Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Domestic Violence and Abuse Protocol

Title	Domestic Violence and Abuse Protocol
Summary	Provides guidance for Trust staff about the correct action to take when working with children and adults who have been affected by domestic violence and abuse.
Responsibility for Updating	Assistant Directors of Safeguarding Adults and Safeguarding Children
Date of Original Policy	2010
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Equality Impact Assessment completed	Yes
Approved Via	Safeguarding Adults and Children Committee
Distribution	All directorates and service lines. All staff via intranet. Available to the public via Freedom of Information Act.
Related Documents	BEH-MHT Safeguarding Adults Policy BEH-MHT Safeguarding Children Procedure BEH-MHT Lone Working Policy

UNLESS THIS VERSION HAS BEEN TAKEN DIRECTLY FROM THE TRUST WEB SITE THERE IS NO ASSURANCE THIS IS THE CORRECT VERSION

EQUALITY STATEMENT

Barnet Enfield and Haringey Mental Health Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the Equality Act (2010) including the Human Rights Act 1998 and promotes equal opportunities for all.

This document has been assessed to ensure that no employee receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.
Members of staff, volunteers or members of the public may request assistance with this policy if they have particular needs. If the member of staff has language difficulties and difficulty in understanding this policy, the use of an interpreter will be considered.

Barnet Enfield and Haringey Mental Health Trust embraces the four staff pledges in the NHS Constitution. This policy is consistent with these pledges.

CONSULTATION RECORD OF PROCEDURAL DOCUMENT FORM

Name and Title of Committee/Individual	Date Consulted
Safeguarding Children Committee Safeguarding Adult Committee representatives. Local Authorities via Domestic Violence co-ordinators of Barnet, Enfield and Haringey and Children's Services Barnet. MARAC Co-ordinators (police). Trust MARAC representatives. Staff groups informed the development of the policy throughout the process- these were accessed in an ad hoc way.	September 2012 - February 2013
Contributing Authors: Veronica Flood, Deborah Perriment, Dee Harris.	
Name of Committee	**Date of Committee**
Safeguarding Adults Safeguarding Children Policy Development and Monitoring Committee	16.01.13 26.02.13 16.05.13

Version Control Summary

Version	Date	Section(s)	Author	Comment(s) Amendments
Version 1	May 2010		D Harris.	Health Visiting Service only
Version 2	16 May	All	V. Flood D. Perriment	This version covers the whole Trust and has been produced in conjunction with staff and stakeholders

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SECTION ONE INTRODUCTION

1. The Protocol

This protocol sets out the Barnet, Enfield, and Haringey Mental Health Trust position concerning the complex issue of domestic violence. Domestic violence infringes fundamental human rights as recognised in the United Nations Convention, and is a major health issue affecting people from all walks of life, across all ages, ethnic groups and socio-economic classes. Its effects are far reaching with numerous significant health and social impacts for both adults and children who have experienced violent relationships[1].

Domestic Violence and Abuse is any type of abuse taking place between adults who are, or have been, intimate partners – whether or not they are married or cohabiting. The Government defines it as "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality". The main characteristic of domestic violence is that the behaviour is intentional and is calculated to induce fear and misuses power to control how the victim thinks, feels and behaves.

The protocol provides guidance for all health professionals on initiating questions about domestic violence within the context of their holistic assessment and the undertaking routine enquiry in health visiting services. The protocol outlines a standardised approach within the assessment and management of domestic violence. It sets out three minimum standards.

All service users should be asked about their domestic violence experiences, if any, at the hands of a partner or family member.

Information regarding domestic violence must be recorded in the health profile/health records.

All services users who are subject to domestic violence must be sign-posted to appropriate support services.

A helpful mnemonic for this is **RADAR**

R	Routine enquiry/ selective enquiry
A	Ask direct questions
D	Document findings accurately
A	Assess service user's safety
R	Resources: provide service users with information on available resources and respect their choices.

Health professionals can make a significant difference to the health and quality of life for individuals experiencing domestic violence by recognising that responding to domestic violence is a process rather than an act. Responding to domestic violence requires a co-ordinated approach, working with other agencies in supporting and providing options for survivors of domestic violence to ensure the best intervention is planned and implemented. The health service on its own cannot meet all of the needs of

[1]Department of Health, Responding to Violence against women and girls- the role of the NHS. London, Department of Health, 2010

individuals experiencing domestic violence but it is uniquely placed to play a pivotal role in the identification, assessment and response process to domestic violence[2].

Barnet Enfield and Haringey Mental Health Trust recognise the need to improve the identification of domestic violence and ensure that all interventions are timely and proactive. Health professionals may be informed of domestic abuse from several sources:

- Initiating questions/routine/ selective enquiry.
- Disclosure by the victim.
- Selective enquiry; asking about experiences of domestic abuse where there are concerns or suspicions**.**
- Routine notification by the police to some staff groups (via Police 78 *Merlin Reports)*.

The main purpose of this protocol is to provide guidance for health professionals about the correct action to be taken. The protocol will also set out the context of domestic violence and explain what it is.

All health professionals have a significant role in the identification of domestic violence. The protocol is informed by the Serious Case Reviews in Barnet, Enfield and Haringey, which emphasis the importance of high quality processes to support local multi-agency working arrangements. Whilst it is understood that some groups will need greater knowledge in these areas, the underlying principles are transferrable across all areas of practice.

2. Domestic Violence

The agreed (From March 2013) United Kingdom HM Government definition of Domestic Violence and Abuse is:

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

- psychological
- physical
- sexual
- financial
- emotional

"Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour".
"Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."
This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

It also includes violence within teenage intimate partner relationships, and abuse of older women, including abuse by adult children, the wider extended family, and carers: women at both extremes of the age spectrum are more vulnerable behaviour, violence or abuse between adults who are or have been in a relationship together, or between family members, regardless of gender or sexuality http://www.homeoffice.gov.uk/crime-victims/reducing-crime/domestic-violence.

[2] Department of Health, Responding to Domestic Abuse: a handbook for health professionals. London, Department of Health 2005.

UK legislation provides a framework with obligations for public bodies to work together to reduce violent crime, including domestic violence, through Crime and Disorder Reduction Partnerships (CDRPs) set up by the Crime and Disorder Act 1998, as part of a wider framework of legislation applicable to victims of domestic violence including the Family Law Act 1996, the Protection from Harassment Act 1997 and homelessness legislation from 1996 onwards. The Domestic Violence Crime and Victims Act 2004 extended the scope of domestic violence legislation to include survivors within same-sex relationships, cohabitees and those in intimate non-cohabiting relationships, and introduced domestic violence homicide reviews as a means of learning from past cases to improve support for future survivors[3].

3. Context

Domestic violence is widespread; it is estimated that one in four women and one in six men are likely to experience domestic abuse at some time during their life. Within this context, it is essential for health professionals to have an understanding of the inter-relationship which frequently exists between domestic violence and the abuse and neglect of children. The guidance on safeguarding children states: *"Where there is evidence of domestic abuse, the implications for any children in the house hold should be considered, including the possibility that the children may themselves be subject to violence or other harm. Conversely, where it is believed that a child is being abused; those involved with the child and family should be alert to the possibility of domestic abuse within the family".* Please refer to BEH MHT Safeguarding Children Procedures (2011) and London Child Protection Procedures(2010) if you have any concerns or suspicions about the welfare of a child/young person that is under the age of 18 years, including any unborn children.

Similarly domestic violence affects adults you may not be able to protect themselves against abuse. Those adults have been referred to as 'adult at risk' and this term has been used to replace the term 'vulnerable adult'. An adult at risk is defined as someone who is aged 18 years or over and 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation' (DH, 2000).

This definition is taken from the current Department of Health guidance to local partnerships. An adult at risk may therefore be a person who:

- is elderly and frail due to ill health, physical disability or cognitive impairment
- has a learning disability
- has a physical disability and/or a sensory impairment
- has mental health needs including dementia or a personality disorder
- has a long-term illness/condition
- misuses substances or alcohol
- is a carer such as a family member/friend who provides personal assistance and care to adults and is subject to abuse
- is unable to demonstrate the capacity to make a decision and is in need of care and support

The Pan London Procedures- Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse (2011) sets out guidance for staff when dealing with an adult at risk who may be subject to domestic violence. Please refer also to the BEHMHT Safeguarding Adults Policy (2011).

Whilst it recognised that domestic violence affects all age ranges and people from every social stratum, it is important to be aware that there are certain factors that increase the risk of domestic violence. Women are at greater risk for becoming targets of domestic violence and to suffer from the effects like physical and emotional damage by their experience. Other increased risks are for the very young and for the very old, individuals suffering with mental ill health, physically disabled, learning disability and those that may be suffering physical ill health. Escalation of violence may also increase during

[3]Call to End Violence Against Women and Girls: Strategic Vision 2010 HM Government

pregnancy. **Women are at greater risk of violence, or even death, around the time of separation from a perpetrator**

Male victims

The incidence of domestic abuse reported to either the police or health professionals (5%) is lower in the male population in both adults and young people (British Crime Survey 2010/11)[4]. Mental health service users are vulnerable individuals and may be more at risk of domestic violence. Their mental health or substance misuse difficulties may be negatively influenced by domestic violence of any type with 39% of victims reporting mental and emotional problems and 4% reporting trying to kill themselves and 14% being users of specialist mental health or psychiatry services in the last year.

Staffs need to be aware that male victims are less likely to disclose domestic violence and enable them to do so by providing opportunities during the risk assessment processes.

There are fewer agencies providing specialist support to male victims. Service users should be helped to access services through signposting or referral. A list of organisations can be accessed in the appendix and as listed in the Trust domestic violence booklet for service users. The local domestic abuse coordinator in each borough will also be able to signpost (see Appendix 5).

