of injury sites on body map or photographs of bruises if possible;
- Record and if possible keep any damaged or stained clothing; record any damage noted on home visit;
- Dates and times of incidents, if known;
- Description of patient’s actions and psychological state. Be descriptive rather than interpretative e.g. in tears;
- Document relevant behaviour by the perpetrator that you may have observed e.g. disclosures that may indicate abuse (but do not interview him);
- Be legible, or write notes on computer;
- Note detailed facts (including observations) rather than assumptions or summaries;
- Record action (e.g. information provided, referral to whom);
- Sign and date records. Print name and role.

The Access to Health Records Act 1990 gives patients the rights of access to manual health records about themselves. The Data Protection Act 1998 gives access to computer-held records.

Additional sources:
CPHVA, 1999 *Keeping the Record Straight*. London: CPHVA.
UKCC, 1993 *Standards for records and record keeping*. London: UKCC.
Local Record Keeping Guidelines.
Local Area Child Protection Committee Guidelines (ACPC)
4.4 Confidentiality and Information Sharing

Introduction
It is vitally important that information on domestic abuse is kept confidential. Without confidentiality, women are less likely to talk about their experiences. Their physical safety can depend on it. Confidentiality should not be breached unless it is in the public interest to do so. Examples of when it might be in the public interest include:

- Where there are Child Protection issues.
- Where a woman’s life is imminently in danger.
- Where a perpetrator is likely to put the lives of others in danger.
- In the administration of justice (under Crime & Disorder Act & Sections 2&3 of Data Protection Act).

Confidentiality is particularly important in general practice, where health professionals might treat other members of a woman’s family – including the perpetrator, who can use information to track down a partner who has left him. It is not unusual for men who are perpetrators of violence towards someone with whom they have been intimate to go to great lengths to seek her out. Statistically, a woman becomes at greatest risk at or after the point of separation. A woman who has children may have significant problems in preventing her partner from finding out where she is staying because the Children Act (1989) gives a parent who has parental responsibility a right to seek to have contact with their child. However, a recent amendment (January 2005) to the Adoption and Children Act recognises the increased risk to children living with domestic violence.

Confidentiality can be a major concern to health professionals. Professionals should be particularly wary of situations in which confidentiality could accidentally be broken. For example, if a child who is staying at a refuge spends time in hospital and the father visits the child, professionals must take care that records that are on display do not include a contact address or any other information that could help a perpetrator track down his former victims.

It may be appropriate to share information with a supervisor/manager, or with colleagues in the team, or with the child protection advisor. It’s important for health professionals to understand – and to explain to women who reveal that they are experiencing domestic abuse – that there are limits to confidentiality. For
example, if there is reason to suspect children are at risk, protection must always take precedence over confidentiality. However, you can guarantee not to talk to the abuser directly about what has been disclosed.

Role-playing elements of conversations related to confidentiality can help staff to feel confident and build their skills in practice.

Confidentiality (10-20 minutes exercise)

Aims: To reflect on the concept of confidentiality in practice.


Method: Show Slide 4.D or provide local guidelines on confidentiality in relation to domestic abuse.

Facilitator asks group to address the three questions outlined on flip chart, as below:

1. If I think there is domestic violence, who should I tell?

2. If she tells me that domestic violence is happening, who should I tell
   o with her permission?
   o without her permission?

3. If I mention Child Protection issues she will be frightened the kids will be taken into care – how do I deal with that?

(Trainer’s note: health professional can reassure woman of their belief/knowledge that she is a good/loving mother; that Social Services, like the mum, are concerned that her children are safe from harm, and that they usually believe that the best way to achieve that is to ensure the mother is protected.) See also trainer’s notes below.

Confidentiality (40 minute exercise)

Aims: To reflect on the concept of confidentiality. To understand the implications of maintaining confidentiality from professional and client perspectives

Materials: Provide handouts and / or examples of the relevant clauses from professional bodies and/or local practice guidelines on
confidentiality in relation to domestic violence; case study (Handout 4.I)

**Method:** Case study and small group discussion. Divide the group into smaller groups. Give each a copy of case study Handout 4.I. Ask each small group to spend about 10 minutes reading their case study and then answering the questions outlined below (which could be written on a flipchart, for the group’s reference). Re-convene the large group and discuss the issues raised by each group in the light of the notes provided and your own knowledge and experience.

Consider:

- The issue of confidentiality
- The rights and needs of the woman
- The rights and needs of the man
- Your professional responsibilities under local and professional guidelines

**Breaches in confidentiality (20-30 minutes exercise)**

**Aims:** raise awareness about potential breaches of confidentiality. To prepare delegates for attempts by abusive men to elicit breaches in confidentiality.

**Materials:** Flipchart, marker pen.

**Method:** Facilitator to ask group ‘what could lead to a breach in confidentiality?’ and to use flip chart to record responses of group.

**Trainer’s notes:**
Ways in which a woman’s confidentiality may be inadvertently breached may include the following:

- Giving out leaflets / contact cards or writing in client-held records.
- Giving an abuser information about a woman’s whereabouts without her permission, e.g. ‘yes, she is here at baby clinic.’
- Giving information as to the whereabouts of children if a woman has left home with them.
- Relaying a message to a woman from a man who is abusing her, or an associate.
- Acknowledging that a woman has been to see you by admitting that you know where she is even if you are not prepared to tell anyone.
- Telling a woman that her abuser has been asking about her (this may be something that needs to be checked out with a woman first – she may want to know, or not want to).
- Sharing information with other agencies without asking the woman’s permission.

Men might ask members of staff if they know the whereabouts of a woman and/or her children, or to pass on messages to a woman and/or her children. The requests may seem plausible and might suggest concern, or regret, or anxiety e.g.

“I’d just like you to tell her I love her and I hope she is alright.”

“Just tell her that I’m really sorry and I’d like her to come home so we talk it through’

“Just tell her that I’m really worried about the safety and well-being of the children.”

“Tell her that her father and mother want her to come home.”

“Just tell her happy birthday from me and remember the roses.”

When requests for help are couched in such a way, a worker may feel sympathy for a man who is searching for his family, and feel that to pass on a message or simply tell a woman he has been asking about her will do no harm. However, even simple acknowledgement by a worker that s/he knows of a woman’s whereabouts may jeopardise a woman’s safety and also create an unsafe situation for staff. It is also impossible for a worker to understand the meaning that a message may have for a woman, e.g. “Just tell her happy birthday from me and remember the roses” may relate to a happy past occasion or it may be a subtle reminder of a time when a woman was abused.

Ensure that participants consider the needs and rights of the woman. The woman should maintain control and have the choice of whether to contact him, if and when she is ready to do so. The group might discuss of what benefit to the woman it will be to be told that the man has been to the health service setting and the potential implications of the contents of a message. The man can gain reassurance about her well-being from the police, who are the appropriate agency to contact in a
situation of missing persons. This exercise may be contentious. Participants may
disagree and may object to partners being seen as potential abusers. It may be
useful to draw comparisons with other situations in which information would not be
disclosed, e.g. if a person has been admitted to a ward via Accident and
Emergency having self-harmed. This exercise may also raise issues relating to
workers’ own safety and vulnerability.

There may be particular difficulties facing black or Asian women who access the
health service, as some women (rightly) fear that they may be ostracised by their
families, communities or social groups if they disclose. Lesbian women may also
have additional difficulties in asking for help, as they may fear being stigmatised or
discriminated against by health professionals.

Trainers might emphasise

- Confidentiality is an issue of fundamental importance for women
  experiencing domestic violence;
- Failure to apply the principles of confidentiality could have disastrous
  implications;
- Passing on information on a ‘need to know’ basis with the knowledge of the
  patient whenever possible;
- Where there may be Child Protection Issues it may be necessary to override
  a woman’s wishes – in these cases workers must consult local guidelines
  and seek advice;
- If confidentiality should be breached in the public interest, staff should
  consult a manager or supervisor and make a record of the reasons for their
  decision and course of action;
- Homicide reviews will investigate the extent to which health professionals
  have met their duty of care under the Crime and Disorder Reduction Act
  (Section 155).

Staff may be concerned about confidentiality and recording information that could
unintentionally harm a victim of domestic violence. All staff must understand, and
be honest about their efforts to maintain confidentiality, and specific about the
limitations of confidentiality (BMA, 1998).

Physical safety can depend on the notes being kept securely, including information
about the patient’s address, particularly if the abuser is registered with the same
practice or hospital. Information elicited over the telephone should always be preceded by a written and signed fax.

Staff might also be concerned about the prospect that their notes could be used in court or externally (e.g. to support an application to a housing agency). In many cases, a woman can submit notes and the information without any direct contact between the member of staff and the agent requesting evidence.

UKCC Code of Professional Conduct states that nurses or midwives should protect all confidential information, and make disclosures without consent only when required by a court order or when the disclosure can be justified in the wider public interest. Health professionals need to be confident that their action will not place someone at greater risk of violence.

**Information Sharing – 20-minute workshop**

**Aims:** to help professionals to decide when information can or should be shared; to raise awareness of information sharing policies.

**Materials:** flipchart, case study (Handout 4.I), marker pen.

**Method:** Group work discussion and feedback. Ask participants to divide into groups of 4 or 5. Give out copies of Handout 4.I. Ask groups to discuss when information should be shared and with which agencies. Feedback to whole group. Training facilitating discussion drawing on notes below.

**Trainer’s notes:**
The trainer should reinforce the points made in the Department of Health Guidance *Responding to Domestic Abuse* Section 4.8. Refer to the Trust policy on sharing information.

**Only ever consider giving information to reputable agencies** – never to individuals making enquiries about a woman’s circumstances. If in doubt, ask them to submit their request in writing or by fax on headed paper.

**The only acceptable reason for sharing information is to increase a woman’s safety and that of her children.** Even then, only share information that is relevant.

**Always follow local multi-agency guidelines** for sharing information about domestic abuse.
If the professional uses clinical supervision for support, s/he should talk about cases without revealing individual identities.

**Respect deadlines.** If a professional is late giving information to solicitors who are dealing with a woman’s immigration application, for example, this could jeopardise her chances of being allowed to stay in the country. Professionals should take time to ask when information is needed if not given a deadline.

**Can information be shared without permission?**

A professional should always ask a woman’s permission to share information. Nevertheless, the request can be followed by explaining the value of sharing information.

But given current legislation (section 115 of the Crime and Disorder Act 1998), it is permissible to pass information to another agency in situations where:

- the courts request information about a specific case; or
- there is significant risk of harm to the woman, her children or somebody else if information isn't passed on.

If information is passed on without permission, the professional should be completely sure that the decision to do so would not place somebody at risk of greater violence. S/he will need to be able to justify the decision. Ideally, a supervisor or manager is consulted.

See guidance in the Home Office’s *Safety and justice: sharing personal information in the context of domestic violence*, which is available online at [www.homeoffice.gov.uk/rds/pdfs04/dpr30.pdf](http://www.homeoffice.gov.uk/rds/pdfs04/dpr30.pdf)

The Crime Reduction website has an easy-to-use interactive tool that asks simple yes/no questions to help staff determine if confidential information can and should be shared with other agencies. It can be found at [www.crimereduction.gov.uk/isp01.htm](http://www.crimereduction.gov.uk/isp01.htm)

Support measures must be in place for staff facing difficult decisions about information-sharing.

The transfer of anonymised data presents no problem.

If partners are to share information effectively, all organisations concerned must share data sets. Signing up to an agreed definition of domestic violence and abuse
Authorities and Trusts will want to determine their own local data requirements and to consider subsequent IT implications. Suggested data requirements include:

- the number of recorded, and repeated, incidents of domestic violence in a year (broken down by age, sex and ethnicity). Electronic patient records will assist in data collection and provide a robust evidence base;
- the proportion of local child protection cases involving domestic abuse; and
- findings from any local research into domestic abuse.

### 4.5 Working with perpetrators

**Introduction**

There may be circumstances where a health professional may encounter perpetrators of domestic abuse as patients, partners of patients or fathers/carers of children whom they know or suspect to be affected by domestic abuse. The approach the professional takes will depend on whether a man is directly acknowledging his domestic abuse as a problem, is seeking help for a related problem or has been identified by others as abusive. As with any interaction with people affected by domestic abuse, the first priority must be the safety of the victim and any children. There has been a general lack of guidance for health professionals working with domestic abuse perpetrators. It is important that training on domestic abuse starts to address the needs of professionals who work with perpetrators.

**Working with perpetrators – 15 minute workshop**

**Aim:** To introduce health professional to some basic principles to inform their work with perpetrators of domestic abuse.

**Materials:** Slides 4.E and 4.F, overhead projector/slide show equipment; copies of Handout 4.J.

**Method:** Presentation and discussion of issues raised for professionals.

Show Slide 4.E – indicators to note. How to respond?

