



RESPONDING TO

DOMESTIC ABUSE

GUIDELINES FOR HEALTH CARE WORKERS IN NHSSCOTLAND



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ACKNOWLEDGEMENTS

This guidance builds on excellent guidelines available from Royal Colleges, both medical and nursing, from professional organisations and other sources. It takes account of recent research and policy documents from the World Health Organisation (WHO), the United Nations and governments across the world, and from women's organisations and other supporting charities. These sources are listed as further reading.

The Executive is grateful to the Short Life Working Group for their help in preparing these guidelines for health care workers.

FOREWORD

By the Minister for Health and Community Care



The Scottish Executive is committed to making Scotland a safer, fairer, more just society, and that means tackling violence and, in particular, violence in families at every level and in every setting. Domestic abuse has serious and long lasting consequences for the health and well-being of sufferers and their children. Its effects are profoundly damaging. Tackling this pervasive problem and the problems associated with it - physical injury, poor mental health, misuse of alcohol or drugs, anxiety and depression, and risk of suicide - must be of crucial importance for the NHS. We must continue to raise awareness about domestic abuse, improve information about the scale and nature of the problem and bring about a shift in attitudes, so that domestic abuse is no longer tolerable in Scottish society.

Domestic abuse is a complex and wide-ranging issue encompassing many areas of Government policy. We need to work to prevent violence crossing the generations. That must begin very early with education, in our nurseries and schools, and pre-birth, in parenting education and support for our young parents. All our public services need to work together to eradicate domestic abuse from our families and communities. There is much that NHS Scotland can do to help and support women experiencing abuse. It is vital that health care staff have the confidence and knowledge to be able to give help to those women who seek it. These guidelines should help clinicians and health professionals identify and respond to women experiencing domestic abuse. I know that the NHS in Scotland will play its part in doing so by ensuring their effective implementation.

Malcolm Chisholm

Malcolm Chisholm, MSP

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SUMMARY

These guidelines describe the nature and prevalence of domestic abuse in Scotland, present a definition of domestic abuse underpinning national policy and outline the Scottish Executive's strategy for tackling domestic abuse in Scotland. They set out the role and responsibilities of the NHS in Scotland, and of health professionals, in responding to domestic abuse. The guidelines have been prepared with help from a Short Life Working Group, convened by the Scottish Executive, which included a wide range of health professionals and other interests.

The guidelines identify the help and support that health care workers can expect from NHS Boards, NHS Trusts, LHCCs and local management to ensure that they are able to respond effectively to anyone experiencing domestic abuse. They provide information about the health effects of domestic abuse and potential signs and indicators of domestic abuse, and offer practical advice about how to approach the difficult task of talking about abuse. The guidelines set out good practice for professionals to help them inform and support women appropriately. The guidelines also describe how NHS employers should facilitate implementation of the guidelines and what they should consider when developing a local strategy, including staff training and development needs and professional education.

The guidelines also include information for NHS organisations about dealing with domestic abuse as employers, outlining their responsibilities to respond sensitively and sympathetically to staff experiencing abuse.

A list of sources of information and support is provided for health care workers to assist their response to individuals who approach them, including contact details for other agencies and bodies which play a role in responding to domestic abuse and provide services.

PART 1: AN OVERVIEW OF DOMESTIC ABUSE



This introductory section outlines the nature and prevalence of domestic abuse. It presents the Scottish Executive's definition and policy, its action plan and campaign and measures taken so far to address domestic abuse and related issues. It describes the roles and responsibility of NHS and of health professionals in responding to domestic abuse.

Aims of the guidance

The Scottish Executive Health Department has produced these guidelines with the help of a Short Life Working Group comprising experienced professionals, to assist health care workers in all NHS settings to respond appropriately to victims of domestic abuse.

The Group was asked to:

- prepare guidelines on domestic abuse for health care workers;
- advise on how best to raise awareness amongst NHS staff, improve the environment for disclosure of domestic abuse and offer effective help
- state what support health care workers should expect from their NHS employer.