Staff need to be aware of the tendency amongst professionals to find dealing with asking and responding to questions about domestic abuse difficult. This may be heightened with male victims. The same consideration of risk factors should be used for male and female victims; the risk of physical violence is reported as similar in both males and females. Supervision should be sought from the member of staff's manager or the safeguarding team if there is any doubt about risk or referral to the MARAC process. (See section 17).

SECTION TWO IDENTIFICATION

4. Early Identification

Early intervention to prevent violence can protect victims from immediate harm and have other indirect positive consequences, such as reducing the number of people requiring treatment for mental ill health or substance misuse, reduced incidence of family breakdown, reduced risk of significant harm to children and a decline in the number of missing and looked after children.

Identification of violence and taking appropriate action has the potential to break the cycle and prevent violence intensifying. All health professionals will need to be aware of the risks of all forms of domestic violence and alert to the indicators of violence.

Possible indicators of domestic violence which should arouse suspicion.

- Does the individual appear frightened, excessively anxious and depressed or distressed?
- Is there a history of mental health illness: depression, anxiety, self-harm or psychosomatic symptoms?
- Is there a history or existence of alcohol/drug dependency?
- Does the individual appear submissive or afraid of their partner? Is there reluctance to speak in front of a partner?
- Does the partner appear aggressive or overly dominant and reluctant to allow the individual to speak?
- Is there evidence of injuries which appear inconsistent with the explanation of causation (such as falls, or walking into doors etc)?
- Do the injuries present to the face, breasts or abdomen?

[4] http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb0212/hosb0212?view=Binary

- Is there evidence of multiple injuries at different stages of healing, for example; bruises, burns areas of redness consistent with slap injuries.
- Does the service user fail to comply or engage with health services? Are there frequent missed appointments?

5. Routine enquiry

Routine enquiry refers to asking questions about the experience of domestic violence, regardless of whether or not there are signs of abuse or whether domestic violence is suspected therefore it is readily incorporated into any holistic assessment. Evidence from practice where routine enquiry has been used on women suggests that most do not mind being asked, when it is explained that, the same inquiry is be made of all women, because of the widespread and covert nature of domestic violence. Section 3.5 provides guidance on how to approach the subject to elicit a positive response.
Health professionals should not assume that a negative response indicates the absence of an abusive relationship, as experiences may often be minimised or possibly not be defined as violence, particularly in the absence of physical violence. If someone is not ready or chooses not to disclose, their privacy should be respected. An affirmative response might well be received at a later date.

Routine enquiry has the potential to:

- Change perceived acceptability of violence in relationships.
- Reveal hidden cases of domestic violence.
- Reduce feelings of stigmatism associated with violence and expose the hidden taboo nature of domestic violence.
- Ensure the safety of individuals experiencing violence is not compromised.
- Communicate an important message that health professionals are aware of the existence of abuse and do not view it as acceptable or insignificant.
- Enable individuals to feel that they are not alone in their experience of domestic violence and that there are services available for them to seek help in changing their situation.

Routine enquiry about domestic violence should be undertaken in the course of an initial assessment in all services. Practitioners should be careful to ensure that they ask only when they are alone with the service user. The presence of a partner or relative may constrain discussions or increase risk. Discussions about domestic violence should never take place in the presence of children. It is imperative for health professionals to weigh up the risk of potential harm against the potential benefits. Before asking direct questions, you should try to put the service user at ease. Questions should be asked in a sensitive supportive manner. It is important to consider well-rehearsed strategies to manage any interruptions safely.

Asking the question

It is important that all health professionals use the same approach and ask similar questions. They can be incorporated into usual assessment process such as those used in adult mental health to assess the risk of violence to self and others or new birth visits. Be confident in asking the questions; the following are some examples of framing or introducing the question.

- Domestic abuse is a common occurrence with 1 in 4 women and 1 in 6 men experiencing domestic abuse at some time during their life; therefore we are now asking all women (service users/patients) whether they have experienced it.
- I hope you don't mind if I ask, but we are now asking all women about problems in their home, are you ever afraid at home?
- In addition to supporting you with the birth of your baby we are now asking all women about the possibility of violence at home, as we find it is very common in women's lives and it affects their physical and emotional health.
- I don't know if this is a problem for you, but we are asking all women/patients/service users if they experience any problem with their partners, because it can be hard to ask for help.
- Are you experiencing any violence or any violence between you and your partner?
- Does your partner ever hit you or control you in any other way?

It is important to ask service users on a number of different consultations about their experiences of domestic violence, thus increasing the likelihood of disclosure.

Provision of information
Asking questions should be coupled with provision of information, irrespective of disclosure. Information should be discreet and in some circumstances may just involve leaving the Practitioners contact number. Always ask the service user whether they want the information first. Consider whether leaving information amongst other materials may provoke a perpetrator. Leave your contact details.

6. Selective enquiry

Health professionals should practice this system of enquiry which requires asking individuals directly about their experiences of domestic violence, if any, where there are concerns or suspicions, including the presence of possible indicators of abuse listed in paragraph 2.6. Using your clinical judgement, ask specific questions. **Always be guided by the need to keep the service user and any children safe. Under no circumstances assume that somebody else will ask the questions**

Avoid asking any questions in the presence of partners, children or other family members. Seeing an individual alone is good practice, health professionals may need to consider inviting a service user to attend an alternative environment for example a clinic base or other safe environment that will ensure privacy. The only exception to this is when a **professional** interpreter is required because the service user does not speak English. **Family or members of the local community should not be used in cases where there may be domestic violence as this may increase the risk to the victim.**

Allow the service user time to talk about experiences, they may feel ashamed, try not to rush the service user – be patient. Arrange another appointment to see an individual that you are concerned about. Think about the conversation as the start of a process and not a one-off event.

7. Disclosure by the Victim

Health professionals must recognise that an appropriate response to service users experiencing violence is of paramount importance. Practitioners should be sympathetic, supportive and non-judgemental when a disclosure has been made. Those who experience domestic violence will often not have spoken to anyone about what has been happening to them, and may be particularly wary of statutory services becoming involved. Women who do eventually disclose their experience of violence typically describe a history of long-standing and escalating violence, and also remark on how much they wanted to be able to talk about what was going on, ***if only someone had asked them.***

Practitioners must be supportive to the service user in whatever decision they choose to make. ***Never advise a woman to leave her partner*****.** It is important that an individual reaches their own decision on what they want to do. Provide support and information on local and national support agencies and help lines, to enable individuals to make a decision on what to do next.

Staff working on inpatient wards and in mental health community teams may find that during the course of their work a service user may disclose that they are a victim of domestic violence. This could either be as part of the admission process to the mental health service, during a mental health assessment or through a routine inquiry. A risk assessment needs to be carried out to determine the level of risk and protection plan. Whilst most domestic violence referrals are managed through the safeguarding adults process a referral to MARAC is required for high risk cases. (refer to BEH-MHT Safeguarding adults policy)

8. Notification of a domestic violence incident by Police (Health visiting and school nursing only).

Upon receipt of a domestic violence notification or police report the family health records should be assessed within 1 week of receiving the notification, to identify increased risk factors. Increased risk factors may include; previous notifications of domestic violence, individuals that are transient, pregnant women, those who misuse drugs or alcohol and individuals with mental health problems.

Women who have left their partner should also be considered to be at greater risk. Deciding to leave a partner does not mean that a woman is safe; it is at this point that a woman is most at risk of serious injury or being murdered.

All domestic violence notifications will be received into the team generic mail box, which needs to be accessed and checked daily.

All domestic violence notifications need to be recorded on RiO and an alert applied. Depending on the practitioner's knowledge of the victim and their family, a follow up maybe required, **however** the HV/SN must consider if they are the most appropriate professional to deal with the issue. It maybe that the incident is best discussed with the GP, who can flag the family and monitor them through routine contact. The notification is then just used as wider information to build a picture of the family and enable a more accurate risk assessment to be undertaken in the future.

If a phone call appears to be appropriate then it is important to ascertain whether it is safe to discuss the domestic violence incident with the victim/service user. Aim to establish whether there is on-going risk of significant harm to the victim and any children within the family. If the family are considered to be at further risk an offer of further support should be made. A follow up call should be made within 1 month if there are no further concerns.

Domestic Violence reports are risk rated using the BRAG system, which indicates a response time and level of response required:
BRAG=
Blue- out of SPOE –early help i.e. back to Community Practitioners
Red- CP urgent, rapid information collecting, pass to Intake and Assessment.
Amber- 4 hour response
Green- 24 hour response time
(The above are all police time scales and are given for information only)

Only the amber and green domestic violence reports are discussed in the Single Point of Entry (SPOE) Therefore if the report is rated blue it will be for the practitioner to decide on the appropriate course of action. Contact may not always be indicated, however at the next available opportunity the practitioner should ensure that victims/service users are given all the available domestic violence resources and work in partnership with the victim/service user to develop a safety plan or emergency action plan.

The practitioner should work in partnership with service users and domestic violence agencies to provide on-going support. These may include Solace Women's Aid, Enfield Women's Centre, Enfield Muslim Women's Aid, Enfield Saheli, Multi-Agency Risk Assessment Conference (MARAC), and National Domestic Violence Helpline (listed in Appendix 5).

When a referral to Social Services is required, this information should be shared with the parent/carer, if safe to do so.

The risk of personal danger should also be considered and health professionals should also ensure that it is safe to visit (refer to BEH MHT Lone Working Policy 2011).

9. Perpetrators

As the incidence of domestic violence is higher in those who a have mental illness or misuse drugs or alcohol, there is a higher incidence of both sex victims and perpetrators of domestic abuse in our secondary care service users than in the general population.

Staff maybe aware of some perpetrators as they may be patients within the forensic services or have known convictions. Those perpetrators involved with the criminal justice system may have been offered (or been mandated) access to therapeutic or behavioural interventions.