Systematic reviews of the literature suggest that so far there is no conclusive evidence about what are effective interventions with perpetrators of domestic abuse (see Buzawa, 2005). It is
not easy to measure effectiveness because so many perpetrators drop out of treatment and intervention programmes. Treatment programmes can be effective for perpetrators who stay on them but up to a quarter show no change at all (Taft & Shakespeare, 2005). Further research is needed to inform the evidence base for practice, particularly in the context of health care. However, as with health care responses to victims of abuse, the present lack of conclusive research should not be used as a justification for doing nothing. Practical experience and research with perpetrators support an approach based on the following principles. Present slide 4.F drawing upon the guidance in Handout 4.J.

**Trainer's notes**

Stress the importance of having local knowledge about services available working with perpetrators to whom professionals can refer. Services which are part of the Respect national network adhere to national policy and practice guidelines.

Professionals should NOT act as mediators or go betweens. This can be dangerous for the victim and for the professional.
Module Three

Positive Response

Training Resources
Slide 4A

What are the risks if women stay (or return) or leave?

Physical

Psychological

To the children

Money

Support

Relationship

The law
Safety strategies used by women experiencing domestic abuse

Legal strategies

Formal help seeking

Informal help seeking

Escape behaviours

Separation

Hiding

Appeals to abuser

Compliance

Resistance

Self defence

Uses children

Personal
Records of domestic abuse can provide:

Accurate, current, comprehensive and concise information on the condition and care of the patient

A record of any problems that arise and the action taken in response

Evidence of care required, interventions by professionals and patient responses

A record of any factors (physical, psychological or social) that appear to affect the patient or client

The chronology of events and the reasons for any decisions made

Support for standard setting, quality assessment and auditing

A baseline against which improvement or deterioration may be judged
Slide 4D

Confidentiality

Promotes safety of and disclosure by victims of domestic violence

Safety may depend on care of notes & protection of whereabouts/address

Be honest about confidentiality limits

If children are at risk, child protection takes precedence over confidentiality

The client’s written consent should be obtained whenever possible
Working with Perpetrators - Indicators of Abuse

A man who is worried about his abusive behaviour may present in the following ways:

- I’ve got a problem with drink
- I need anger management
- I’m not handling stress at work
- My wife says I need to see you
- My wife and I are fighting a lot
- My wife and I need counselling
- My wife is not coping and taking it out on me
- The kids are out of control and she’s not firm enough
- I’m depressed/anxious/stressed/not sleeping/not coping/not myself
- I feel suicidal (or have threatened or attempted suicide)
- I’m worried about my rage at work, in the car, in the street, at the football.

Additional indicators to be aware of:

- Attempts to accompany or speak for women partners
- Sexual jealousy or possessiveness
- Psychotic/manic/paranoid symptoms
- Substance use/dependence

Although rare, a man might present with a physical injury such as a hand injury caused by punching, or you might notice injuries caused by the woman defending herself such as scratch marks.
Slide 4F

Working With Perpetrators – Basic Principles

1. Look/listen
2. Ask
3. Assess risk
4. Respond
5. Refer
6. Record
Module Three

Positive Response

Handouts
Handout 4.A

What should a safety plan cover?

Safety in the relationship

- Places to avoid when abuse starts (such as the kitchen, where there are many potential weapons).
- People a woman can turn to for help or let know that they are in danger.
- Asking neighbours or friends to call 999 if they hear anything to suggest a woman or her children are in danger.
- Places to hide important phone numbers, such as helpline numbers.
- How to keep the children safe when abuse starts.
- Teaching the children to find safety or get help, perhaps by dialling 999.
- Keeping important personal documents in one place so that they can be taken if a woman needs to leave suddenly.
- Letting someone know about the abuse so that it can be recorded (important for cases that go to court or immigration applications, for example).

Leaving in an emergency

- Packing an emergency bag and hiding it in a safe place in case a woman needs to leave in an emergency.
- Plans for who to call and where to go (such as a domestic violence refuge).
- Things to remember to take: documents, medication, keys or a photo of the abuser (useful for serving court documents).
- Access to a phone.
- Access to money or credit/debit cards that a woman has perhaps put aside.
- Plans for transport.
- Plans for taking clothes, toiletries and toys for the children.
- Taking any proof of the abuse, such as photos, notes or details of people who know about it.

Safety when a relationship is over

- Contact details for professionals who can advise or give vital support.
- Changing landline and mobile phone numbers.
- How to keep her location secret from her partner if she has left home (by not telling mutual friends where she is, for example).
- Getting a non-molestation or exclusion or a restraining order.
- Plans for talking to any children about the importance of staying safe.
- Asking an employer for help with safety while at work.

Department of Health (2005) *Responding to Domestic Abuse*, page xxx
Handout 4B
Safety Strategies for Women
How to be prepared to leave urgently
A woman who realises that she may need to leave home suddenly can be greatly assisted by being prepared. She needs to plan where she and the children would go, how they would get there and what they would take. The following checklist might help:

- Have important telephone numbers available (Free-phone 24 hour National Domestic Violence Help-line 0808 2000 247, local domestic violence services and refuge organisations, friends, family.)
- Keep birth and marriage certificates, passports, medical cards together, or copies in a safe place
- Keep benefit books, bank and building society books handy
- Have rent or mortgage details written out
- Carry change, phone card or mobile phone all the time
- Carry driving licence, car registration and details of car insurance
- Hide some money, credit cards, or open own savings account
- Hide or leave spare keys to house and car with someone
- Have necessary medication for self and children ready
- Have someone write out a statement of her situation in English if English is not her first language
- Photograph of violent man (useful for serving court documents)
- Decide what to do about personal items or valuables; e.g. family photos are often important later.
- Have packed bag with a change of clothes, toiletries, toys etc. hidden or at someone else’s house
- Plan to take all the children that she wishes to have with her. (The longer children are left at home with the abuser, the harder it is to get them later)
- Talk to the children about the situation
- Keep together any documents relating to her immigration status
- Talk to friends or family about staying in an emergency
- Use a call box or a friend’s phone to keep calls private
- Be ready to call 999 if she or her children are in danger
- Tell people she trusts about the abuse
- Talk to agencies e.g. a solicitor about her legal rights, or the GP, Midwife, Health Visitor
- Develop and keep reviewing her safety plan if there is the risk of abuse. For instance, avoid some rooms (kitchen, because of potential weapons; or bathroom, with no exit). Help her think about all possible escape routes: windows, doors, stairs (and suggest she practice before it’s needed, if possible). An alternative may be a safe room to barricade while the police are coming.
- Ask neighbours and friends to call 999 if they see or hear noises that could mean she or the children are in danger. (Think about what she will scream or shout if attacked.)
- Teach the children to use 999 and ask for the police. Talk to the children about staying safe, how they get out, where to go.

If she decides to leave, a health practitioner could help with some things she could do before she goes including:

Help her think about a place she can go where she will be safe, or where the abuser will not know to look for her, such as to a friend or relative (only if it is safe), to a hotel, or refuge, or to another town or city. She can also ask the Housing Department (or Homeless Person’s Unit) or Social Services for help. Suggest she plans now, and also makes a back-up plan. Suggest that she gets legal advice. If possible, suggest the following:

- Put some money away in a safe place a little at a time
- Move some of her things out a little at a time (for example, identification and other things that may not be noticed, or take copies of them),
- Keep a diary and record the abusive incidents (only if she can do this safely, in a hiding place or a safe address)

At any stage she can, encourage her to make careful notes of everything that happened, including times, dates, names, and what everyone said. If she is able to keep a diary, it can help her to remember. If she was injured, she (and you, or the GP or other health practitioner) might record all of the details including:

- Exactly where she received the injuries (for example, the upper thigh),
- How she was hurt (for example, by a fist or boot),
- How many times she was hit, and
- How severe her injuries were (for example, bruises or cuts requiring stitches).

These notes are very important. They may help her access legal rights, welfare rights and benefit her and the children. Keep them in a safe place.

- Identification including benefit books or evidence of benefits, medical cards, legal papers (like court orders, marriage certificate, passports, birth certificates, drivers licence,)

- Proof of her housing situation e.g. mortgage paper, tenancy agreement, a bill with name and address, rent book

- Money for fares, credit or debit cards, cheque book if she has them

- Clothes for two or three days, in a bag which is not too heavy

- Things of special personal value (like writing, photos), or she might hide or store them

- A few of the children’s favourite toys, books or games

- Toiletries, nappies, sanitary towels, medications

- Any proof of the abuse like notes, photos, taped messages, her diary, crime reference numbers, names and numbers of professionals who know

Especially if there is a residence or contact order, or a parental responsibility order in place, she might consult a solicitor who specialises in child and family work before leaving, or as soon as possible after she has left with the children. It may prevent a missing persons’ investigation or an emergency order being issued by the abuser for the children’s return. Ideally, she might leave a note that says that she has left with the children, that they are safe, and that she will contact the non-resident parent in the near future. (She should keep a copy of the note).

She can also contact the freephone 24 hour National Domestic Violence Help-line (0808 2000 247), or voluntary organisations in her area, or statutory agencies such as the Police, Social Services or the Housing Department.

**Increasing safety in the longer term**

Whether a woman is living with her abuser or not, there are ways in which she can feel safe and better supported. The following list may be helpful in planning this:

- Have an emergency plan (as above)

- Inform trusted family / friends and explain what support is needed;

- Have contact numbers for different support agencies;
• Inform selected neighbours of violence and tell them when to call the police;
• Inform appropriate colleagues at work and ask for calls to be screened;
• Inform schools and/or those who take care of the children of the situation, and names of who can collect them;
• Report and explain all injuries or stress symptoms to the doctor, health visitor or other health worker;
• Change locks, install smoke and intruder alarms, and outside lighting system;
• Attend a support group, college course or other activities;
• Explain situation to the children; talk honestly with the children.

Every woman’s needs are individual and therefore it is essential that any list is prepared in partnership with her, but these lists may offer some guidance and identify things she may not have thought of.

When a woman decides to act, she has several options. She can stay at home and might apply for a court order to exclude the abuser from her home or she can leave. Whether or not she chooses to leave her partner, her safety is the most important thing. The role of the professional is not to cajole or insist; it is more important that the choice is always the client’s, and that the door remains open for her to talk some more when she is ready.

Joint counselling is not advisable when there is domestic violence because women are not free to speak, may be at greater risk or can be abused after a session. Moreover, joint counselling could give her the message that she has ‘joint’ responsibility for his violence and responsibility for managing his behaviour. This is not a safe message for a woman living with an abuser because all too often her efforts to ‘manage’ his behaviour or to keep the peace can result in the abuser’s tightening of control. (e.g. keeping the peace by not seeing her family because it upsets him results in her isolation and increased vulnerability).

Suggestions if she is at risk from an ex-partner

• Change locks, and put locks on windows and perhaps a bedroom door. The local Housing Office, Victim Support or Community Safety Team may be able to give advice or practical help;
• Make the doors and entry system more secure; ask the police for advice;
- Speak to a Community Safety Unit or Domestic Violence Officer (police who specialise in domestic violence). One report to the police can secure her rights later;
- Get security systems e.g. small CCTV, burglar alarm, movement-sensitive light, panic alarm linked to the police station;
- Think about an escape route, as above, even when she is upstairs in bed;
- Teach children to dial 999, or to phone a friend or someone close by;
- Use 141 before she makes a call, or telephone 150 (Customer Services for BT), so her number cannot be traced;
- Tell school who can pick up her child and who cannot;
- See a solicitor, taking evidence of or means to claim benefit, wage slips or proof of income, NI number; name, address and photo or description of abuser; any information about contact with police; name and address of Housing Officer, or details of her property;
- Keep a diary of any harassment or threatening behaviour from the ex-partner, his family or friends;
- Contact local advocacy group or specialist domestic violence outreach service for support or advice;
- Ensure that if the children want contact with the father that this has been properly assessed and it can be arranged so that she and the children are safe and free from fear or harassment. Seek advice from Women’s Aid or Refuge children’s services, a family lawyer, a domestic violence advocacy service or specialist supervised child contact service for advice.

Increasing safety is a dynamic process, akin to stages of change. Escaping domestic violence may be a slow and incremental process (Brown, 1997). Women may leave and return a number of times. Even when they remain with the abuser, they can still be making important changes. Being with him or returning to him does not mean that help from a health professional has been wasted or that she has given up or that she is not taking action. She may view the situation differently, she may act differently if the violence re-occurs and she has prepared to take action or make changes in her life to free herself from violence.

1 Terms vary according to area
Handout 4C
Sample safety plan
This safety plan can be used by women experiencing domestic abuse, but is meant as a guide or prompt rather than as a form to be filled in. Remember that it might not be safe for women to fill in safety plans and take them away.

Increasing safety in my relationship

• Where can I keep important phone numbers so that they are always accessible to my children and me?