Service users or patients may disclose that they use domestic violence within an intimate or family relationship during risk assessment. The interventions that they receive from the Trust may reduce the risk of this violence. Staff should also be aware that the emotional stress of therapeutic interventions, changes in therapeutic drugs or changes in illegal drug use may, for some patients, increase the short term risks and include this in a risk assessment and discuss with the patient/service user how this will be managed.

The same consideration of use of the MARAC process should be considered. The disclosure of the referral to the MARAC process for medium or high risk cases to the perpetrator should first be discussed with the police or domestic violence coordinator as the risk of violence to the victim may increase if the perpetrator is in formed. The member of staff should inform the perpetrator that they will discuss how to get them help and feed back to them at the next meeting.

If the patient/service user is willing to be referred to a source of help, such as a Domestic Violence Intervention Project, then the practitioner should refer them and follow this up. Care should be taken in referral to non-specialist service such as generalised anger management courses as in high risk cases there is evidence that his increases the risk to victims as the perpetrator learns how to mask their anger and intention.

A list of suitable services can be found on the Appendix 5.

10. Staff who are victims or perpetrators of domestic violence

Although it is not within the scope of this policy to cover the role of the Trust in relation to staff who may be victims of domestic abuse, the Trust recognises that many Trust staff will have experienced some form of domestic violence. If staff would like to obtain support with this or think that it may be affecting their work or think that may be at risk at work, they can discuss this with their line-manager, People and Organisational Development Department, Occupational Health or the Employee assistance Programme as detailed below. They may also wish to seek help through one of the local support groups or organisations listed in the appendix of this policy such as the free phone National Domestic Violence Helpline 0808 200 0247.

Occupational Health:

The Occupational Health and Wellbeing service provides assessment, support and guidance to staff on a range of health and wellbeing issues. The Occupational Health Team can be contacted by telephone on 020 3301 3999 or via e-mail on north.londonclinic@people-am.com or via the intranet.

Employee Assistance Programme (EAP),

This is provided to staff by a company called Positive People Company (PPC). The EAP service offers confidential independent help, information, and guidance. It is accessed by telephone and is totally confidential. The Helpline is available 24 hours a day, 365 days a year to employees and their immediate families (some of the advice is limited for family members). It also allows for up six face-to-face counselling sessions, offered near the caller's home or place of work. Access via the intranet or call the Helpline 0800 282 1937.

Perpetrators

If a member of staff is known to be a perpetrator of abuse they may be supported to get help with this as described in Section 9. They may also be referred to Occupational Health or the EAP as outlined above. Specific consideration and a risk assessment should be carried out by the manager of the staff member as to their suitability to work with either children or vulnerable adults. The process for allegations against staff as outlined in the Safeguarding Children Procedures (2011)should be followed if the perpetrator has access to children and young people within work.

11. Confidentiality and Information Sharing

Confidentiality is essential for creating the conditions in which individuals feel comfortable disclosing domestic violence. A service user's physical safety can be dependent on it. It is however important to understand and to explain to service users – **that there are limits to confidentiality**. For example where children are at risk, safeguarding and protection will always take precedence over confidentiality.

Health professionals should be aware that they should usually only share information after an Individual has given their permission. Accordingly, it is important to be aware of the circumstances under which information can be shared without consent. The Data Protection act 1998 allows for disclosure without consent in certain circumstances. The Crime and Disorder Act 1998 additionally also allows for the disclosure of information to the police, local authority, health authority or probation. Health professionals can also refer to their local *information sharing policy, London Child Protection Procedures2010 and Information Sharing: Guidance for Practitioners and Managers H M Government 2008*for guidance on how to share information safely.

Circumstances in which sharing confidential information without consent can normally be justified, for the purposes of preventative interventions. For example Information should be shared with the midwife when the victim/service user is pregnant. Where there are school aged children within the household information should be shared with the School Nurse. General Practitioners may be treating other members of a family, including a perpetrator, who may seek to use information to locate a partner who has left him; therefore the General Practitioner should also be informed of domestic violence.

Information should always be shared where there may be a safeguarding risk concerning children and if there is a high risk referral to MARAC and this may be done without the victim's consent. The balancing of confidentiality against the interests of disclosure is not always easy; in these circumstances health professionals should seek guidance from the Adult/Children's Safeguarding Team or Managers. The only acceptable reason for sharing information is to increase a victim's safety and that of their children.

12. Record keeping

Record keeping and documentation have an important role in responding to domestic violence. Records should be accurate, detailed and clear. They may ultimately assist a service user in living a safer life, for example in obtaining an injunction or court order against a perpetrator. Records may also be used in criminal proceedings where a perpetrator of violence faces charges.
Documentation should be as detailed as possible, avoid the use of statements such as the service user was assaulted, use the individuals own words, for example, service user states she was hit twice in face by husband.

A record should be made if an injury and an individual's explanation for it are inconsistent. Where training has been provided, use drawings or body maps.

To maintain confidentiality, great care needs to be taken to ensure that any record of domestic abuse should not be kept in any record that a perpetrator may have access to. Confidentiality should be discussed with the service user and consent should be obtained if information needs to be shared with other health care professionals. Consent is not required to record a disclosure of domestic violence. Health professionals should make it clear that there is a duty of care to record disclosures. Letters and assessments that are copied to the patient/service user **should never** mention the domestic violence as this may increase the danger for the victim.

Professional and BEH MHT Record keeping processes should be adhered to for domestic violence documentation. A domestic violence data set for notes should include.

- Date of birth
- Ethnicity
- Response to routine or selective enquiry – if undertaken
- Relationship to perpetrator
- Whether the woman is pregnant

- Presence of children in the household
- Nature of violence and injuries
- Description of varying forms of violence experienced
- History of violence; whether first episode of violence, and if not – what frequency over what period
- Enhanced risk factors/risk assessment
- Indication of information provided on local sources of help and Indication of any action taken, for example referrals made.
- An alert on RiO

SECTION THREE Responding to Domestic Violence

13. Responding to non-disclosure

Continuing support for service users for whom there are domestic violence concerns, will allow opportunities for monitoring a situation and alert health professionals to signs of escalating violence and increasing risk.

It is important for health professionals to recognise that disclosure is not the only effective outcome. Be prepared that even if an individual is experiencing violence it might be denied. **Accept "no",** as an answer and continue to be supportive. For some individuals simply knowing that the health professional is interested in domestic violence experiences, will allow them the opportunity to speak when they choose.

14. Responding to disclosure

Attending to the service users health needs following disclosure must be a priority, as there may be mental and physical injuries and these should be appropriately referred. Referral to specialist domestic violence services or to Children's Services for further assessment should be considered. Health professionals will need to consider to what extent disclosure about their domestic violence concerns should be made to third parties (See section 11 information sharing).

All safeguarding adults' alerts relating to alleged abuse by partners or family members need to be screened and considered as to whether this is domestic violence. If domestic violence is occurring steps will need to be taken to support the adult at risk so they are able to protect themselves from further abuse. When contacting the adult at risk give attention to the way in which contact will be made. This may be via the GP, another health service or educational services if there are children. Every effort should be made not to alert the person alleged to have caused the harm that a safeguarding referral has been made.

The safeguarding adult's strategy meeting should review the risk assessment and protection plan including it to other appropriate services. There are specialist domestic violence services which offer support to victims of domestic violence. BEH-MHT staff needs to assess the level of risk to determine what intervention is required. Cases assessed to be high risk should be referred to MARAC.(appendix 4)

15. Risk assessment

Together with any response to immediate needs, an assessment of risk/safety will be required. Health professionals will need to consider the immediate risks that an individual may be confronted with in a domestic violence situation, including whether there is any risk of serious injury or even death. Development of a risk assessment with the service user will enable them to think things through and make a decision about what they need to do but it may also be carried out by the professional or with their supervisor or colleague.

Professionals must use their judgement in assessing the level of risk, however a CAADA multi-agency risk assessment tool (Appendix 1) used by local agencies to help guide their assessment may also assist the practitioner. The following list may be helpful in determining risk.

A risk assessment should consider:

1. History of the violence *(physical, emotional, financial or sexual)* the service user has experienced including that to any children.

2. Escalation; has the violence increased in intensity, frequency and severity. Consider: first, worst and last episodes of violence.

3. Is the perpetrator:

- Making verbal threats: for example threatening to kill, threatening to harm or abduct the children.
- Frightening, disturbing, and threatening friends and neighbours?
- Attempting strangulation, or is there use of a weapon? Is there any other form of physical violence?
- Frequently intoxicated (*misuse of drugs or alcohol)* leading to more violence.

4. What is the service user's perspective of the risks? How much does the service user feel endangered?

5. Is there threat of suicide or self-harm from either party?

6. Has there been previous attempts to get help, for example from the police, refuges, courts etc.

7. Availability of support; emotional and practical, for example, friends and family.

8. If the service user does not wish to remain or return home, is there the availability of a*'safe haven'* or alternative accommodation.

The specific risk assessment for children and young people is covered under section 18

Health professionals are expected to facilitate referrals to appropriate services and domestic violence agencies that have the knowledge and resources to provide support and advice (Please see section 16 and 17). It is not the role of the health practitioner to provide all of the support or to manage on-going situation themselves.

16. Who to refer to

This will depend upon the level of risk involved

Low risk:

Provide the victim with information regarding support organisations and continue to support them. You may refer them with their consent to support services.

Medium Risk:

Suggest referral to specialist domestic violence support services with the victim.

An essential element of the support to a victim is ensuring that there are contingency arrangements for what to do when the violence starts. Practitioners should emphasise the importance of the development of a safety plan. Prompting a service user to think about what they can do to reduce the risks in an emergency situation may be safer than the development of a written action plan. Health professionals should not take sole responsibility to create a plan on the service user's behalf, but should work in partnership with specialists domestic violence agencies that can help to create a plan of safety (refer to Appendix 3 for a sample safety plan).

High Risk

Refer to the MARAC process (see section 17).

You may fill out the MARAC referral form at Appendix 5 or refer to the Domestic Violence co-ordinator to do this. The option that you chose will depend on your level of experience:

If the situation is one of very high immediate risk you should call the police:

If the victim is a vulnerable adult you should also make a referral to the vulnerable adult team.

17. Multi Agency Risk Assessment Conference (MARAC)

MARAC is an evidenced-based approach to coordinate effort from all agencies and organisations in high risk cases. It contributes to reducing the risk of serious harm or homicide for a victim and increases the safety and wellbeing of victims-adults and children.

MARAC meetings are held 3-4 weekly in every borough to help to ensure that high risk victims are supported and better protected from further abuse. Local multi-agency partners will meet together to discuss the highest risk victims and agencies agree and undertake actions that form part of an effective safety plan for the victim and the children. The Trust has a representative at local MARAC meetings but sometimes the professionals directly involved also attend. Victims do not attend MARAC meetings. After a case is discussed in MARAC, the Independent Domestic Violence Advocate (IDVA) or the lead agency that supports the victim will feedback the outcome from the MARAC to the victim.

Referral to a MARAC

MARACs are coordinated by the police or local authority. **Practitioners of all agencies can refer high risk cases.** Clients cannot self-refer.

The referral criteria for high risk are:

1. professional judgement where the professional has serious concerns about the victim's situation;
2. 'Visible High Risk' if you have 14 ticks in the Community Action Against Domestic Abuse (CAADA)-DASH risk identification checklist including extended family violence so called 'honour' based violence;
3. potential escalation is where there are numerous incidents reported or police call-outs and where there is not a positive identification of a majority of the risk factors but abuse appears to be escalating and
4. The local threshold of 10 ticks in the CAADA-DASH risk identification checklist.
5. Repeat cases where there are incidents reported within the twelve months when the victim was first discussed at MARAC.

The referral pathway differs in each borough. Please refer to the borough where the victim lives as set out below.

You should seek consent from the victim when making a referral to MARAC but it is not always possible or best practice to do so. There are circumstances when you have to make a referral without consent. This could be

- when you make a judgement that the risk to the victim is so high and it is not possible to carry out risk assessment with the victim but you have access to information from other sources such as the Police or supportive members whom the victim had disclosed the abuse;

- When a victim may have been so normalised to violence or abuse that they either minimise or fail to recognise the true dangerous nature of their relationship particularly if they still believe they "love" the perpetrator. A disclosure about the MARAC from the victim to the perpetrator under these circumstances is likely to reduce the effectiveness of the measures taken to protect the victim or even seriously increase the risk of harm to them or their children. Even if the victims are asked explicitly for consent to have their information shared it is possible the full extent of the issues may not be understood or that the level of information already held by agencies is not appreciated and therefore the validity of the consent may be disputed.

The alleged perpetrators are not asked for their consent or informed about the MARAC referral as to do so might jeopardise the victims safety. Sharing of information is further explained in the Department of Health (2012) document "Striking The Balance' Practical Guidance on the application of Caldicott Guardian principles to Domestic Violence and MARACS."

If you are unsure if the case meets the MARA threshold you can ring the MARAC co-ordinator for advice.

Barnet

The Barnet domestic abuse website for professionals outlines how to refer and meeting dates. The MARAC Co-ordinator is The MARAC Co-ordinator, Mee.Cheuk@barnet.gcsx.gov.uk, is based in Children's Services and can be contacted on 020 8359 5622.

To refer you must complete the Risk Identification Check list that forms part of the CAADA-DASH referral form and return to the co-ordinator via the email address on the form.

Enfield

The Enfield MARAC co-ordinator can be contacted on 0208345 4528. Their email is enfieldmarac@met.pnn.police.uk.

Haringey

Haringey Police Community Safety Unit (020 8345 1941) oversees the MARAC process. You should refer cases that meet the criteria above by contacting the MARAC Co-coordinator, at 0208 345 1944 who will forward you a copy of the referral form.

18. Assessment of Risk and Referral for Children and Young People

The risk to children should be assessed whether the victims are living with the perpetrator or not or whether they themselves are the victim as a partner who is also either a young person or an adult.

The risks to the victim, and any related or dependent children or young people, are increased at the time around separation and at subsequent contact. You must consider the effect of domestic abuse on all ages of children less than 18 years of age and follow the Safeguarding Children Procedures in all cases where there may be a risk to their mental or physical health or development.

The Barnardo's risk assessment tool and example safety plans (Appendix 2) may be used to help establish levels of risk to children. It is a helpful tool for use in supervision.

You must always refer to Children's Services where there is:

- a high risk to the victim
- any indication the children have suffered or are at risk of suffering significant harm

Where there is any level of risk and:

- A pregnant women
- A baby under one year of age
- A child who is disabled
- The victim does not have mental health capacity

You should consider referral to Children's Services if:

- The victim is medium risk
- Any combination of domestic violence, substance misuse or mental health problems as any combination of these factors is associated with higher risks and poor outcomes for children and young people.

Barnet Children's Services:

Family Support: 02083597933

Child Protection: 020 8359 4066

Out of hours: 020 8379 2000

Enfield Children's Services:

Early Intervention Single Point of Entry (SPOE): 02083795555

Child Protection 020 8379 2507

Out of hours 020 8379 1000

Haringey Children's Services:

Family support: 020 8489 3671

Child protection: 0208489 4592

Out of hours: 020 8348 3148

19. Support for Staff

The impact on health professionals working with individuals, who are experiencing domestic violence, must not be underestimated. It is important for staff to engage in regular clinical supervision, to support the delivery of good practice and to access a safe place for reflection on practice. It is important to recognise that having domestic violence responsibilities introduced into practice may inevitably trigger painful emotions for some staff that may have had personal experience of violence and just as victims require specialist support this may also be extended to staff members. Supervisors need to consider the impact of any staff disclosure of domestic violence and the practitioner's ability to continue to work with the victim and their family. See section 10 for staff support for victims.

20. Dissemination and Training

The protocol will be launched through Trust communications and disseminated to managers and staff both through Trust wide email of new policies and through service line Clinical Governance meetings,. Staff will continue to receive training on domestic abuse within mandatory safeguarding adult and children training. Staff will also be encouraged to attend multi-agency domestic violence and abuse training that is available in each borough through the local authority.

21. Monitoring

The protocol will be reviewed as a minimum every three years by the Safeguarding Adult and Children Committees. Any amendments will be ratified by the Policy Development and Monitoring Group.

The effectiveness of this policy will include the monitoring of the number and quality of referrals to MARAC. MARAC referrals are reported to and monitored by the Adult Safeguarding Committee. See Appendix 6.

References and further reading

Co-ordinated Action Against Domestic Abuse Website www.caada.org.uk

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486 Department of Health (2000) No Secrets: guidance on developing multi-agency policies and procedures to Protect vulnerable adults from abuse.

Department of Health, Responding to Domestic Abuse: a handbook for health professionals. London, Department of Health 2005.

Department of Health, Responding to Violence against women and girls- the role of the NHS. London, Department of Health, 2010

Department of Health (2012) document "Striking the Balance' Practical Guidance on the application of Caldicott Guardian principles to Domestic Violence and MARACS."

HM Government, Information Sharing: Guidance for Practitioners and managers. Nottingham, 2009.

London Safeguarding Children Board, *London Child Protection Procedures.* London, 2010.

Call to End Violence Against Women and Girls: Strategic Vision 2010 HM Government

Call to End Violence Against Women and Girls Action Plan 2011HM Government

http://www.scie.org.uk/publications/reports/report39.asp The Pan London Procedures- Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse (2011)

APPENDIX 1

CAADA Risk Assessment Tool with comprehensive guidance notes can be accessed via **CAADA.**

CAADA-DASH Risk Identification Checklist (RIC)[i] for MARAC Agencies,*To use for referral to MARAC or to guide assessment or supervision*

To help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.

- To decide which cases should be referred to MARAC and what other support might be required. A completed form becomes an active record that can be referred to in future for case management.
- To offer a common tool to agencies that are part of the MARAC process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence.
- To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

How to use the form:
Before completing the form for the first time we recommend that you read the full practice guidance and Frequently Asked Questions and Answers. These can be downloaded from http://www.caada.org.uk/marac/RIC_for_MARAC.html. Risk is dynamic and can change very quickly. It is good practice to review the checklist after a new incident.

Recommended Referral Criteria to MARAC

Professional judgement: if a professional has serious concerns about a victim's situation, they should refer the case to MARAC. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. ***This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers particularly in cases of 'honour'-based violence.*** This judgement would be based on the professional's experience and/or the victim's perception of their risk even if they do not meet criteria 2 and/or 3 below.

1. **'Visible High Risk':** the number of 'ticks' on this checklist. If you have ticked 14 or more 'yes' boxes the case would normally meet the MARAC referral criteria.
2. **Potential Escalation:** the number of police callouts to the victim as a result of domestic violence in the past 12 months. This criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at MARAC. It is common practice to start with 3 or more police callouts in a 12 month period but this will need to be reviewed depending on your local volume and your level of police reporting.

Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a MARAC or in another way.
The responsibility for identifying your local referral threshold rests with your local MARAC.
What this form is not:
This form will provide valuable information about the risks that children are living with but it is not a full risk assessment for children. The presence of children increases the wider risks of domestic violence and step children are particularly at risk. If risk towards children is highlighted you should consider what referral you need to make to obtain a full assessment of the children's situation.