....................................................................................................................................

• The names of two people I can tell about the abuse and ask them to listen out for unusual noises from my home, so that they can call the police if I am being assaulted.
  1. ....................................................................................................................................
  2. ....................................................................................................................................

• What code word or phrase can I use in an emergency to let my children know that I want them to get to safety immediately?

....................................................................................................................................

• Four places I can go to if I leave my home:
  1. ...................................................................................................................................
  2. ...................................................................................................................................
  3. ...................................................................................................................................
  4. ...................................................................................................................................

• Who can I leave extra money, car, keys, clothes and copies of documents with?

....................................................................................................................................

• What will I take with me if I leave?

....................................................................................................................................

....................................................................................................................................
• Where can I leave an emergency bag?
..............................................................................................................................
..............................................................................................................................

• Where can I hide emergency money and important documents?
..............................................................................................................................
..............................................................................................................................

• What parts of the house should I avoid when the abuse starts? Where is there no exit? Where are there things that can be used as weapons?
..............................................................................................................................
..............................................................................................................................

Increasing safety when a relationship is over

• Things that I might need to do straight away:

☐ change locks  ☐ get smoke detectors  ☐ get a security system

☐ get stronger (metal) doors  ☐ get an outdoor lighting system  ☐ change landline and mobile numbers

Who will I tell that my partner no longer lives with me?

1. ..............................................................................................................................
2. ..............................................................................................................................

Who will I ask to call the police if they see my partner near my home or children?

1. ..............................................................................................................................
2. ..............................................................................................................................

I will tell the people who care for my children who is allowed to pick them up. The people I have given permission to are:

1. ..............................................................................................................................
2. ..............................................................................................................................

Who can I tell about my situation at work and ask them to screen my calls?
..............................................................................................................................

What shops, banks and other places that I used to use with my partner do I need to avoid?
Who can I call if I’m feeling down and am tempted to return to my partner?

1. ................................................................................................................................

2. ....................................................................................................................................

**Important phone numbers**

Police ................................................................................................................................

Helpline .........................................................................................................................

Friends ......................................................................................................................

Refuge/outreach service ............................................................................................

*Always dial 141 before calling out, so that your number can’t be traced.*
Handout 4.D
Handout for Women
Where to seek help

It is not easy to talk about domestic abuse, but you do not have to cope by yourself. Seeking help not only can mean that you are acting responsibly but sets an example to your children about their rights to get help rather than cope alone when something is troubling them. You might all need support to rebuild your new family, free from fear, particularly if you have all been used to punishment and criticism. It is time to seek help if anyone’s behaviour makes you afraid for your own safety the safety of your children or the safety of others. Taking action now may help prevent things from getting worse and may start to improve your relationship with your child; help them feel better in themselves and help them relate better to others – all crucial elements of becoming an adult.

Apart from friends, there are several agencies in your local area, each with a variety of people working within them, who might be a source of help, as follows:

Health: You might talk to your Health Visitor, Midwife or G.P. Your G.P. can refer you and your child to Child and Adolescent Services, which may help you access child psychiatrists (who might help in, diagnosis, medication and accessing other professionals within their team) or psychologists (who offer therapy on an individual, family or group basis and who might help you and your child explore feelings and reactions to your experiences and also offer advice on managing recurring or worrying thoughts and behaviours). Your G.P. might also refer you to a counsellor within the Health Centre.

School: You can contact your child’s teacher, Head of Year or Head Teacher. There may be a counsellor or specialist worker attached to the school who can offer emotional support to your child, and who may help negotiate changes in behaviour. The school will have behaviour support teams and an Educational Psychologist who assesses the learning and behavioural needs of children and can recommend further support, special schools and sometimes direct counselling. If you inform the school they will better understand your child’s difficulties and can work alongside you to manage more difficult behaviour.

Social Services: can offer a Social Worker and may fund or help you find support in parenting classes, child-care and nursery provision, among other services. A
Social Worker may provide one-to-one attention for your child and guidance and resources for you.

**Voluntary agencies**: such as Child-Line and NSPCC offer telephone counseling and can advise you about support in your area. Refuges may or may not have psychological or counseling services, child-care or nursery facilities, depending on where you go; but all will know of local services for parents and children escaping domestic violence. You might consider local groups such as mums and tots groups or drop-in centres; you might gain social support and feel less trapped at home, while helping your child develop relationships. Find out about lone-parent family support groups from your local library or Citizen’s Advice Bureau.

Your health professional may be able to give you a list of local and national contact numbers for the services you need.

0808 2000 24 7

24 hour National Domestic Violence Freephone Help-linerun in partnership between Refuge and Women’s Aid
If it is no longer safe to return home

You may decide that to be free from violence, you can no longer stay at home. You may choose to make a private arrangement, or seek support from family and friends, but you also have rights by law. If you decide to stay with someone you know, be careful about staying with someone who does not fully understand the situation. Although there may be a great advantage in their emotional and practical support, it may be unhelpful if they encourage you to return to a situation, which might only lead to more violence. It may also be dangerous if your abuser knows where you are, and could track you. You might plan for the short-term (such as to stay in a crisis with neighbours or friends close by) medium term (to stay with family, old friends or in a hotel) and longer term (to rent, buy or move in to a different property). Information about local housing options should be available from the council, advice centres (such as Citizen’s Advice) and housing associations.

You can also telephone the free 24-hour national domestic violence help-line run by Refuge in partnership with Women’s Aid. The trained staff can provide information and support, help you think through options or advocate on your behalf to find a place to stay to escape violence, including a refuge.

0808 2000 24 7

Free 24 hour National Domestic Violence Help-line

Refuges

Refuges are crisis accommodation for women and children escaping domestic violence. Refuges vary, but have in common the offer of help and a place to stay. Other women and children living there left abusive situations and are deciding on their next step. You and the children will have your own room, probably with shared kitchen, lounge and bathroom facilities. Most refuges have staff available during office hours to offer support and comprehensive information about your options, to help you to access welfare, housing and legal rights. They may liaise with other agencies on your behalf, although they are not wardens and the emphasis is on empowering you to make your own decisions.
Refuges prioritise safety and security, with secret addresses and telephone numbers. Men are not allowed to know the number, address, or visit the house, for the safety of women and children at risk from abusive men trying to find them. The charge to stay there may be covered by your rights to benefits (even if you already have a property covered by Housing Benefit), or by Social Services. You may choose a specialist refuge for women from ethnic minorities. Since staff are usually available only in office hours, if you have special needs including support for mental health problems, substance abuse or violence, the Refuge help-line staff may advise you about alternative options to meet your needs, including access to specialist refuges. The shortage of longer-term accommodation, particularly in specific areas of London, may mean that you stay in a refuge for months or, in some areas of London, for up to two years. Toward the end of your stay, staff may help you with planning to move, and to apply for a Community Care Grant for furniture for your new home.

If no refuge space is available, the Homeless Persons Unit or Social Services have a duty to help you. Help-line staff can liaise on your behalf, when it is out of hours, or provide you with contact telephone numbers. You may be offered temporary accommodation, such as a bed and breakfast, or a hostel, until a refuge place can be found. You may prefer this accommodation to a refuge if you need direct visits or calls at home from a male friend, relative or partner. If your children are with you, Social Services also have a duty to ensure that you have a place to stay.
**Reading list**

**Specially on domestic violence**


**Suggestions about healing from post-traumatic stress**


**Dating**


**Relationships**

How to cope with relationship breakdown. MIND 0845 330 1585 www.mind.org.uk


**Childhood abuse**


**Parenting children**


Getting positive about discipline: A guide for Today’s Parents. Barnardo’s

**Information on law, housing, money, education & children**

Handout 4E
Disclosure Interview - Role-play script
To be role-played by three people taking roles of health visitor, woman (Jane), child (Jason, age 2):

Jane comes to clinic with her son Jason who is 24 months old. She has brought him for his 21-month developmental check.

Health visitor: Hi! Come in. Have a seat.

(Jane sits down at the low table on which there are some toys. Jason stands holding his mum’s hand and leaning up against her).

Health visitor: (Bending down to be at Jason’s level) Hi Jason. I’ve got some toys here if you would like to play. (She puts a bag next to him, which has toys in it. Jason looks at his mum)

Jane: What’s in the bag Jason?

(Jason opens the bag and looks inside)

Health visitor: (Looking at Jane) How’s things?

Jane: (In a bright voice but without smiling) Okay really…. I suppose.

Health visitor: Okay?

Jane: Hmm. Yes. Well Jason’s sleeping better now.

Health visitor: Jason’s sleeping better. That sounds like a good thing.

Jane: Well it is really, considering.

Health visitor: Considering?

Jane: Well. Yes…I…well the way things are with John, I don’t think I could manage with Jason being up half the night as well.

Health visitor: How is John?

Jane: Oh he’s okay really, just going through a stage I suppose.

Health visitor: A stage?

Jane: (Eyes filling with tears) Oh I don’t know….You know how they are at seven.
Health visitor: (picks up a box of tissues from the shelf behind her and sets them on the table beside Jane. Jason looks up from his toys and stands up and leans on his mother)

Jason: Mummy….

Jane: It’s all right baby…look there’s a bus – can you make it roll on the floor?

Jason: Bus, vroom, vroom.

Health visitor: You seem upset about something. Is it something you want to talk about?

Jane: (Eyes fill with tears again)

Health visitor: I can ask Julie (receptionist) to look after Jason for 10 minutes if it would help?

Jane: (Nods)

(Health Visitor goes out to get Julie, who then takes Jason to play with toys in an adjacent room).

Health visitor: How does that feel?

Jane: (Nods)

Health visitor: You were saying that you though John was going through a stage….

Jane: (Looks up) Oh I might as well tell you –

Health visitor: You don’t have to tell me but if you want to tell me, I’m here to listen.

Jane: No, I will. I can’t keep it together any more. I’ll go mad. Bob hits me.

Health visitor: Bob hits you.

Jane: Yes, no, I mean well only if ….. it’s when he has been drinking. He goes to the Swan on Fridays with the lads and when he comes back…. If he can’t have his own way… (Her voice is a whisper) he hits me.
Health visitor: When Bob has been drinking in the pub he comes home and hits you if he can’t have his own way.

Jane: Yes.

Health visitor: Has he hurt you?

Jane: Yes, I think I’ve just had a miscarriage.

Health visitor: You think you have just had a miscarriage? Have you seen anyone about that?

Jane: Well I did a pregnancy test and it was positive but I haven’t been to the doctor yet. I was only two months…

Health visitor: Have you told anyone you think you have miscarried?

Jane: No. It only happened on Friday. He punched me in the stomach….He knew I was pregnant…. (Starts to cry again)

Health visitor: You sound really sad about the pregnancy.

Jane: I don’t know. How could he….He knew…

Health visitor: I know that this might not make sense and we cannot speak for Bob but it is not unusual for some men to be violent towards their partners when they know they are pregnant.

Jane: He said he wanted another baby.

Health visitor: It sounds like it doesn’t make much sense….What he said and what he did…

Jane: No. He was upset on Saturday though – when I told him. He said he would make it up to me… How can he… (Cries)

Health visitor: I feel concerned that you haven’t seen a doctor.

Jane: I don’t want to. I’d have to tell him.

Health visitor: You could see one of the women doctors. You wouldn’t have to say if you really didn’t want to. It is up to you but if the doctor doesn’t know what happened to you she might not be able to tell if you need any treatment.

Jane: Oh I know. I suppose I just feel so ashamed. I don’t want anyone to know. You won’t tell anyone will you? (Anxiously)
Health visitor: Do you remember when we first met, when I gave you your red book, I explained to you about confidentiality? The only time I would ever tell anyone else anything you told me would be if a child was in danger or if I or another adult was in serious danger from someone’s behaviour. And even then I would always discuss it with you first if I possibly could.

Jane: Does that mean you are going to tell?

Health visitor: Do you think I need to tell anyone…. What do you think?

Jane: If you are worried about the children they always go to my mum’s on Friday nights – they are not in danger.

Health visitor: Your mum’s sounds like a safer place for them to be but if Bob has punched you hard enough to cause you to have a miscarriage….

Jane: You won’t tell Bob? Please don’t do anything. I don’t want Bob to know I’ve told anyone.

Health visitor: If you were to talk to the doctor, the doctor wouldn’t tell anyone who didn’t need to know except for medical reasons. The doctor wouldn’t have any reason to tell Bob that you had told her how it happened.

Jane: I know I should go to the doctor. I’m still bleeding and I’m scared.

Health visitor: If you feel you would like to see the doctor you are welcome to ring from here for an appointment. If it would help I could explain the situation to the doctor for you.

Jane: Yes. I’d like that.

Health visitor: I need to make a record of your visit today. Our record is confidential and Bob would not see it, as it is your information not his.
Handout 4F
Improving Record Keeping
Always keep a detailed record of what you have discussed with a woman – even if your suspicions of domestic abuse haven't led to disclosure. They might in the future.