CAADA-DASH Risk Identification Checklist for use by IDVAs and other non-police agencies for identification of risks when domestic abuse, 'honour'-based violence and/or stalking are disclosed

Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned. Tick the box if the factor is present ☑.Please use the comment box at the end of the form to expand on any answer. It is assumed that your main source of information is the victim. If this is <u>not the case</u> please indicate in the right hand column	Yes (tick)	No	Don't Know	State source of info if not the victim e.g. police officer
1. Has the current incident resulted in injury? (Please state what and whether this is the first injury.)	☐	☐	☐	
2. Are you very frightened? Comment:	☐	☐	☐	
3. What are you afraid of? Is it further injury or violence? (Please give an indication of what you think (name of abuser(s)...) might do and to whom, including children). Comment:	☐	☐	☐	
4. Do you feel isolated from family/friends i.e. does (name of abuser(s) ……..) try to stop you from seeing friends/family/doctor or others? Comment:	☐	☐	☐	
5. Are you feeling depressed or having suicidal thoughts?	☐	☐	☐	
6. Have you separated or tried to separate from (name of abuser(s)….) within the past year?	☐	☐	☐	
7. Is there conflict over child contact?	☐	☐	☐	
8. Does (……) constantly text, call, contact, follow, stalk or harass you? (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.)	☐	☐	☐	
9. Are you pregnant or have you recently had a baby (within the last 18 months)?	☐	☐	☐	
10. Is the abuse happening more often?	☐	☐	☐	
11. Is the abuse getting worse?	☐	☐	☐	
12. Does (……) try to control everything you do and/or are they excessively jealous? (In terms of relationships, who you see, being 'policed at home', telling you what to wear for example. Consider 'honour'-based violence and specify behaviour.)	☐	☐	☐	
Tick box if factor is present. Please use the comment box at the end of the form to expand on any answer.	Yes (tick)	No	Don't Know	State source of info if not the victim
13. Has (……..) ever used weapons or objects to hurt you?	☐	☐	☐	

14. Has (……..) ever threatened to kill you or someone else and you believed them? (If yes, tick who.) You ☐ Children ☐ Other (please specify) ☐	☐	☐	☐	
15. Has (……) ever attempted to strangle/choke/suffocate/drown you?	☐	☐	☐	
16. Does (……..) do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? (If someone else, specify who.)	☐	☐	☐	
17. Is there any other person who has threatened you or who you are afraid of? (If yes, please specify whom and why. Consider extended family if HBV.)	☐	☐	☐	
18. Do you know if (……..) has hurt anyone else? (Please specify whom including the children, siblings or elderly relatives. Consider HBV.) Children ☐ Another family member ☐ Someone from a previous relationship ☐ Other (please specify) ☐	☐	☐	☐	
19. Has (…….) ever mistreated an animal or the family pet?	☐	☐	☐	
20. Are there any financial issues? For example, are you dependent on (…..) for money/have they recently lost their job/other financial issues?	☐	☐	☐	
21. Has (……..) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? (If yes, please specify which and give relevant details if known.) Drugs ☐ Alcohol ☐ Mental Health ☐	☐	☐	☐	
22. Has (……) ever threatened or attempted suicide?	☐	☐	☐	
23. Has (……) ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? (You may wish to consider this in relation to an ex-partner of the perpetrator if relevant.) Bail conditions ☐ Non Molestation/Occupation Order ☐ Child Contact arrangements ☐ Forced Marriage Protection Order ☐ Other ☐	☐	☐	☐	
24. Do you know if (……..) has ever been in trouble with the police or has a criminal history? (If yes, please specify.) DV ☐ Sexual violence ☐ Other violence ☐ Other ☐	☐	☐	☐	
Total 'yes' responses				

For consideration by professional: Is there any other relevant information (from victim or professional) which may increase risk levels? Consider victim's situation in relation to disability, substance misuse, mental health issues, cultural/language barriers, 'honour'- based systems, geographic isolation and minimisation. Are they willing to engage with your service? Describe: Consider abuser's occupation/interests - could this give them unique access to weapons? Describe:
What are the victim's greatest priorities to address their safety?
Do you believe that there are reasonable grounds for referring this case to MARAC? Yes / No If yes, have you made a referral? Yes/No **Signed:** **Date:**
Do you believe that there are risks facing the children in the family? Yes / No If yes, please confirm if you have made a referral to safeguard the children: Yes / No Date referral made …….

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

Practitioner's Notes

APPENDIX 2

Domestic Violence Risk Assessment for Children and Young People and Example Safety Plans (Barnardos 2007) – can be used by Practitioners or in supervision.

ASSESSMENT OF RISK - TRIGGER QUESTIONS TO DETERMINE THRESHOLD INTERVENTION LEVEL

Children and young people's needs often change over time and may cross different levels, i.e., high in some areas and low in others. The age of the child/young person and protective factors that may enhance resilience are also important contributory factors. Of central importance in understanding where a child's needs might lie on this continuum, is the cooperation and engagement of the parents and carers – a lack of cooperation or appreciation about the concern may of itself raise the level of the need and required response. In the BARNARDOS DOMESTIC VIOLENCE RISK ASSESSMENT MATRIX the kind of things that can be risk indicators are shown very graphically.

1. **ASSESS NATURE OF DOMESTIC VIOLENCE**
   - Severity of the incidents – pattern, frequency and duration/process of domestic violence – not isolated incident
   - Perpetrator's level of dangerousness – weapons, criminal history
   - Is mother pregnant?
   - Escalation of abuse – separation violence, stalking/harassment and use of isolation
   - Protracted custody/contact disputes?
   - Prior evidence of victim or perpetrator being in an abusive relationship
   - Co-existence of child abuse, child sexual abuse, parental mental health problems, substance misuse?
   - Parental learning issues

2. **ASSESS RISKS TO CHILDREN/YOUNG PEOPLE**

   - Increased risk to children under 7 years and/or with special needs. How were children caught up in the abuse: directly witnessed? Intervened? Coerced into abuse of mother? Summoned help?
   - Child's demeanour – impact of incident at the time and afterwards
   - Evidence of exposure to DV: changes in behaviour/demeanour; self harm; lack of concentration; aggressive; neglect; bullying or being bullied; over anxious to be and remain in school

3. **ASSESS PROTECTIVE FACTORS**

   - Victim acknowledges risk to self and children
   - Victim is receptive to supportive services – if risk level is high will separate and go to protective services
   - Significant 'safe other' in network/positive family support
   - Perpetrator has made initial attempts to be accountable for behaviour; motivation to seek appropriate help
   - Protective orders in place/being sought – NB recent separation does not guarantee safety – risk of separation violence, retaliation violence or reconciliation

BARNARDOS 2007

London safeguarding children board

You do not need training to use this identifier or the advanced DVRIM

Notification Matrix (DVRIM) - Basic

Believe in children Barnardo's

Using this identifier: When you know or are fairly certain that a child is living in a family where there is domestic violence, answer the following questions, and act according to the arrowed instruction.

⇒ **If the answer to any one of the following five statements is 'yes', then you should make an immediate referral to LA children's social care:**

1. The child is under 12 months (especially a pre-mobile baby) or disabled
2. The child has a Protection Plan
3. The child has injuries/discloses that s/he has been harmed by family violence
4. An adult has delusions about the child and/or there are threats to the children or actual violence to the elderly or animals
5. Violence between the adults is severe (Severity includes frequency, duration and use of weapons/instruments and can be taking place post separation/contact

⇒ **If the answer to any of the following statements is 'yes' or 'suspected', you should have a detailed discussion with your designated CP officer. If the case does not reach the threshold for a referral to LA children's social care, you should ensure that a Common Assessment (CAF) is undertaken by an appropriate person**

How I Grow and Develop (child's developmental needs)	Y	S	**What I Need from People who Look After Me** (parenting capacity)	Y	S	**My Wider World** (family and environment)	Y	S
1 The child is frequently unwell, not explained by a pre-existing medical condition			6 Parent/caregiver and/or a close family member has additional vulnerabilities such as, mental health issues, has debilitating physical ill health, is disabled or misuses substances (alcohol and/or drugs)			11 There are emotional stressors within the household (financial, illness, substance misuse, threats or actual violence over or to the child, elderly or animals (incl. post separation/contact)). Violence between the adults is severe, of long duration and/or frequent		
2 Attendance at nursery/school/college is irregular; the child is home educated or the child goes missing			7 One or both parents had an abusive childhood; is unable to get their own needs met appropriately; has a history of violence to people or animals; is deceitful or manipulative			12 There are disruptions to living accommodation, education etc and social/family networks through frequent moves. Repeated 'life-event' crises and/or chaotic responses. Chaotic/co-sleeping arrangements		
3 The child presents with particular behaviours - aggression, withdrawal, starving/over eating, sexualized or risk-taking behaviour including misuse of substances; frequent soiling, disturbed sleep patterns and/or self harm/injuries			8 One or both parents have experienced victim/perpetrator abuse in a previous intimate relationship. There is evidence of grooming/control (see cultural issues also)			13 The family structure is divided. Person with new or renewed access to child (new partner, carer or sibling)		
4 Child shows little or disrupted attachment to caregivers - e.g. excessive clinginess, ongoing distress on separation, ambivalence to parent/caregiver, lack of interaction, does not look to parent/caregiver for reassurance at times of stress			9 Neither parent empathises with the child; there is little time for, or evidence of, appropriate interaction between parent and child			14 There is a lack of any other safe significant adult with whom the child can or does, have a close positive relationship		
5 The child is under 7 years old (unable to protect him/herself); relates poorly to peers / has no friends, is being bullied; cannot engage with adults			10 Lack of clear boundaries/consistency for children e.g. re discipline, daily routine or bedtime. Lack of emotional warmth or unpredictable responses towards children			15 Within a cultural context: - do the mother and the child fear involvement from services because they do not have (or have been led to believe they do not have) 'leave to remain' in England - is the mother not be able to or not comfortable to, communicate in English - does the family and the community culture support/promote constraints on the mother's and a girl child's behaviour, clothing and relationships; including punishment for transgressions do the family and the community promote/collude with, forced marriage and/or honour based violence and/or female genital mutilation		
						16 The family is experiencing additional stresses such as, social isolation, poor access to services, unemployment, limited opportunity to achieve and living in an area where there is high mobility and low community cohesion		

APPENDIX 3

AN EXEMPLAR DOMESTIC VIOLENCE SAFETY PLAN

The other end of the continuum from a risk assessment is the agreed intervention to protect victims and children and the way that the risk is managed. In the context of domestic violence, key to the risk management is a safety plan to which the adult victim and any children sign up. A safety plan is not a child protection plan although it has as its primary objective the protection of a child who witnessed domestic violence. It should always link to a child protection or child in need plan if there is one. The safety plan builds on the healthy strategies a child may already have been deploying to protect him/herself. The basis for safety planning is working with the child to explore exactly what happens at home when domestic violence takes place.

The professional needs to be confident in building up a trusting relationship with the child and in being able to provide reassurance and guidance to the child.

Key questions that need to be asked in order to complete a safety plan:

1. Where are you when mum and dad are fighting (use pictures to assist the child to explain)

Further details:

2. Where do you go?
3. Do you stay in the room?
4. Can you leave the room?
5. Do you hide? Where?
6. How do you get help?
7. Have you ever called the police?
8. If so, what happened afterwards when the police had gone (you are trying to establish the risk of recriminations and punishment by the perpetrator or even by the mother, motivated by fear)
9. Have you tried to stop the fighting?
10. Did you get hurt?
11. How did you feel?
12. What about the other siblings (older, younger)? What do they do? Do you try to protect them?
13. Have you told anyone else what happens at home?
14. Is there another adult you can talk to or go to for help, safety?
15. What makes you feel better when you think about mum and dad or mum and boyfriend fighting?
16. Do you have a mobile phone you can use in an emergency?

Key messages and attitudes professionals need to convey to children who witness domestic violence:

▪ It is right to be frightened but that doesn't make it ok ▪ Violence is not ok ▪ It is not up to them to stop it	▪ They are not responsible for the violence ▪ They have done nothing wrong ▪ They are not responsible for protecting Mummy

▪ They have a right to be safe and not be afraid ▪ They can talk about their experience ▪ They will be heard, believed and understood ▪ They matter and their safety matters	▪ It is important that they go to school, play with their friends, have fun, be healthy, learn well, have ambitions For boys in particular they need reassurance that they won't turn out to be violent as well

Example 1: A SAFETY PLAN FOR WOMEN & CHILDREN

Developing a safety plan

Women experiencing violence will already have survival strategies they find effective. It is essential to acknowledge these and use them as guidance for your work. A safety plan is about allowing women to identify the options available to them within the context of their current circumstances. Some questions to ask in drawing up a safety plan:

• Who can you tell about the violence who will not tell your partner/ex-partner?

• Do you have important phone numbers available e.g. Family, friends, refuges, police? Do your children know how to contact these people?

• If you left, where could you go?

• Do you ever suspect when your partner is going to be violent? e.g. After drinking, when he gets paid, after relatives visit

• When you suspect he is going to be violent can you go elsewhere?

• Can you keep a bag of spare clothes at a friend's or family member's house?

• Are you able to keep copies of any important papers with anyone else? e.g. passport, birth certificates, benefits book.

• Which part of the house do you feel safest in?

• Is there somewhere for your children to go when he is being violent and abusive (don't run to where your children are as your partner may harm them as well)?

• What is the most dangerous part of your house to be in when he is violent?

• Have you discussed with your children a safety plan for what they need to do during an incident (do not intervene, get away and get help)?

Sample personal safety plan for women & their children

This safety plan has been adapted from a variety of existing plans. It should be used with women who are escaping violence. Remember it may not be safe for a woman to fill in the plan and take it with her. Always offer to keep any information or documentation on your premises. Drug and alcohol agencies may wish to ask additional questions about how her or her perpetrator's substance use is affecting the violence she is experiencing.

Suggestions for increasing safety - In the relationship

- I will have important phone numbers available to my children and myself.
- I can tell ……..and
  ……
  about the violence and ask them to call the police if they hear suspicious noises coming from my home.
- If my children are hurt, I will tell ……..
- If I leave my home, I can go (list four places):
  ..... ……..
  ..... or ……..
- I can leave extra money, car keys, clothes, and copies of documents with.....
- When I leave, I will bring.....
- To ensure safety and independence, I can: keep change for phone calls with me at all times / keep my mobile phone on me at all times; open my own savings account; rehearse my escape route with a support person; and review safety plan on .....(date).
- When the violence begins which areas of the house should I avoid? E.g. bathroom (no exit), kitchen (potential weapons)
  .....

Suggestions for increasing safety - when the relationship is over

- I can: change the locks; install steel/metal doors, a security system, smoke detectors and an outside lighting system.

- I will inform.....and
  ..... that my partner no longer lives with me and ask them to call the police if s/he is observed near my home or my children.

- I will tell people who take care of my children, and my children themselves, the names of those who have permission to pick them up. The people who have permission are:
  .....
  and.....

- When I make phone calls I can use 141 so my number cannot be traced.

- I can tell..... at work about my situation and ask ..... to screen my calls.

- I can avoid shops, banks, and..... that I used when living with my abusive partner.

- If I feel down and ready to return to a potentially abusive situation, I can call.....for support.

Important phone numbers

Police..... Helpline.....

Friends..... Refuge .....

Items to take checklist

- ☐ Identification
- ☐ Birth certificates for me and my children
- ☐ Benefit books
- ☐ Medical cards for me and my children (e.g. children's "red books", school immunisation records etc)
- ☐ Phone card, mobile or change for a pay phone
- ☐ Money, bankbooks, credit cards
- ☐ Keys – house / car / office
- ☐ Keys to a friend or relative's house
- ☐ Medicine or medication for me and my children
- ☐ Driver's license
- ☐ Change of clothes for me and my children
- ☐ Passport(s), Home Office papers, work permits, national insurance numbers
- ☐ Divorce papers and legal orders
- ☐ Lease / rental agreement, house deed
- ☐ Mortgage payment book, current unpaid bills
- ☐ Insurance papers
- ☐ Address book
- ☐ Pictures, jewellery, items of sentimental value
- ☐ Children's favourite toys and/or blankets
- ☐ Any proof of abuse, notes, tapes, diary, crime reference numbers, names and numbers of professionals who know.

Example 2: A SAFETY PLAN FOR A CHILD

Child's safety plan

This is my safety plan …… (name of child)

and ……(name of worker)

If there are any angry actions or words in my house – I can't stop it

This is what I can do:

1. GET OUT OF THE WAY

2. Find a safe place. In my house this is ……

…….

3. If it's **SAFE**, phone the police

- The number is 999.

I will say:

- My name
- My home address …….

  ……..

- What's happening (i.e. someone is hurting my mum)

4. I can also get help from …… (i.e. next door)

5. Later I can talk with …… about what happened

6. If I am hurt I will tell …….

It's OK to feel (e.g. scared, angry etc) …….