Her consent is not required to record, although you may assure a patient no action will be taken without her consent unless children at risk.

Explain the potential benefits to her of making a record, including providing support for future action she might want to take e.g. accessing legal, welfare or housing rights.

Document the time, date, place of assault(s) and any witnesses, including children.

Keep records as detailed as possible. ‘Patient states she was kicked twice in stomach by husband’ is better than ‘patient assaulted’. Diagnostic codes for domestic violence will be included in Electronic Patient Records (due to go live late 2005).

Use the patient’s own words (with quotation marks) rather than your own.

Avoid subjective information when woman blames herself e.g. It was my fault that he…

If the woman denies an assault, but her injuries are inconsistent with her explanation, your suspicion should be written down.

Record the size, pattern, age, description and location of injury using a body map and photograph if possible (and if possible, the woman should sign and date the photo on the back). Photographs as proof of injuries must be taken with a Polaroid camera.

Record any non-bodily abuse e.g. torn clothes, destruction of belongings, behaviour of perpetrator, ongoing harassment/stalking, threats, behaviour to children or animals.

Record victim’s perception of situation, including whether she believes perpetrator may seriously injure her and/or children.

Record previous episodes of violence and effects.
Record names, ages of children; where children were during incidents and how woman thinks they were affected; name of health visitor.

Ensure records are kept safely: never left where a partner or someone else can see them. To ensure confidentiality, you should record domestic abuse separately from the main patient record and ensure that the record can only be accessed by those directly involved in her care. Domestic abuse should never be recorded in handheld notes, such as maternity notes.

In Accident and Emergency, for medical legal reasons, it is necessary to identify a person experiencing abuse and her relationship to her abuser but not the name of the abuser.

In General Practice domestic violence records must be seen in the context of the whole health record, to get a clear understanding of repeat consultations for health problems connected to the abuse. However, practices that encourage handheld records should record abuse separately.

If your organisation has computerised records, ensure that nothing about domestic abuse is visible on the opening screen (which could be seen by a perpetrator or a member of staff who doesn’t need to see information about the abuse). If routine enquiry is practised, devise a code to indicate whether the question has been asked, when it was asked and what the outcome was – to alert staff to potential risks.

You should adhere to the processes and documentation for recording domestic abuse that your Trust has put in place.

**What to include in notes**

- Ethnicity;
- Whether routine enquiry has been undertaken;
- Response to routine or selective enquiry – if used;
- Relationship to perpetrator;
- Whether the woman is pregnant;
- The presence of children in the household;
- Nature of abuse and injuries – if any exist;
- Description of all kinds of domestic abuse experienced and reference to specific incidents;
• Whether this is the first episode. If not, how long has it been going on and how regularly?
• Presence of enhanced risk factors;
• Indication of information provided on local sources of help; and
• Indication of action taken (for example direct referrals).
The importance of photographs

Photographic evidence can

- Provide crucial evidence in a criminal prosecution. It can capture the results of an attack;
- Support a victim's testimony; often vital when there are no witnesses and the allegations are denied by the perpetrator;
- Refresh a victim's memory, particularly if she has minimized the injury sustained or a long time has elapsed;
- Encourage a prosecution and/or a guilty plea;
- Contradict the evidence of the perpetrator who may minimize his action (e.g. say it was a slap) when the injury sustained was a black eye (more consistent than a punch);
- Provide evidence in civil proceedings e.g. application for supervised contact with children.

Protocol for photography

Items needed: Consent form; Towel or blanket; Camera and film; instructions for camera, Folder to contain photographs

1. Explain to the woman the purpose of the photographs, where they will be kept, who has access. Explain it is her choice which parts of her body and injuries are photographed, and that they will never be used without her written permission. Ensure privacy and sufficient time for reassurance.

2. Choose a room with a wall that can act as a clear background that is free from clutter, major shadows or reflections. Adjust lighting to minimize shadow or casts. Familiarise yourself with the camera and take a test picture to ensure the camera works and the lighting is correct. Lean on a desk or against wall to hold camera steady if need be.

3. First picture: full face & body to enable the woman to be identified.
   
   Second picture: mid-range to locate the injury.

   Third picture: close-up to show size/extent of injury (can place a size gauge eg a coin close by).
Take each injury separately, making sure the part of the body can be identified.

Ensure the woman remains as fully clothed as possible, only revealing the part of body that enables injury to be seen. Use a towel or blanket to cover other parts of body.

4. Leave photos to dry. Mark which is top and bottom on each photo and body part eg top right leg

Each photo must be signed & dated by the photographer in a place that does not deface the picture.

5. Show the photos to the woman and check she is satisfied with the results. Ask if she has any questions. File the dry photos in an envelope marked photographs, secured in medical records
Handout 4H

Sample routine enquiry form 1
Please ensure the woman is alone and cannot be overheard before completing this form

Patient number……………………..DOB (dd/mm/yy)…./…. Date (dd/mm/yy)…./….…..

Ethnicity (circle relevant number)
1. White UK 2. White Irish 3. White other (please specify)……………………………..
7. Black other (please specify)……………………………………………………………
11. Asian other (please specify)……………………………………………………………..

Suggested enquiry
Research shows that one in four women experience domestic violence at some point in their lives, so we are now routinely asking every woman these questions.

Please circle according to patient’s response
As an adult have you ever been emotionally or physically abused by your partner or someone important to you? Yes No
(If yes) Did the abuse occur in the last 12 months? Yes No
(If yes) Who hurt you? (relationship)…………………………………………………………
How often? .......................................................................................

Action
Please tick boxes according to action taken
- Telephone referral made (or patient given phone to speak to any of following)
- Freephone 24 hr. National Domestic Violence Helpline run in partnership between Women’s Aid and Refuge (0808 2000 24 7)
- Police Community Safety Unit/Domestic Violence Unit
- Hospital Social Worker
- Child Protection
- Social Services Tel. No. ……………………….. Contact name…………………………
- Health professional (e.g. Health Visitor, Xray) please specify name and contact no……..
- Patient declines referral

Tick information provided to patient
- Freephone 24 hour National Domestic Violence Helpline number given
- Local resources related to domestic violence
- Information booklet
- Telephone number card
- Use of telephone
- Patient declines information

Signature……………………………… Print Name…………………………………………………. Position …………………………………………………………………………………
Sample form following disclosure of domestic violence

Please ensure the woman is alone and cannot be overheard before completing this form

Patient number……………………DOB (dd/mm/yy)….../….. Date (dd/mm/yy)….../…..

Incident of abuse
Date of incident……………………Time of incident…………………… Place………………………….. Perpetrator’s relationship to victim ……………………………………………………………………….. Witnesses………………………………………………………………………………………………………

Injury

(insert body map – front and back views)
Indicate injuries on body map and use key
1. Amputation
2. Bite mark
3. Bleeding
4. Bruising
5. Burn
6. Foreign body (specify)
7. Fracture
8. Gun shot wound
9. Laceration
10. Pain
11. Puncture
12. Reddened
13. Stab wound
14. Swelling/deformity
15. Tear
16. Other (please specify)

Photos
Was written consent obtained (see below)? Yes No
Are photos signed, dated, identified, attached to notes? Yes No
Consent For Photography

I, ...........................................................................(name of patient), consent to have photographs taken of my injuries. I understand that these will be kept securely in my medical records. I understand that these photographs will not be released without my written permission.

Signature of patient......................................................................................................................

Signature of photographer .........................................................................................................

Position of photographer ...........................................................................................................

Date (dd/mm/yy) ........../....../........

Patient's explanation of injury and cause
....................................................................................................................................................
....................................................................................................................................................
....................................................................................................................................................

Professional opinion of causation of injury & (in)consistency with patient’s explanation
....................................................................................................................................................

Frequency & severity of all forms of current abuse (physical, emotional, sexual, financial, social, threats made) as described by patient
....................................................................................................................................................
....................................................................................................................................................

Frequency & severity of all forms of past abuse as described by patient
....................................................................................................................................................

Emotional state e.g. in tears, fearful
....................................................................................................................................................

Non-bodily evidence (e.g. torn clothing; damage to room)
....................................................................................................................................................

Signature..........................................................Print Name..................................................

Position ................................................................Date..........................................................
Please complete the whole page whether or not you ask routinely about domestic violence.

<table>
<thead>
<tr>
<th>Name:</th>
<th>………………………………………………………………………</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth:</td>
<td>………………………………………………………………………</td>
</tr>
<tr>
<td>Hospital number:</td>
<td>………………………………………………………………………</td>
</tr>
<tr>
<td>Date of interview:</td>
<td>………………………………………………………………………</td>
</tr>
<tr>
<td>Midwife/nurse's name</td>
<td>………………………………………………………………………</td>
</tr>
<tr>
<td>Type of appointment:</td>
<td>antenatal booking, antenatal 7 months, post natal</td>
</tr>
</tbody>
</table>

Checklist prior to asking routine question(s) about domestic violence

1) **Can you be overheard?**
   - Yes □
   - No □ → 2
   - Do not introduce routine questions but complete Q. 2 and 3

2) **Is a professional female interpreter required?**
   - Yes □
   - No □ → 3
   - Is a professional female interpreter present?
     - Yes □
     - No □ → Do not question further but complete Q. 3

3) **Is the woman accompanied?**
   - Yes □
   - No □ → Begin the questions
   - a) By whom? Partner       Friend       Relative/family       Other ……………………
   - b) Did you manage to see the woman alone?
     - Yes □
     - No □ → Do not introduce questions
     - Begin questions

Introduction

"We have started to ask all women about domestic violence as a routine because we know it is common and it can sometimes increase during pregnancy. As in all midwifery/nursing care we maintain strictest confidence at all times; the only exception is if you choose to tell us that a child is being hurt. In that case we'd do everything possible to support you and your child(ren), but I may need to pass the information on, and get further help for you and the children. Have you got any questions?
"May I carry on?"

- Yes □
- No □

"Would you mind telling me why not?"
……………………………………………………………………………………………………
……………………………………………………………………………………………………
"You may be asked about this again, always when you are on your own. You don't have to answer then either. You can talk to a midwife/nurse at any time about problems with violence or anything else that is concerning you. We offer everyone these referral numbers as a routine. Is it OK to continue with your antenatal appointment and invite your partner/friend back in?"

<table>
<thead>
<tr>
<th>Yes</th>
<th>□</th>
</tr>
</thead>
</table>

As an adult, have you ever been emotionally or physically abused by your partner or someone close to you?  
Yes  No

(If yes) Did the abuse occur in the last 12 months?  
Yes  No
If yes, by whom? ……………………… Number of times……………

(If applicable) Did the abuse occur while you were pregnant?  
Yes  No
If yes, by whom? ……………………… Number of times……………

If no disclosure took place: "Thank you for answering the questions and you may be asked about this again, always when you are on your own. You can talk to a midwife/nurse at any time about problems with violence or anything else that is concerning you. We offer everyone these referral numbers as a routine. Is it OK to continue with your antenatal appointment and invite your partner/friend back in?"

If disclosure of abuse took place, please record response by nurse/midwife:

<table>
<thead>
<tr>
<th>Offered</th>
<th>Accepted by woman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td></td>
</tr>
<tr>
<td>Women's Health Counsellor</td>
<td></td>
</tr>
<tr>
<td>Freephone 24 hour National domestic violence helpline number given to woman</td>
<td></td>
</tr>
<tr>
<td>Use of telephone</td>
<td></td>
</tr>
<tr>
<td>Police Community Support Unit</td>
<td></td>
</tr>
<tr>
<td>Social Services</td>
<td></td>
</tr>
<tr>
<td>Other outcome</td>
<td></td>
</tr>
</tbody>
</table>
Handout 4I
Confidentiality Case Study
A man comes into your workplace. He appears upset and anxious. He tells you that he is very concerned about his partner who has left home with their child last week. He has heard from someone that she came down to see you before she left home. He says that his partner has been feeling a bit depressed lately and he is worried about her safety and the safety of the child.
He asks if you know, or can find out where she is and pass a message to her saying that he wants to see her.
Handout 4J
Guidelines for working with perpetrators of domestic abuse

Background and acknowledgements
These guidelines are part of ‘Domestic Abuse: A guide for healthcare staff in primary care’ published in draft form by South West Edinburgh Local Health Partnership.

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Introduction
You may encounter perpetrators of domestic abuse as patients, partners of patients or fathers/carers of children whom you know or suspect to be affected by domestic abuse. The approach you take will depend on whether a man is directly acknowledging his domestic abuse as a problem, is seeking help for a related problem or has been identified by others as abusive.