8. The people that know about this plan are (draw a picture):

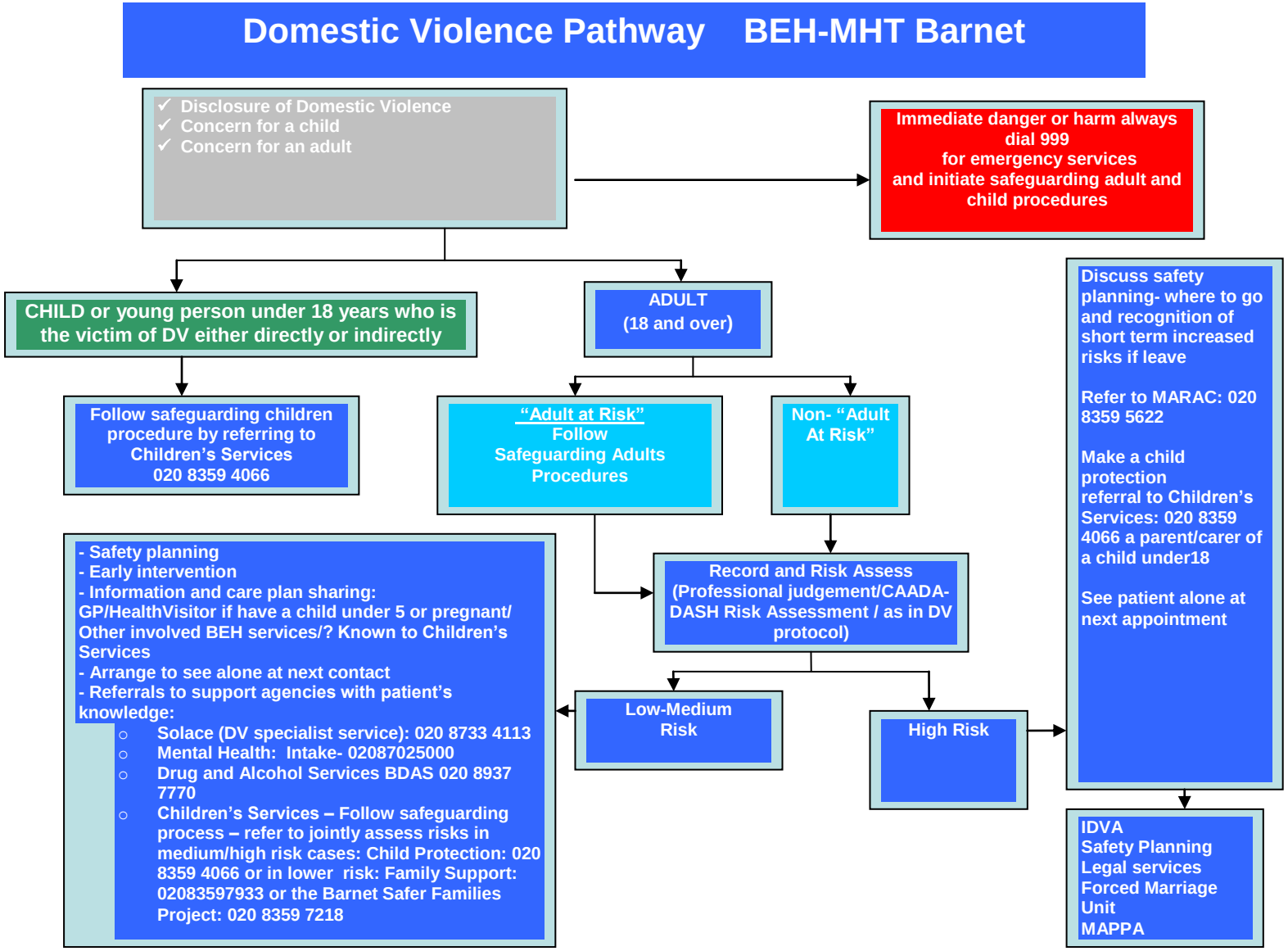
ME	FAMILY	OTHER PERSON

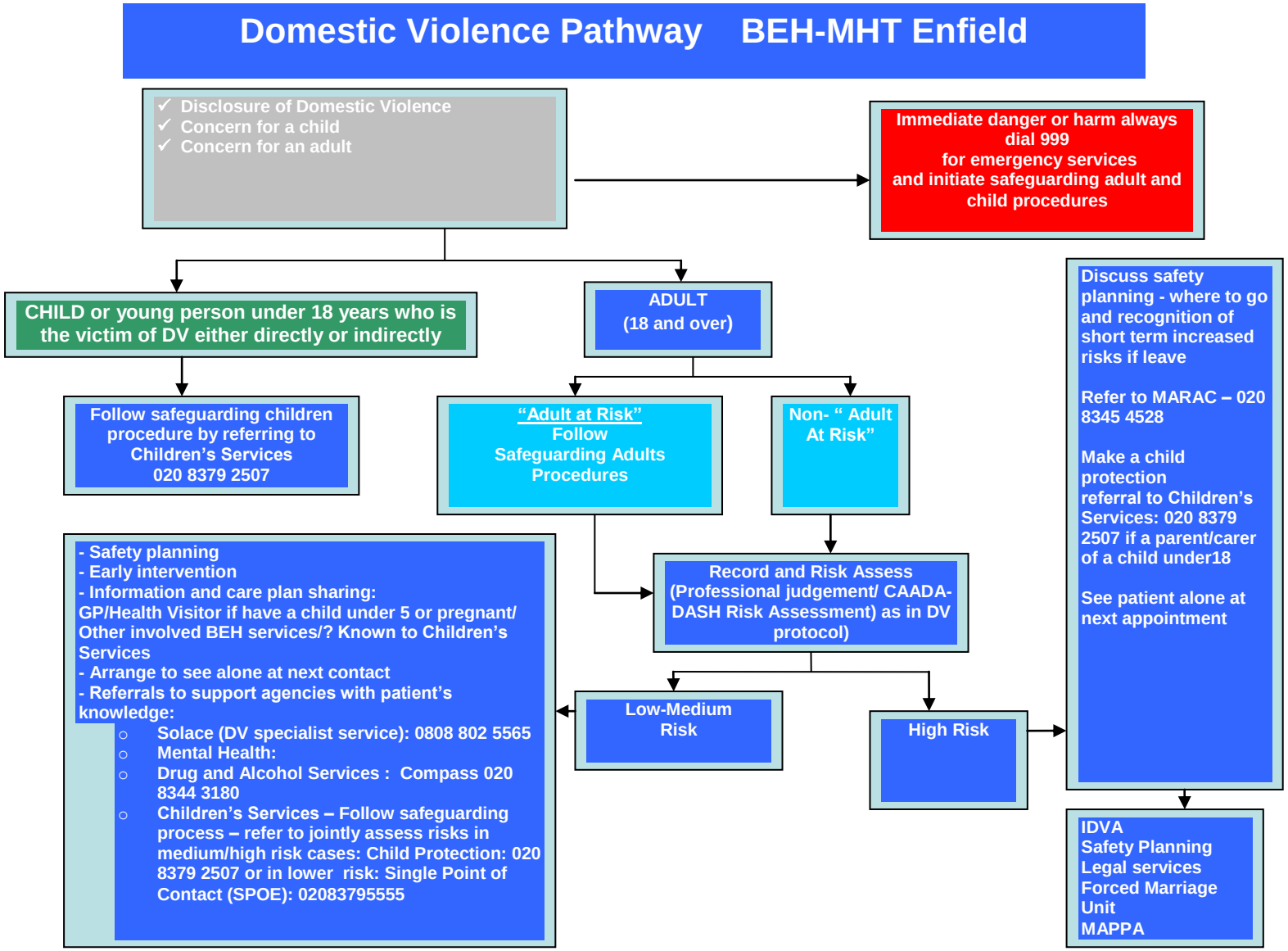
Signed …….. (Child)

Mother ……..

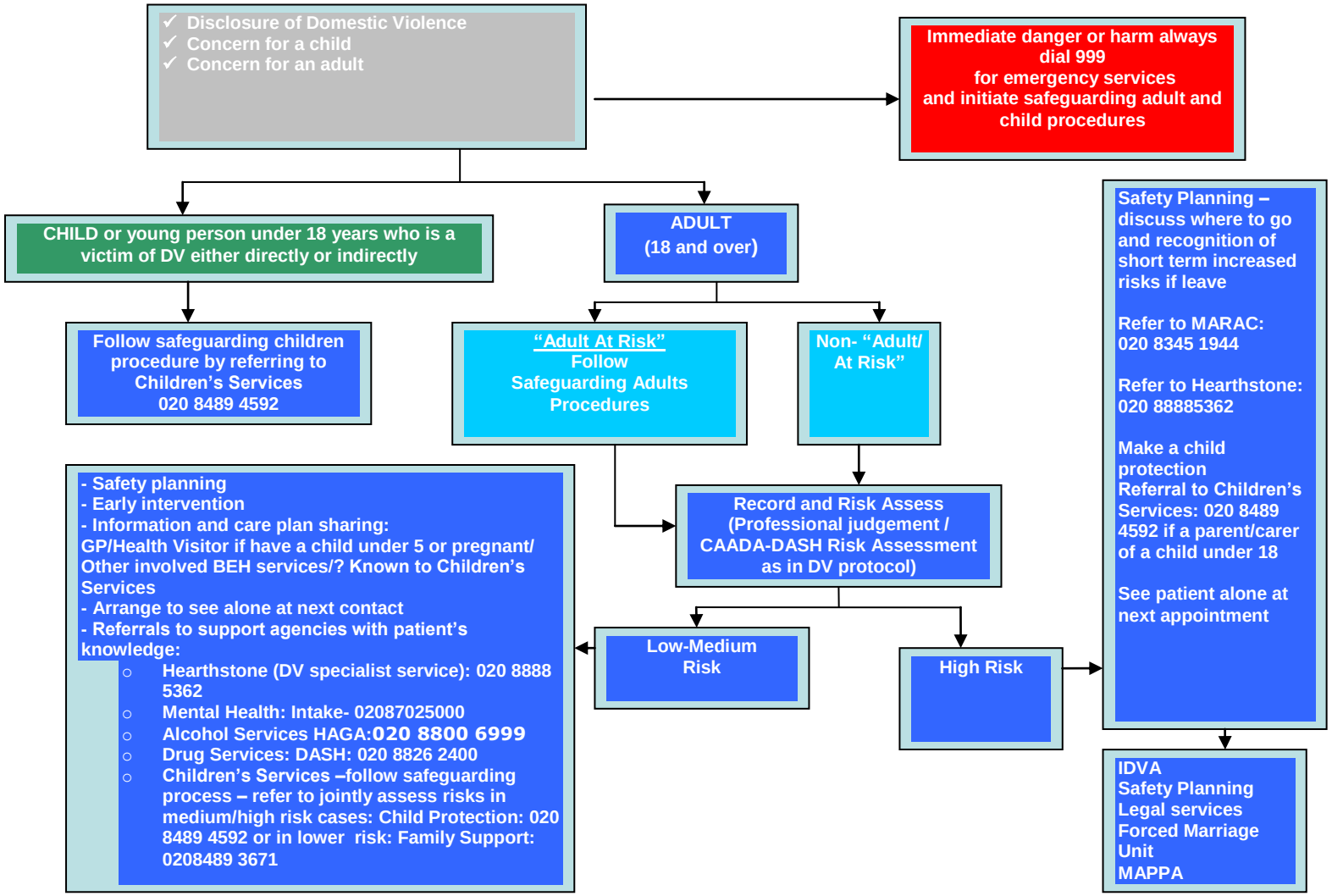
Professional …….. Date ……..……

APPENDIX 4


Domestic Violence Pathway BEH-MHT Barnet
✓ Disclosure of Domestic Violence
✓ Concern for a child
✓ Concern for an adult
Immediate danger or harm always dial 999 for emergency services and initiate safeguarding adult and child procedures
CHILD or young person under 18 years who is the victim of DV either directly or indirectly
ADULT (18 and over)
Follow safeguarding children procedure by referring to Children's Services 020 8359 4066
"Adult at Risk" Follow Safeguarding Adults Procedures
Non- "Adult At Risk"
Discuss safety planning- where to go and recognition of short term increased risks if leave
Refer to MARAC: 020 8359 5622
Make a child protection referral to Children's Services: 020 8359 4066 a parent/carer of a child under18
See patient alone at next appointment
Record and Risk Assess (Professional judgement/CAADA-DASH Risk Assessment / as in DV protocol)
- Safety planning
- Early intervention
- Information and care plan sharing: GP/HealthVisitor if have a child under 5 or pregnant/ Other involved BEH services/? Known to Children's Services
- Arrange to see alone at next contact
- Referrals to support agencies with patient's knowledge:
Solace (DV specialist service): 020 8733 4113
Mental Health: Intake- 02087025000
Drug and Alcohol Services BDAS 020 8937 7770
Children's Services – Follow safeguarding process – refer to jointly assess risks in medium/high risk cases: Child Protection: 020 8359 4066 or in lower risk: Family Support: 02083597933 or the Barnet Safer Families Project: 020 8359 7218
Low-Medium Risk
High Risk
IDVA
Safety Planning
Legal services
Forced Marriage Unit
MAPPA