We suggest the following approach:

1. Look/listen
2. Ask
3. Assess risk
4. Respond
5. Refer
6. Record

1. Look/listen

Abusive men as patients
Some men may identify their abusive behaviour directly and ask for help to deal with their violence. This is likely to have been prompted by a crisis such as a particularly bad assault, an arrest or ultimatum from the abused partner. Such men – even though they have come voluntarily – are unlikely to admit responsibility for the seriousness or extent of the abuse, and may try to “explain” the abuse or blame
other people or factors. Even those who are concerned enough about the abuse to approach a health worker may present with other related problems such as alcohol, stress or depression, and may not refer directly to the abuse.

Some men may say they are victims of their (female) partner’s violence. While any such allegations must be treated seriously, research indicates that a significant number of male victims are also likely to be perpetrators of domestic abuse.

**Abusive men as partners of patients**
You may encounter men who insist on accompanying their partners to appointments or who want to talk for their partners. You may have patients whom you know to be abusive because their partners are also your patients and they have told you about it.

The normal standards of patient confidentiality and the overriding need to avoid any intervention that might increase risk to the woman, mean that directly engaging with an abusive man who is not your patient may be difficult. However, being aware of indicators of abuse is important for your dealings with the man.

**Abusing men as fathers of patients**
There are clear links between domestic violence and child abuse and we know more about the effects on children of witnessing domestic abuse. In your role as a health worker, you may know children affected by domestic abuse, and consequently the abuser. You may be in contact with him in clinics, in his home or at child protection case conferences. If the issue of the man’s violence has been openly stated as a cause of a child’s problem - for example as the reason for a child being on the child protection register – it may be appropriate and necessary to speak to him directly about his abusive behaviour.

**2. Ask**
Your response to any disclosure, however indirect, could be significant for encouraging responsibility and motivating a man towards change.

If the man presents with a problem such as drinking, stress or depression, for example, but does not refer to his abusive behaviour, these are useful questions to ask:

“How is this drinking/stress at work/depression affecting how you are with your family?”

“When you feel like that what do you do?”
“When you feel like that, how do you behave?”

“Do you find yourself shouting/smashing things…………?”

“Do you ever feel violent towards a particular person?”

“It sounds like you want to make some changes for your benefit and for your partner/children. What choices do you have? What can you do about it? What help would you like to assist you to make these changes?”

If the man has stated that domestic abuse is an issue, these are useful questions to ask:

“It sounds like your behaviour can be frightening; does your partner say she is frightened of you?”

“How are the children affected?”

“Have the police ever been called to the house because of your behaviour?”

“Are you aware of any patterns – is the abuse getting worse or more frequent?”

"How do you think alcohol or drugs affect your behaviour?"

“What worries you most about your behaviour?"

If a man responds openly to these prompting questions, more direct questions relating to heightened risk factors may be appropriate. Examples of more direct questions are:

"Do you feel unhappy about your partner seeing friends or family - do you ever try to stop her?"

"Have you assaulted your partner in front of the children?"

"Have you ever assaulted or threatened your partner with a knife or other weapon?"

"Did/has your behaviour changed towards your partner during pregnancy?"

The information you gather will be the basis for your decision about how best to engage and what kind of specialist help is required - either for the man or to manage risk.

3. Assess risk

It is important to assess risk before deciding what to do next. Although risk assessment is primarily informed by the woman’s experience and insights, there
may be other factors which you identify through your contact with or knowledge of the perpetrator. Research shows that there are significant indicators of heightened risk. You should consider these in deciding whether to undertake multi-agency consultation or risk management measures, together with agencies such as children and families social work, police domestic abuse liaison officers or other health practitioners. Some of these risk factors are static and some may be subject to change. Risk awareness should be a continuous process and risk assessments should be regularly reviewed.

4. Respond

Domestic abuse is a serious health issue and all health professionals involved have a role in providing good health care, which holds perpetrators responsible. Your response to the man and any disclosures could affect the extent to which he accepts responsibility for his behaviour and, therefore, for the need to change. You can say things to a perpetrator that make a difference and you can influence the situation.

In any dealings with perpetrators you should adopt the following good practice response. This is not a ‘cure’ or a ‘treatment’ but principles to observe within your own health care context, which are both safe and constructive.

**Good Practice in Dealing with Perpetrators of Domestic Abuse**

- Be clear that abuse is always unacceptable
- Be clear that abusive behaviour is a choice
- Affirm any accountability shown by the man
- Be respectful and empathic but do not collude
- Be positive men can change
- Be clear that you might have to speak to other agencies and that there is no entitlement to confidentiality if children are at physical or emotional risk
- Whatever he says, be aware that, on some level he is unhappy about his behaviour
- Be aware, and tell the man, that children are always affected by living with domestic abuse, whether or not they witness it directly
- Be aware, and convey to the man, that domestic abuse is about a range of behaviours, not just physical violence (see definition)
- Do not back him into a corner or expect an early full and honest disclosure about the extent of the abuse
- Be aware of the barriers to him acknowledging his abuse and seeking help (such as shame, fear of child protection process, self-justifying anger)
- Be aware of the likely costs to the man himself of continued abuse and assist him to see these
- If you are in contact with both partners, always see them separately if you are discussing abuse.

**Safety Planning with Man**

If the man has responded to your questions in a way which suggests that he is worried about his behaviour, and is ready to take responsibility for his need to change, it may be appropriate to start to discuss plans for keeping his partner safe from his abusive behaviour. Ask questions such as:

- "What kind of situations do you get worked up about?"
- "What are the physical sensations you can note when you are getting wound up?"
- "What are the feelings you have or the thoughts that come into your head during these times?"
- “What would your partner recognise in you at these times?”

Encourage the man to think about how he could use this knowledge about early signals to keep his partner or children safe in the future. It may be appropriate to discuss a ‘time-out’ plan with him for use when the warning signals are present, and he feels that he is becoming risky to her. This involves a man deciding, in advance, to remove himself from the high-risk situation for a time-limited period in order to keep his partner safe. If you discuss such ‘time-out’ strategies with him there are points you must emphasise:

- Time-out should only be used as an emergency measure to keep her safe; not to avoid hearing criticism
- He should discuss the plan with his partner in advance so that she knows its purpose and exactly what he will do
- He must decide (and she should know) how long he will leave for (usually one hour) and where he will go
- He must not drink and shouldn’t drive during the time-out
- He must not use time-out to rehearse and strengthen his own arguments.
Warning
We know that men can misuse the idea of ‘time-out’ to avoid arguments or to provide an excuse to leave a situation which they find uncomfortable and thereby to further disempower their partner. There is also a risk that using time-out might encourage men to see the problem simply as one of temper control. Before introducing the concept of time-out with a man you should judge the extent to which he is taking responsibility for the risk which he represents and about his likely level of commitment to keeping to any ‘rules’ which he may set himself.

At best, time-out is a short-term safety measure; it does nothing to address the attitudes and expectations which underpin men’s abuse.

Safety issues
- If you are the woman’s main support, he will probably see you as a threat. Be mindful of this in any contact with either partner
- If you are in contact with both partners, always see them separately when discussing violence and abuse
- If your information about the man’s violence comes only from the woman, you cannot use that to challenge the man. Her safety is paramount
- Do not attempt ‘couple work’ as this is likely to be ineffective or dangerous
- Be especially careful if he is under the influence of alcohol or other substances and do not engage with him about his violence at such times.

5. Refer
Specialist Services for Perpetrators of Domestic Abuse
The primary role of specialist services for perpetrators is to confront and tackle the violence.

The national Respect Phoneline (0845 122 8609) offers a clear, non-collusive response to men concerned about their abusive behaviour and advice on short-term strategies to prevent further abuse (see contact list).

Generic Services
It may be possible to refer a man to a generic service. The primary role of such a service is not to address the violence. While alcohol/substance use is neither an excuse nor a cause of domestic abuse there are links and, for some abusive men, it is appropriate to refer to alcohol/drug services. If you suspect that a man is
suffering from a mental health problem it may be useful to refer him to primary care mental health services (see contact list).

Some abusive men you encounter will have issues relating to past traumatic experiences and might benefit from a referral to a general counselling/psychotherapy service. However there is a risk that focusing on such issues may allow the man to avoid responsibility for his current behaviour and attitudes - especially if such a service is provided in the absence of a specialist domestic abuse perpetrator programme. You should be aware of this in making any referral and should, in any case, continue your involvement with the man in line with the good practice approach outlined above.

**Multi-agency response**

The purpose of attempting to engage with an abusive man is not simply the hope of assisting him to change his attitudes and behaviour, but to ensure that his behaviour and his responsibility for it, are at the centre of a multi-agency response. Some men will not change even if they have the opportunity to attend a perpetrator programme.

Communication with other agencies involved with a family is important and, when children are involved, essential. If a man refuses to engage, or does not change his abusive behaviour, the response of other agencies involved with that family may need to change in response to this. For example, risk management measures may need to be put in place or changes made to safety plans for the woman.

**6. Record**

It is important to keep detailed records if a man discloses abusive behaviour. This is important health information which will enable continuity of care. Good records may also help in any future legal proceedings which the woman or the police may take.

Record the information and file in his case notes. Remember that medical records are strictly confidential. However, if an individual, especially a child may be at risk of significant harm, this will override any requirement to keep information confidential. You should explain this to the man.
**Indicators of Abuse**

A man who is worried about his abusive behaviour may present in the following ways:

- I’ve got a problem with drink
- I need anger management
- I’m not handling stress at work
- My wife says I need to see you
- My wife and I are fighting a lot
- My wife and I need counselling
- My wife is not coping and taking it out on me
- The kids are out of control and she’s not firm enough
- I’m depressed/anxious/stressed/not sleeping/not coping/not myself
- I feel suicidal (or have threatened or attempted suicide)
- I’m worried about my rage at work, in the car, in the street, at the football.

Additional indicators to be aware of:

- Attempts to accompany or speak for women partners
- Sexual jealousy or possessiveness
- Psychotic/manic/paranoid symptoms
- Substance use/dependence

Although rare, a man might present with a physical injury such as a hand injury caused by punching, or you might notice injuries caused by the woman defending herself such as scratch marks.
Module Four

Professional Issues

Training Guide
5. PROFESSIONAL ISSUES

5.1 Introduction

This section of the training manual is aimed mostly at managers and those with responsibility for policy development. It can also be used to help train professionals in the referral of women and children at risk to specialist services. The main focus is on how to develop local policy and partnership working.

5.2 Self Assessment

HEVAN\(^7\) has adapted an American instrument\(^2\) for assessing services for women and children affected by domestic abuse. The tool can be used by managers to raise awareness and assess service provision. The tool can be used to assess the whole Trust/organisation, or a department or a particular team or service (whichever is the most relevant). Repeated use will enable managers to assess service development against a baseline. The self assessment tool is included in Handout 5.A. and can be given to delegates to complete.

The trainer can facilitate a discussion on the self assessment tool:

Did the tool reveal any gaps in service or any practice issues that should be addressed?

What would be the priorities for action and policy development?

What is needed to take this forward?

What resources could be used to help with this?

What other agencies could be involved?

For further information on policy guidance and staff support see Responding to Domestic Abuse.

\(^7\) The HEVAN (Health Ending Violence and Abuse Now) forum aims to promote work with health care practitioners to identify, support, document, provide information and positive choices to survivors of domestic violence.

\(^2\) Jeff Coben and the Agency for Healthcare Research and Quality (AHRQ) 2004 Delphi Instrument for Hospital-Based Domestic Violence Programs.
5.3 Multi-Agency and Partnership Working

Introduction
A multi-agency approach is widely accepted as the best way to approach domestic abuse issues. It is strongly recommended by Government. In April 2004, Primary Care Trusts were given the statutory duty to work in partnership with other agencies in Crime and Disorder Reduction Partnerships (CDRP) to reduce crime. This includes:

- providing anonymised data for the CDRP audit;
- signing up to local information sharing protocols;
- actively promoting advice on information sharing in line with the Home Office’s *Safety and justice: sharing information in the context of domestic violence*;
- displaying or giving out information about support services for victims of domestic abuse;
- developing and implementing a domestic abuse policy;
- training staff to understand and implement the domestic abuse policy;
- developing domestic abuse services – either alone or in partnership with other agencies.

Where possible, the trainer might take a list of local sources of support, and laminates of leaflets from available from national referral agencies (such as Women’s Aid, Refuge or the Home Office) and local agencies for delegate’s use at work. Emergency cards and posters could be distributed to delegates. Where time permits, the role of each agency could be explained, or representatives invited to speak for 10 minutes.

The trainer might ensure that information about the following sources of support are included:

**Police** 999; Community Safety Units or Domestic Violence Units; Victim Support; Witness Services

**Accommodation** agencies: Housing Department, Homeless Persons Unit, refuges

**Solicitors:** (specialising in child & family) for injunctions, orders, contact issues, immigration

**Counselling** services
**Domestic violence** services – Women’s Aid, Refuge, local help-lines, outreach services, community one-stop shops, advocacy services

**Voluntary sector** services e.g. Samaritans, advocacy services, Citizen’s Advice Bureau, rape crisis services, Mind, Lone Parents etc.