Domestic Violence Pathway BEH-MHT Enfield
✓ Disclosure of Domestic Violence
✓ Concern for a child
✓ Concern for an adult
Immediate danger or harm always dial 999 for emergency services and initiate safeguarding adult and child procedures
CHILD or young person under 18 years who is the victim of DV either directly or indirectly
ADULT (18 and over)
Follow safeguarding children procedure by referring to Children's Services 020 8379 2507
"Adult at Risk" Follow Safeguarding Adults Procedures
Non- " Adult At Risk"
Discuss safety planning - where to go and recognition of short term increased risks if leave
Refer to MARAC – 020 8345 4528
Make a child protection referral to Children's Services: 020 8379 2507 if a parent/carer of a child under18
See patient alone at next appointment
- Safety planning
- Early intervention
- Information and care plan sharing: GP/Health Visitor if have a child under 5 or pregnant/ Other involved BEH services/? Known to Children's Services
- Arrange to see alone at next contact
- Referrals to support agencies with patient's knowledge:
Solace (DV specialist service): 0808 802 5565
Mental Health:
Drug and Alcohol Services : Compass 020 8344 3180
Children's Services – Follow safeguarding process – refer to jointly assess risks in medium/high risk cases: Child Protection: 020 8379 2507 or in lower risk: Single Point of Contact (SPOE): 02083795555
Record and Risk Assess (Professional judgement/ CAADA-DASH Risk Assessment) as in DV protocol)
Low-Medium Risk
High Risk
IDVA
Safety Planning
Legal services
Forced Marriage Unit
MAPPA

Domestic Violence Pathway BEH-MHT Haringey



APPENDIX 5

Resources and Support Agencies

The number of available services are too numerous to be listed here. The best source of information is the Domestic Violence page of the borough that the victim or perpetrator lives in. There is also a Domestic Violence Co-ordinator in each Borough who advises on strategy, training and support services.

Barnet:

DV Co-ordinator: 020 8359 5625
DV Website: www.barnet.gov.uk

Enfield:

DV Co-ordinator: 020 8379 4184
DV Website: www.enfield.gov.uk

Haringey:

DV Co-ordinator: 020 8489 2832
DV website: www.haringey.gov.uk

National Contacts

Victim advice and support:

National Domestic Violence Helpline (Run in partnership between Women's Aid and Refuge)
Telephone: 24- hourfree phone:0808 2000 247

National Centre for Domestic Violence
24 hour, 365 days a year emergency free phone: 0800 970 20 70 or

08709 220 704

For help with obtaining an injunction.

Victim Support National 24 hour telephone number: 0845 30 30 900

Refuge London Wide
Telephone: 0870 599 5443
http://www.refuge.org.uk/

Womens Aid National Domestic Violence Helpline

Telephone: 0845 023 468

National Society for the Prevention of Cruelty to Children (NSPCC) Helpline

Telephone: 0800 800 500
Text phone 0800 056 0566

Email: help@nspcc.org.uk

Website: www.nspcc.org.uk

Project Sapphire
Metropolitan Police unit, that specialises in investigating rape and sexual assault cases

Telephone: 020 7321 7359

The Roofie Foundation Drug Rape and Sexual Abuse Advice
1 Prime Parkway, Prime Enterprise Park, Derby, DE1 3QB, UK

Telephone: 0800 783 3980 – 24 hour helpline.

Established 1997 – Britain's only specialised agency dealing with issues surrounding drug rape and sexual abuse. Originators of a helpline that provides a one stop-shop information service for victims of drug rape and sexual abuse caused through drink spiking.

Respect
A Men's advice line that provides a range of services aimed at men experiencing domestic violence from their partner.

Telephone: 020 7022 1801

Shelter line – National 24 – Housing Helpline
Telephone: 0808 800 4444

Perpetrator advice and support

Respect

A helpline and programmes for male and female perpetrators. Call freephone 0808 802 4040 Monday-Friday 10am-1pm and 2pm-5pm or email info@respectphoneline.org.uk

Barnet have a specific Domestic Violence Intervention Project (DVIP) for perpetrators. These include services for men, women and young people (aged 11 and up). Partners and family members are also offered support. If you want to access these services, please contact DVIP by telephone on 020 7633 9181 or email vpp@dvip.org.

The Domestic Violence Intervention Project programmes information leaflets have further information about the programmes run.

APPENDIX 6

EQUALITY IMPACT ASSESSMENT AND ANALYSIS FORM

Name of the policy/service development, strategy or plan being analysed:
Domestic Violence Policy

Name and job title of the manager responsible for carrying out this analysis:
Deborah Perriment. Assistant Director, Safeguarding Children.

Please summarise your policy

To support staff in responding safely and effectively to domestic violence by providing a standardised approach to assessment and response.

What are the main objectives or intended outcomes of the policy/service development, strategy or plan?

- Objective or benefit 1 To provide a framework and guidance for staff to enable them to respond safely and effectively to domestic violence
- Objective or benefit 2 To safeguard adults and children.

1. Please indicate the expected impact of your proposal on people with protected characteristics

Characteristics	Significant +ve	Some +ve	Neutral	Some -ve	Significant -ve
Age:	X				
Disability:	X				
Ethnicity:	x				
Gender re-assignment:			X		
Religion/Belief:			X		
Sex (male or female)	X				
Sexual Orientation:			X		
Marriage and civil partnership			X		
Pregnancy and maternity	X				
The Trust is also concerned about key disadvantaged groups event though they are not protected by law					
Substance mis-users	X				
The homeless	X				
The unemployed			X		

2. Consideration of available data, research and information

Monitoring data and other information should be used to help you analyse whether you are delivering a fair and equitable service. Social factors are significant determinants of health outcomes. Please consult these types of potential sources as appropriate. There are links on the Trust website:

- Joint strategic needs analysis (JSNA) for each borough
- Demographic data and other statistics, including census findings
- Recent research findings (local and national)
- Results from consultation or engagement you have undertaken
- Service user monitoring data (including age, disability, ethnicity, gender, religion/belief, sexual orientation and)
- Information from relevant groups or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or complaints or compliments about them
- Recommendations of external inspections or audit reports

	Key questions	Reference data, research and information that you have reviewed which you have used to form your response

2.1	How does this change/development/plan relate to the Trust's corporate equality objectives and the public sector duty?	**It supports the Trust to fulfil its responsibilities to safeguard children under Section 11 of The Children Act 2004 and the London Safeguarding Children Board Procedures 2010. It enables a response in line with the London multi-agency Procedures to safeguard adults from abuse 2011.**
2.2	What are the relevant equalities characteristics of the staff involved or affected?	**Nil**
2.3	What are the relevant equalities characteristics of the service users and carers involved or affected?	**Female service users are more likely to be the victims of domestic violence so the policy will be used more frequently with this group. There is an known increase in the prevalence of domestic abuse within certain age groups, during pregnancy, in those who are homeless, those who misuse substances or who have mental health difficulties.**
2.4	What other relevant data do you have in terms of service users or staff? (e.g. results of customer satisfaction surveys, consultation findings, census data, and health needs assessments etc).	**None**

3. It is Trust policy that you explain your proposed development or change to people who might be affected by it, or their representatives. Please outline how you plan to do this.

Group	Methods of engagement
All staff involved in the provision of clinical care and their managers.	Presentations to the clinical governance meetings of the service line Memo via Assistant Directors of relevant services including the circulation of the two sided fact sheet- this will be borough specific. Inclusion in all safeguarding children and adult training Training has been arranged- a combination of multi-agency and two sessions a year through the WDD calendar using local authority trainer at no cost.

4. Equality Impact Analysis Improvement Plan

None

6. Sign off and publishing

Once you have completed this form, it needs to be 'approved' by Service Director, Clinical Director or an Executive Director or their nominated deputy. If this Equality Impact Analysis relates to a policy, procedure or protocol, please attach it to the policy and process it through the normal approval process. Following this sign off by the Policy Review and Monitoring Committee your policy and the associated EqIAn will be published by the Trust's policy lead on the website.

I have conducted this equality Impact analysis in line with Trust guidance	
Your name: Deborah Perriment	Position assistant Director Safeguarding Children
Signed:	Date:
Approved by:	
Your name:	Position
Sign:	
Date	

MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF PROCEDURAL DOCUMENTS FORM

1.	**How will the document be monitored?**	**Audit**	Yes	**Review**	Annual
		Methodology: The protocol will be reviewed as a minimum every three years by the Safeguarding Adult and Children Committees. Any amendments will be ratified by the Policy Development and Monitoring Group. This document will be updated annually to ensure that contact details for services are accurate. The effectiveness of this policy will include the monitoring of the number and quality of referrals to MARAC. MARAC referrals are reported to and monitored by the Safeguarding Adult Committee.			
2.	**What is the process for reviewing results of monitoring?**	MARAC referrals are monitored quarterly and should indicate a rise in number regarding Trust Service users. There will also be feedback from working practice via the Domestic Violence Working Group across adult and child safeguarding. Current adult and child safeguarding audits include domestic abuse and will continue; these are monitored by the relevant adult/child committee and will provide useful triangulation of outcomes from the protocol.			
3	**Report to:**	Safeguarding Adult Committee which reports this to the Governance and Risk Committee			
4.	**Who is responsible for conducting the monitoring?**	**Group / Committee** Safeguarding Adult Committee			
		Name / Title (also include position of individuals): Assistant Directors of Safeguarding Adults and Children			
5.	**How often will the document be monitored?**	Yearly			
		Comments:			
6	**Responsibility for action planning after review**	**Assistant Director Safeguarding Adults**			