**Specialist support** services for ethnic minorities; for refugees and asylum seekers; for gay and lesbian people; and interpreting services

**Social Services** if children within family or a young vulnerable adult, CAMHS, Sure Start.

**Services for Perpetrators:** Perpetrator programmes; Respect helpline.

It might be appropriate for the trainer to say whatever the agency, women might be asked to provide information to explain their situation, such as proof of identity, income, property details (e.g. rent book), solicitors letters, crime reference numbers or court orders, addresses of previous homes. Part of their safety planning may include deciding where to keep these documents.

**Identifying local support (10-15 minute exercise)**

**Aims:** To pool knowledge of sources of help in local area.

**Materials:** Flipchart completed by trainer or participants or give out sheets in which there is a central circle (about the size of a coin) to represent the woman, surrounded by eight circles of similar size joined by lines to the central circle.

**Method:** Ask participants to enter one agency in each circle around the woman to represent to whom she might turn for support locally.

**Identifying local partners (10 minute exercise)**

**Aims:** To raise awareness about agencies in local community; to encourage participants to consider referral

**Materials:** case study Handout 5. A

**Method:** small group discussion
Trainer’s Notes
Suggestions might include:

Client a) Homestart (for a befriender matched for ethnicity)

Local woman’s group e.g. Asian family resource centre, Bengali women’s group

GP for documentation of experience/injuries for use as future evidence

A&E for urgent treatment of injuries if required and documentation to promote future access to rights

Local or National Domestic Violence Help-line (accessing Language Line)

Client b) Advice centre for advice and assistance on debt management (advise her to take her account details, statements, outstanding bills)

Citizen’s Advice: for advice on options open to her and benefits entitlement

Local group e.g. local church group with volunteers able to assist ‘needy’ families

Client c) Social Services

Domestic Violence help-line or local outreach group

Client d) Child & Family consultation service: for specialist consultation

School nurse; for advice on management of enuresis

Domestic Violence help-line information

The following sections outline information about the role of specific agencies with respect to domestic violence. They could be used in presentations, as discussion topics, or in handouts

The Police Role
- To hold perpetrators of domestic violence accountable, since domestic violence is a crime
- to protect the individual from further attack
- to take positive action against the perpetrator which may include arrest
- to give details of other agencies which can offer immediate or continuing support
- should speak to woman in a separate room from person who was violent

**Police powers**
- to enter a house without a search warrant to prevent a breach or the peace or injury
- can be invited into a house by an occupier, which cannot be withdrawn by another person while the complaint is being investigated
- can arrest any person reasonably suspected of committing an offence if it is necessary to prevent that person from injuring someone

**Additional help**
- support to women and children experiencing domestic violence
- woman police officer available
- will arrange medical assistance if needed and wanted
- arrange for a safe place to stay and transport if needed
- accompany a woman home under police protection to collect her belongings
- provide follow-up support and advice from a police officer, including information about case developments and legal rights (civil and criminal)
- provide personal alarms, links to station or advice on security
- to gather evidence which may include interviews, photographs of the scene

**Crown Prosecution Service (CPS)**
CPS is a public service and a national organization to prosecute cases begun by the police.

Their role is to

- To help reduce crime and the fear of crime
- To increase public confidence in the criminal justice system
- To help firm, fair and effective prosecution at court
- To help women experiencing domestic violence give their best evidence by applying for special measures for intimidated witnesses, such as screens in court to separate the woman from the abuser, videotapes or statements for use as evidence
See the Crown Prosecution Service
www.cps.gov.uk/publications/prosecution/domviolencepol.html and
www.cps.gov.uk/publications/docs/dv_protocol_goodpractice.pdf or Home Office
website www.homeoffice.gov.uk for recent CPS policy on domestic violence.

Solicitors
Anyone experiencing domestic violence may wish to see a solicitor or get legal
advice about civil means to protect herself or children from abuse. A solicitor can
assess whether a woman is eligible for public funding at the first meeting. She does
not have to pay for legal advice if she is claiming Income Support or Family Credit.
A solicitor can advise women on their financial rights. Any woman experiencing
domestic violence may need information about injunctions (court orders which
forbid the abuser from doing certain things). The type of injunction depends on the
relationship of the abuser to the victim and the court. These orders can be granted
within 24 hours, without the perpetrator being present if the woman and children
are at risk. They include

Non-molestation Order: for ‘associated’ persons (who are or were married, co-
habitating, part of the same household, relatives, engaged within the last three years,
parents of or responsible for the same child). The order will forbid the abuser to ‘to
use or threaten violence against’ (a woman, or the children) or to ‘harass,
intimidate or pester’.

Occupation Order: decides how a property is occupied, and by whom. Women
can apply if they are a single or joint owner, tenant or have a legal right to be there;
or their current or former spouse or partner has the right. If women were
cohabiting, but not married, they have no automatic rights of occupation, but can
apply if experiencing domestic violence. The court can order the abuser to be
excluded and forbid him to enter, try to enter or come within a certain distance of
the property.

Protection from Harassment: A woman can apply under the PHA for protection
against anyone, including a stranger. Harassment is deliberately not defined other
than as ‘harassing a person’ and includes ‘alarming the person or causing the
person distress’. It could be something personal, such as leaving flowers on the
doorstep, if that frightens the woman.

Other orders include:
**Parental Responsibility (PR) Orders:** Parental responsibilities include all the duties, powers and responsibilities of a parent of a child under 18, such as deciding a child’s names, school, religious education, medical treatment and whether or not they have a passport or leave the country. If a woman does not want the father to have or seek PR, she should get good legal advice from a solicitor who specializes in child and family law and domestic violence.

**Residence Orders:** settle the person with whom a child will live, and who makes day to day decisions about them. It does not dictate a place where the child should live, can be shared between people and applies until the child is 16.

**Contact Orders:** require the person with whom the child lives to allow the child to contact, visit or stay with another named person. It might specify overnight stay, telephone or email contact.

Although women may have wanted a good relationship between the child and their father, they may find that contact is used to undermine, harass, threaten or abuse. The child may also be at risk, because

- abuse of women is closely associated with increased likelihood of the perpetrator directly abusing his child
- post separation is a time of heightened danger, and
- contact may be the first time the perpetrator has had sole adult responsibility for his child.

**Temporary Housing**
Women who have to leave their home due to domestic violence can make a homeless application to a local housing department’s Homeless Persons Unit (HPU), which is run by the borough council. If it is an emergency, out of hours, rather than asking women to attend for interview, they may offer emergency accommodation or a refuge, not necessarily within the local area. The local housing department may also be able to give advice on how to remain in or return to the home without the perpetrator and get support to be safe. Shelter, a national charity, has a help-line whose staff can advise on local options. The 24-hour Domestic Violence help-line can also make calls for women in crisis.

**Refuges**
Refuges are crisis accommodation for women and children escaping domestic violence. Refuges vary, but have in common the offer of help and a place to stay
with other women and children escaping domestic violence. Each family (woman and children) has their own room, probably with shared kitchen, lounge and bathroom facilities. Staff are available to offer support and offer information about options and to help access welfare, housing and legal rights. Refuges prioritise safety and security, with secret addresses and telephone numbers. Men are not allowed to know the number, address, or visit the house, for the safety of women and children at risk. The charge to stay there may be covered by women’s rights to benefits or by Social Services. There are some specialist refuges for women from ethnic minorities. The shortage of longer-term accommodation, particularly in specific areas of London, can mean a stay from a few months for up to two years.

**Jobcentre Plus/Benefits Agency**

Jobcentre Plus may also be called the Benefits Agency or Social Security office. If a woman has been financially dependent on her partner, or he has controlled her access to finances, she may be able to claim benefits at the Jobcentre Plus (or she can seek the advice from a solicitor or voluntary agency). When she makes a claim, she is likely to be required to attend an interview with a Personal Advisor or an officer from Jobcentre Plus might visit her. The interview is to assess her needs, claim and circumstances before benefits can be calculated and paid.

**Social Services**

Can provide a range of services to support families where abuse has occurred including parenting support, nursery places, help where there is special need and funds to help with accommodation or basic needs for women without recourse to public funds. Whenever possible, social workers promote the upbringing of children within their own families

**Victim Support Witness Service**

The Witness Service, run by Victim Support, is in every Crown Court and some Magistrates courts. Staff can give information and support about the court process before, during and after the trial. They can arrange a visit to the court beforehand; offer to accompany a woman, give practical help with forms and liaise on her behalf with the police and the court. They can organise her arrival at court through a separate entrance, safe waiting facilities and a chance to re-read her statement before the trial.
**Domestic Violence Workers**

Domestic violence workers may offer outreach support to women living at home who are at risk or who are recovering from the effects of domestic violence. They may advocate for legal, welfare and housing rights and offer emotional and practical support. To find local workers, contact the free national 24 hour domestic violence help line on 0808 2000 247.
Module Four

Professional Issues

Handouts
Domestic Violence Services in Healthcare Settings

Instructions for self-assessment

HEVAN8 has adapted an American instrument2 for assessing services for women and children affected by domestic violence. The tool can be used to raise awareness and assess your service provision.

The tool can be used to assess the whole Trust/organisation, or your department or team or service (whichever is the most relevant). Repeated use will enable you to assess service development against your baseline.

Your details

Department/Team/Service: ________________________________
(delete as appropriate)

Trust/organisation: ________________________________
(delete as appropriate)

Date: ________________________________

Name: ________________________________

Job title: ________________________________

This is a self-assessment tool, but HEVAN aims to collate responses to provide a national picture. To help us build a complete picture as possible, please send a copy of your completed tool to Loraine Bacchus loraine.bacchus@kcl.ac.uk F: 020 7620 1227 Women’s Health Academic Unit, 10th Floor North Wing, St. Thomas’ Hospital Lambeth Palace Road London SE1 7EH.

8 The HEVAN (Health Ending Violence and Abuse Now) forum aims to promote work with health care practitioners to identify, support, document, provide information and positive choices to survivors of domestic violence.

2 Jeff Coben and the Agency for Healthcare Research and Quality (AHRQ) 2004 Delphi Instrument for Hospital-Based Domestic Violence Programs.
1. Policy and Procedures

1.1. Is there a written policy related to domestic violence in your department/team/service?
☐ Yes ☐ No ☐ Don’t know

1.2. Are there written procedures or guidelines related to domestic violence in your department/team/service?
☐ Yes ☐ No ☐ Don’t know

1.3. Do the policies or guidelines:
   i. define domestic violence ☐ Yes ☐ No ☐ Don’t know
   ii. recommend routine enquiry ☐ Yes ☐ No ☐ Don’t know
   iii. address documentation of domestic violence ☐ Yes ☐ No ☐ Don’t know
   iv. address safety planning ☐ Yes ☐ No ☐ Don’t know
   v. specify information on sources of appropriate support ☐ Yes ☐ No ☐ Don’t know
   vi. address child protection requirements ☐ Yes ☐ No ☐ Don’t know
   vii. make staff training on domestic violence compulsory ☐ Yes ☐ No ☐ Don’t know
   viii. cover responding to employees who disclose they are suffering domestic violence ☐ Yes ☐ No ☐ Don’t know
   ix. cover protecting employees experiencing domestic violence from their perpetrator while at work ☐ Yes ☐ No ☐ Don’t know
   x. cover responding to staff who are perpetrators of domestic violence? ☐ Yes ☐ No ☐ Don’t know

1.4. Does your occupational health service have policies for supporting employees experiencing domestic violence?
☐ Yes ☐ No ☐ Don’t know

1.5. Is there an identified practitioner within your service, team or department taking the lead on services related to domestic violence? (please tick one option)
☐ No ☐ Don’t know ☐ Yes, a full time position responsible solely for services related to domestic violence

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9 By ‘written policy’ we mean a written statement of strategic aims and objectives
10 Related to direct patient-professional interaction in day to day practice or delivery of services
Yes, a part time position responsible solely for services related to domestic violence
Yes, but domestic violence is only part of the responsibilities of the post
2. Asking about women’s experience of domestic violence

2.1. Is there a policy for mandatory routine enquiry in your department/team/service\textsuperscript{11}?

- [ ] No  \hspace{1cm} \textit{Please go to question 2.6}
- [ ] Don’t know  \hspace{1cm} \textit{Please go to question 2.6}
- [ ] Yes  \hspace{1cm} \textit{Please continue below}

2.2. Does the policy on routine enquiry require staff to be appropriately trained before implementing routine enquiry?  

- [ ] Yes  
- [ ] No  
- [ ] Don’t know

2.3. Does the policy require universal routine enquiry of all unaccompanied women coming into your department?  

- [ ] Yes  
- [ ] No  
- [ ] Don’t know

2.4. Does the policy specify seeing women alone to ensure privacy for routine enquiry?  

- [ ] Yes  
- [ ] No  
- [ ] Don’t know

2.5. Do you record whether or not a woman is asked about domestic violence?  

- [ ] Yes  
- [ ] No  
- [ ] Don’t know

If yes, how do you record it? \hspace{1cm} 

2.6. Do you record if a woman discloses domestic violence?  

- [ ] Yes  
- [ ] No  
- [ ] Don’t know

If yes, how do you record it? \hspace{1cm} 

2.7. Are there procedures in place to audit patient records for routine enquiry?  

- [ ] No  \hspace{1cm} \textit{Please go to question 2.9}
- [ ] Don’t know  \hspace{1cm} \textit{Please go to question 2.9}
- [ ] Yes  \hspace{1cm} \textit{Please continue below}

2.8. When was the last audit of routine enquiry within the department/team/service?  

- [ ] more than one year ago  
- [ ] 6-12 months ago  
- [ ] in the last six months

- [ ] Don’t know  
- [ ] Other, please specify: \hspace{1cm} 

2.9. Are there positive reinforcers to promote routine enquiry (such as recognition of individuals with high rates of routine enquiry)?  

- [ ] Yes  
- [ ] No  
- [ ] Don’t know

2.10. Are supervisors required to discuss routine enquiry with each member of staff?  

\textsuperscript{11} By routine enquiry we mean aiming to ask all women about experience, if any, of domestic violence, on her own in a private and confidential area, with a female interpreter if necessary. The aim of routine enquiry is to facilitate, and not force, disclosure. It must remain the woman’s choice as to if, when, and to whom, she discloses.
2.11. Is there a standardised form for documenting known or suspected cases of domestic violence?

☐ Yes  ☐ No  ☐ Don’t know

2.12.a. What percentage of women patients seen by your department/team/service have experience of domestic violence? ________

2.12.b. Is this figure (please tick one option only):

☐ an estimate based on a sample audit
☐ the result of routine data collection
☐ source of figure unknown

3. Resources

3.1.a. Are there any posters about domestic violence on public display in the site(s) where your department/team/service is based?

☐ No  ☐ Yes

3.1.b. Are there any posters about domestic violence in the women’s toilets at the site(s) where your department/team/service is based?

☐ No  ☐ Yes

3.2. Are there leaflets giving information about domestic violence on display and available to the public at the site(s) where your department/team/service is based?

☐ No  ☐ Yes

3.3.a. Are the posters on domestic violence available in languages other than English?

☐ Yes  ☐ No  ☐ Don’t know  ☐ Not applicable: no posters

3.3.b. Are the leaflets on domestic violence available in languages other than English?

☐ Yes  ☐ No  ☐ Don’t know  ☐ Not applicable: no leaflets

3.4.a. When women do not speak English as a first language, does your department/team/service arrange for interpreters (not family members or friends)?

☐ Yes  ☐ No  ☐ Don’t know

3.4.b. Do you arrange a female interpreter for women for whom English is not their first language?

☐ Yes  ☐ No  ☐ Don’t know
3.4.c. Does your department/team/service access the National Interpreting Service or Language Line?  
☐ Yes  ☐ No  ☐ Don’t know  

3.5. Have you or a colleague ever assessed the staff’s knowledge of and attitudes to domestic violence within the department?  
☐ Yes  ☐ No  ☐ Don’t know  

4. Department/Team/Service Training and Support on Domestic Violence  

4.1. Is there any training on domestic violence for staff in your department/team/service?  
☐ No  ☐ Don’t know  Please go to Section 5  
☐ Yes  Please continue below  

4.2. How often is basic training on domestic violence delivered? (please tick one)  
☐ Once/year  ☐ Once/quarter  ☐ Once/month  
☐ Don’t know  ☐ Other, please specify:__________________________  

4.3. How long does basic training last for? (please tick one)  
☐ 2 hours or less  ☐ ½ day  ☐ 1 day  ☐ 2-5 days  
☐ Don’t know  ☐ Other, please specify:__________________________  

4.4. Is the basic training specific to your team/department/service?  
☐ Yes  ☐ No  ☐ Don’t know
4.5. Does the basic training on domestic violence include information about:

i. definitions of domestic violence [ ] Yes [ ] No [ ] Don’t know

ii. social context of domestic violence [ ] Yes [ ] No [ ] Don’t know

iii. myths and stereotypes about domestic violence [ ] Yes [ ] No [ ] Don’t know

iv. prevalence [ ] Yes [ ] No [ ] Don’t know

v. health consequences [ ] Yes [ ] No [ ] Don’t know

vi. strategies for routine enquiry, including how to ask direct questions about experience of abuse [ ] Yes [ ] No [ ] Don’t know

vii. assessment of risk [ ] Yes [ ] No [ ] Don’t know

viii. documentation [ ] Yes [ ] No [ ] Don’t know

ix. how to support following disclosure or identification [ ] Yes [ ] No [ ] Don’t know

x. information on local and national sources of specialist help [ ] Yes [ ] No [ ] Don’t know

xi. safety planning [ ] Yes [ ] No [ ] Don’t know

xii. confidentiality boundaries [ ] Yes [ ] No [ ] Don’t know

xiii. child protection [ ] Yes [ ] No [ ] Don’t know

xiv. an overview of legal, welfare and housing rights [ ] Yes [ ] No [ ] Don’t know

xv. equal opportunities [ ] Yes [ ] No [ ] Don’t know

xvi. clinical signs and symptoms [ ] Yes [ ] No [ ] Don’t know

xvii. mechanisms for responding to needs of staff in relation to domestic violence [ ] Yes [ ] No [ ] Don’t know

4.6. During the past year, has the department/team/service provided training on domestic violence as part of mandatory induction procedures? [ ] Yes [ ] No [ ] Don’t know

4.7. During the past year, has the department/team/service provided training on domestic violence as part of continuing professional education? [ ] Yes [ ] No [ ] Don’t know

4.8. Is there a system of clinical supervision for staff in the department? [ ] No Please go to question 4.11 [ ] Yes Please continue below
4.9. Does clinical supervision recognise the particular needs and issues for professionals working with women and children experiencing domestic violence?

☐ Yes ☐ No ☐ Don’t know

4.10. Are supervisors trained in supporting professionals working with women and children experiencing domestic violence?

☐ Yes ☐ No ☐ Don’t know

4.11. Do supervisors receive specialist training on trauma and domestic violence?

☐ Yes ☐ No ☐ Don’t know

4.12. Are there systems for providing staff with emotional support for their work with women and children experiencing domestic violence?

☐ Yes ☐ No ☐ Don’t know

If yes, please specify (tick all that apply)

☐ Informal/peer ☐ Formal with supervisor ☐ Occupational health

☐ Other, please specify: ____________________________

5. Ensuring safety

5.1 Is there a standardised safety assessment form that is used when a woman discloses domestic violence?

☐ Yes ☐ No ☐ Don’t know

5.2. Are there written procedures to ensure the safety of women and children when domestic violence is identified?

☐ Yes Please continue below

☐ No Please go to Section 6

☐ Don’t know Please go to Section 6

5.3. Are there written procedures to ensure the safety of staff when domestic violence is identified?

☐ Yes ☐ No ☐ Don’t know

5.4. Are there written procedures for giving information and contact details for voluntary sector services (e.g. refuges or community support)?

☐ Yes ☐ No ☐ Don’t know

5.5. Are there supplementary or specific written procedures on confidentiality regarding names & location of victims of domestic violence while they are on the premises where your team/department/service is based?

☐ Yes ☐ No ☐ Don’t know
6. Documentation

6.1 Is there a standardised form for documenting known or suspected cases of domestic violence?

☐ No  Please go to question 7
☐ Don’t know  Please go to question 7
☐ Yes  Please continue below

Does the form include:

a) the woman’s response to being asked about domestic violence?  ☐ Yes  ☐ No  ☐ Don’t know
b) the woman’s account of current and/or past abuse?  ☐ Yes  ☐ No  ☐ Don’t know
c) the name of the alleged perpetrator and the relationship to the woman?  ☐ Yes  ☐ No  ☐ Don’t know
d) a body map picture to document the location of injuries?  ☐ Yes  ☐ No  ☐ Don’t know
e) information about referrals provided to the woman?  ☐ Yes  ☐ No  ☐ Don’t know
f) information about whether or not the woman accepted referral information?  ☐ Yes  ☐ No  ☐ Don’t know
g) information about safety plans developed with the woman?  ☐ Yes  ☐ No  ☐ Don’t know
h) Are photographs used?  ☐ Yes  ☐ No  ☐ Don’t know

7. The wider picture: the Trust/organisation and Inter-agency involvement

We are aware that you may not know the answers to some of the following questions. Please answer to the best of your knowledge.

7.1. Is there a written policy related to domestic violence for your whole Trust/organisation?

☐ Yes  ☐ No  ☐ Don’t know

7.2. Are there procedures or guidelines related to domestic violence for the whole Trust/organisation?

☐ Yes  ☐ No  ☐ Don’t know
7.3. Is there someone taking the lead within the Trust/organisation on services related to domestic violence? (please tick one option)

- No
- Don’t know
- Yes, a full time position responsible solely for services related to domestic violence
- Yes, a part time position responsible solely for services related to domestic violence
- Yes, but domestic violence is only part of the responsibilities of the post

7.4.a. Is your Trust/organisation working with other organisations on domestic violence issues?

- Yes
- No
- Don’t know

7.4.b. If yes, are you developing/have you developed a joint domestic violence policy and associated protocols?

- Yes
- No
- Don’t know

7.5. Are there any protocols on information sharing about domestic violence across the health sector in your area?

- Yes
- No
- Don’t know

7.6 Is there an inter-agency domestic violence forum (DVF) in your area?

- No
- Don’t know
- Yes

7.7. Has the Trust/organisation been involved in the DVF (over the last 12 months)?

- No
- Don’t know
- Yes

7.8. Is there a Crime & Disorder Reduction Partnership (CDRP) or Crime Reduction Partnership in your area?

- No
- Don’t know
- Yes

Thank you, there are no further questions

Please continue below
7.9. Is your Trust/organisation represented in this partnership?

☐ No
☐ Don’t know
☐ Yes

Thank you, there are no further questions.

If there are any further details you would like to add about how your Department/team/service or Trust/organisation is tackling the issue of domestic violence please add these below:

This is a self-assessment tool, but HEVAN aims to collate responses to provide a national picture. To help us build a complete a picture as possible, please send a copy of your completed questionnaire to Loraine Bacchus loraine.bacchus@kcl.ac.uk (Tel: 020 7620 1227) or by post to: Loraine Bacchus, Women’s Health Academic Unit, 10th Floor North Wing, St. Thomas’ Hospital Lambeth Palace Road London SE1 7EH. Your name and site will be treated as confidential. If you contribute your data to our national analysis, HEVAN will send you anonymised national findings for comparison purposes. Please provide your contact details so we can send you the national analysis. Please note that in order to provide this analysis we need to receive at least 50 completed tools. This may take some time.

Your contact details so that we can return the national analysis:
Handout 5B
Partnership working

a) An 18 year old woman of Bengali origin with a one-year old child is unsupported and isolated from women of her own age. Her husband of six months is physically abusive
Which agencies would you refer her to?

b) A woman’s partner has been stealing money from her. She is now in debt and unable to buy the children’s school uniforms
Which agencies would you refer her to?

c) A father has accidentally hit his daughter in a fight with his partner because she walked in between them during an argument. She has a bruise on her cheekbone. The father has told the mother it will never happen again and he is very sorry.
Which agencies would you refer her to?

d) Both parents are arguing frequently and their 11 year old son has developed enuresis. He has also started causing fights at school.
Which agencies would you refer her to?
Post Training Evaluation
6. POST TRAINING EVALUATION

Follow-up questionnaire for health professionals

Date (d/m/y) …/…/…..     Site ________________

We continually review the training that we provide and your input is valuable. Thank you for completing this evaluation form. All responses will be treated confidentially.

Please circle the answers below that fit best with your experience
Where there is a line, please answer in detail

About you

Name:______________________________________________________________________

Job
Title:_____________________________________________________________________

1.Gender
   Male   Female

2.Age       18-25  26-30  31-40  41-50  51-60

3.Ethnicity___________________________________________________________________

4.Place of work_________________________________________________________________

5.Specialism/department________________________________________________________

6.Profession/grade____________________________________________________________

About the way the course was organized

7. What did you think about the course content?
   Very good     Good     Adequate     Poor

8. What did you think about the presentations by the trainers?
   Very good     Good     Adequate     Poor

9. What did you think about the exercises and group work as a way of learning?
   Very good     Good     Adequate     Poor

10. How were the handouts and presentation of information?
    Very good     Good     Adequate     Poor
11. Has the course raised your understanding of the nature and effects of domestic violence?
To a great extent To some extent To a limited extent Not at all

12. Which sections of the course were most helpful?

13. Which sections of the course were least helpful?

14. How could the course content be improved?

15. How could the delivery of the training be improved?

16. Will you ask questions if you think a woman's injury or complaint is related to domestic violence?
Yes No Don't know

17. Will you document it in case notes if you think a woman has experienced domestic violence?
Yes No Don't know

18. Will you tell women you suspect are at risk about the range of agencies for help and support?
Yes No Don't know

19. Any comments about the course, your experience of working in this area, implications for practice or any other area?

About your department
20. Does your department have written policies and procedures or guidelines for dealing with domestic violence?
Yes No Don't know

21. Does your department have leaflets, pamphlets or information about domestic violence that can be given to service users?
Yes No Don't know
22. Is there a printed list in your department of local or national domestic violence agencies and resources where abused women can be referred?  
Yes  No  Don’t know

23. In your department is there an identified person to who you can refer abused women for advice and support?  
Yes  No  Don’t know

If yes, are they:  Social worker  nurse  doctor  patient advocate  
Other (please specify)…………………………………………………………………………………..

About your knowledge and experience of domestic violence

24. Before attending this course, how aware were you of domestic violence?  
To a great extent  To some extent  To a limited extent  Not at all

25. Regarding the facts and issues of domestic violence, do you now feel:

uninformed  slightly informed  well informed  fully informed

26. Which of the following resources for abused women do you know by name in your community?  
Refuge/shelter  support groups  legal  counselling  Perpetrator treatment programmes  Other (please specify)……………………

27. How often will you take each action below when you identify a patient as abused:  
always  often  rarely  never

document facts in case notes  1  2  3  4
record patient’s comments in case notes  1  2  3  4
refer patient to a refuge  1  2  3  4
reassure patient she is not alone  1  2  3  4
refer patient to a domestic violence helpline  1  2  3  4
give printed information on domestic violence  1  2  3  4
refer to police Community Safety Unit  1  2  3  4
call the police  1  2  3  4
counsel patient about violence  1  2  3  4
safeguard evidence  1  2  3  4
record suspicion of domestic violence even if patient denies  1  2  3  4
review safety plan  1  2  3  4
refer to a social worker  1  2  3  4
refer patient for counseling  1  2  3  4
refer patient to mental health team  1  2  3  4
share information with GP  1  2  3  4
record site of injuries on body map  1  2  3  4
involve child protection  1  2  3  4

28. How certain are you that you can:
<table>
<thead>
<tr>
<th></th>
<th>very certain</th>
<th>fairly certain</th>
<th>certain</th>
<th>not at all certain</th>
</tr>
</thead>
<tbody>
<tr>
<td>*identify a patient who is abused</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>*ask a patient directly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>about domestic violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*ask follow-up questions about domestic violence</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>*respond appropriately to service users who experience domestic violence</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>*know enough about domestic violence to intervene for your abused patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Thank you very much for completing this questionnaire.

All responses will be treated confidentially.
Further Reading
7. FURTHER READING

Notes for the Trainer


References


British Association of Accident and Emergency Medicine (1993) Academic Committee


Mooney, J. (1994). The Hidden Figure: Domestic Violence in North London. London Borough of Islington Police & Crime Prevention Unit/Middlesex University Centre for Criminology


Taft, A. & Shakespeare, J. (2005) Managing the Whole Family When Women are Abused By Intimate Partners : Challenges for Health Professionals in Roberts, G. Hegarty, G. & Feder,


US Preventive Task Force (2004). *Screening for family and intimate partner violence: summary of recommendations*


**Audiotapes of women’s accounts:**
‘Women speak out’ can be purchased from Leeds Inter-Agency Project 0113 234 9090
‘The Silent Scream’ South Devon WA Outreach Project 01362 643866

**Videos**
Bristol Midwives – through Dept of Health
Unlocking the doors and breaking down the barriers - Intercept, Eastern Wakefield PCT 01977 665712
Useful Organisations
8. USEFUL ORGANISATIONS

Contacts

Free 24 hour National Domestic Violence Help-line
0808 2000 247

Trained staff and volunteers are always ready, willing and able to:
listen and offer confidential emotional support
give information on housing, welfare, health and legal rights
refer women and children to refuges across the country
make referrals to temporary emergency accommodation
help get support from the police
help contact emergency services, support agencies and specialist help

Culturally specific Helplines

Southall Black Sisters       0208 571 9595
Information on domestic violence and immigration issues, advocacy and counselling for
women, particularly Asian women. Mon-Fri 10am-12-30pm, 1.30-4pm, closed Wed.

Akina Mama Wa Afrika       020 7713 5166
Advice, information, counselling for African women on DV, HIV/AIDS, mental health.
Mon-Fri 10am-5pm, Mon 7-9pm.

Karma Nirvana
Reception       01332 299 166
Emergency       01332 604 098
Bilingual befriending and support for Asian women in Midlands. Mon-Fri 10am-4pm.

Muslim Women's Helpline       0208 904 8193
or 0208 908 6715
Listening, counselling and information for Muslim women and girls. Mon-Fri 10am–4pm.

Jewish Women's Aid Helpline       0800 591 203
Advice and support for Jewish women and children. Mon, Wed, Thurs 9.30am–9.30pm.

Irish Women's Centre       0207 249 7318
Counselling, advice and advocacy for women of Irish descent. Mon-Fri 9.30am–5.30pm.
Closed between 1pm–2pm.

Asian & Minority Group Counselling Service       0208 861 3884
Ethnic counselling service for alcohol and mental health issues. Mon-Fri 9.30am- 5pm.

Turkish Community Project       0208 318 2864
For men & women. Translation services, advocacy, housing and welfare advice. Residents of
Lewisham, Lambeth, Southwark, Bromley. Mon-Fri 9.30am–5.30pm.

Somalian Women’s Centre       0208 752 1787
Advice on housing, immigration, benefits for Somalian women, West London.
Mon-Thur 10am–4pm.

Asian Women’s Resource Centre 020 8961 6549
or 020 8961 5701
Advice and information, counselling, English classes, parenting, women’s support group, multi lingual translation service. Mon-Fri 10am–5pm.

Newham Asian Women’s Project 0208 472 0528
Mon, Tue, Thur 9.30am–6pm, Wed 9.30am–1pm, Fri 9.30am–4.30pm.
Family Law solicitor – Thurs 2-4pm.

MENS HELPLINES
Mankind
www.mankind.org.uk
General helpline 0870 794 4124
11am-11pm 01480 396 500
7:30pm-9:30pm 01626 775 244
For male victims of violence 0127 87 83 074
or 01922 615 957
Emergency 01643 863 352

Respect 0845 122 8609
For information on national services for perpetrators of domestic violence:
PO Box 34434, London W6 0YS www.respect.uk.net

IMMIGRATION:
Asylum Aid 020 7377 5123
Advice for refugees on asylum applications & welfare rights www.asylumaid.org.uk
Mon, Tue 2-4.30pm, Thur 10-12.30pm.

NASS (National Asylum Support Service) 0845 6000 914
For professionals only, not public. Mon, Tue, Thur, Fri 10am-1pm, 2pm–5pm; Wed 2pm–5pm.

Immigration Advice Service 0207 357 6917
Advice on immigration problems. Main office open 9.30am–5.30pm.

Language Line 020 7520 1430
Immediate interpreter provision in 100 languages, 24 hr service.

National Asylum Seekers
General Helpline 0845 602 1639
Accommodation 0208 633 0573
Emergency 0208 633 0672

Refugee Council 020 7346 6777
Information and referral to local refugee councils. www.refugeecouncil.org.uk
Open Mon, Tues, Thurs, Fri 10am-1pm and 2pm-4pm, Wed 2pm-4pm.
AGENCIES FOR PARENTS AND CHILDREN

Childline
24 hr FREEPHONE 0800 1111
Confidential counselling service for any child with any problem. www.childline.org.uk

Careline 0208 514 1177
Telephone counselling for children, young people and adults. Mon-Fri 10am-4pm, 7-10pm.

The Children's Legal Centre 01206 873820
Free legal advice on law and policy affecting children and young people clc@essex.ac.uk.

Kidscape
General advice 020 7730 3300
Helpline for parents of bullied children 0845 1205 204
Helpline; educational programmes for parents. Information on preventing bullying and abuse.
Mon-Fri 10am-4pm. www.kidscape.org.uk

Family Matters 01474 537 392
Counselling support for sexual abuse survivors aged 8 and over.

National Association of Child Contact Centres 0845 4500 280
Arranges supported or supervised contact at neutral places for separated families.
www.naccc.org.uk

NCH Action For Children 020 7704 7000
Advice and information for families and children. Mon-Fri 9am-5pm. www.nch.org.uk

NSPCC
24 hour FREEPHONE 0808 800 5000
National Society for the Prevention of Cruelty to Children Help-line for anyone concerned a child may be at risk, including runaways.
www.nspcc.org.uk

Parentline Plus
FREETEL 0808 800 2222
24 hr telephone advice & support for anyone in a parenting role. www.parentlineplus.org.uk

reunite International Child Abduction Centre 0116 255 6234
24 hr advice and support to parents or families who fear or experience child abduction.

TULIP (Together United Living In Peace) 0151 637 6363
Help and support for parents being abused by their children.

Young Minds 0800 018 2138
Support for anyone with concerns about the mental health of a child or young person.
Mon-Fri 9.30am-5.30pm www.youngminds.org.uk 0207 336 8445
Connected to Barnardo’s www.barnados.org.uk 020 8550 8822
LESBIAN AND GAY SERVICES
London Lesbian and Gay Switchboard 0207 837 7324
24 hour help-line.
Directory of local services: http://www.queery.org.uk/StaticPages/Advice.asp

Broken Rainbow 07812 644 914
Referral service for LGBT people experiencing domestic violence. Mon- Fri, 12pm-4pm.

OTHER USEFUL NUMBERS
24 hr National Domestic Violence Freephone Helpline 0808 2000 247
Run in partnership between Refuge and Women’s Aid.

Alcohol Concern 020 7928 7377
Directory of local advice centres & services across nation. www.alcoholconcern.org.uk

Benefits Agency Helplines
Dept. of Work & Pensions Public Enquiry Line 020 7712 2171
Textphone 0800 243 355 (or telephone local office) www.dwp.gov.uk
Information on social security benefits.

DIAL UK (Disability Information & Advice Lines) 01302 310 123
Information and help for people with disability and their families. 9am-9pm. www.dialuk.org.uk

Drinkline 0800 917 8282
Telephone support for adults and young people.
Mon, Fri, Sat, Sun: 24hrs; Tue, Wed, Thur 9am-11pm.

Drugscope 020 7928 1211
Mon-Fri 10am-4.30 pm. www.drugscope.co.uk

Get Connected 0808 808 4994
Service for young people 16yrs-25yrs. Housing options. Mon-Son 1pm-11pm.

Gingerbread 0800 018 4318
Information, help and local groups for lone parents. Mon-Fri 9am-5pm. www.gingerbread.org.uk

The Greater London Domestic Violence Project (GLDVP)
A second tier project which works to end domestic violence in Greater London by supporting
direct service providers and promoting joint working.
Contact: Davina James-Hanman (Director) on 020 7785 3864 or davina.james-
hanman@london.gov.uk

The Stella Project
Promotes good practice and supports direct service providers across the drug, alcohol and
domestic violence sectors in Greater London. The Stella project has produced guidelines for
working across the two sectors and regularly holds events and training days to facilitate this
process. Contact: Michelle Newcomb (Stella Project Co-ordinator) on 020 7785 3862 or
michelle.newcomb@london.gov.uk
Inland Revenue  
Information about benefits, tax  
www.inlandrevenue.gov.uk

National Debtline  
0808 808 4000  
Telephone and email advice on debt, free self-help packs  
www.nationaldebtline.co.uk  
Mon-Fri 9am-9pm, Sat 9.30 am-1pm.

RASAC (Rape and Sexual Abuse Counselling)  
08451 221 331  
Mon 11.30am-1.30pm, Tue 7pm-9.30pm, Thur 7pm-9.30pm.

Rights of Women  
0207 251 6577  
Free confidential legal advice for women by phone. Tue, Wed, Thur 2-4pm, 7pm-9 pm; Fri 12-2pm.

Samaritans  
0845 790 9090  
24hr service (automatic transfer to local branch).  
www.samaritans.org.uk

Shelter  
0808 800 4444  
National 24 hr help-line. Expert advice on housing and homelessness.  
Signposting service for further help and advice.  
www.shelternet.org.uk

Victim Support National Helpline  
0845 303 0900  
Mon- Fri 9am-9pm; weekends 9am –7pm.