The Group was asked to advise the National Group to Address Domestic Abuse in Scotland and the Scottish Executive on implementation of the guidelines by NHS Boards and Trusts. A list of members of the Short Life Working Group can be found in Annex A.

Domestic abuse in Scotland – what does it mean?

Domestic violence refers to a wide range of physical, sexual, emotional and financial abuse of people who are, or have been, intimate partners, whether or not they are married or cohabiting. Domestic abuse can occur in any relationship and in all social groups, regardless of race, religion, social class or age.

Domestic abuse is a criminal, social and medical problem with serious consequences. It infringes fundamental human rights, and causes far reaching damage to people's lives and development. It is difficult to know how many Scots are experiencing domestic abuse at any one time. Evidence demonstrates that it is widespread and under reported, and the level of repeat incidence is high. It is estimated that anything between a quarter and a third of all women in Scotland will experience abuse at some point in their lives.

Statistics show that in 2000 there were 712 incidents per 100,000 population in Scotland.¹ 330 people experienced serious assault and 17 people were murdered by their partners in the same year. The *Confidential Enquiries into Maternal Deaths in the United Kingdom (2001)* notes that of the 378 women

¹ *Domestic Abuse Recorded by the Police in Scotland 1 January – 31 December 2000* Statistical Bulletin, Scottish Executive Dec 2001

whose deaths were reported between 1997-1999, 45 (12%) volunteered information about violence during pregnancy to a health care professional.

Violence may increase when a person experiencing abuse tries to end the relationship, on separation or divorce or, for women, during pregnancy and following the birth of a child. Domestic abuse has harmful, sometimes even life threatening, impact on the physical and mental wellbeing of those affected. Elderly people, same sex couples and people with learning difficulties are particularly vulnerable; they may experience greater difficulty in reporting incidents of violence or abuse.

Domestic violence can take place in any relationship, including gay and lesbian partnerships and abuse of men by female partners does occur. Nevertheless the majority of domestic abuse is perpetrated by men against women, and their children. Of the 660 non-sexual crimes of violence, 559 involved a female experiencing violence from a male perpetrator.² Therefore this document refers throughout to people experiencing domestic abuse as women.

Definition of domestic abuse

The Scottish Executive has adopted the following definition of domestic abuse:



Domestic abuse (as gender-based abuse) can be perpetrated by partners or ex-partners and can include physical abuse (assault and physical attack involving a range of behaviour), sexual abuse (acts which degrade and humiliate women and are perpetrated against their will, including rape) and mental and emotional abuse (such as threats, verbal abuse, racial abuse, withholding money and other types of controlling behaviour such as isolation from family and friends).

Children in families where domestic abuse occurs may be witnesses to, or also subject to domestic abuse. Exposure to domestic abuse may cause significant harm to children and there is some correlation between domestic abuse and the mental, physical and sexual abuse of children. Other family members, connected to a woman through marriage or through her relationship with her partner, may participate in domestic abuse of the woman, as members of her own family.

Forms of abuse

The term 'domestic abuse' embraces physical, sexual, or emotional (including financial abuse) and takes specific and identifiable forms. See table 1.

² *Domestic Abuse Recorded by the Police in Scotland 1 January – 31 December 2000* Statistical Bulletin, Scottish Executive Dec 2001

Table 1 Forms of abuse:

PHYSICAL VIOLENCE	SEXUAL ABUSE/ASSAULT	PSYCHOLOGICAL ABUSE
Biting	Enforced prostitution	Convincing of mental illness
Bruising	Female genital mutilation	Criticism
Burning	Forced pregnancy or continuation of pregnancy	Destruction of personal belonging
Choking/strangling	Forced enactment of pornography	Financial deprivation
Hitting	Forced participation in pornography	Imprisonment
Kicking	Forced sex – anal/vaginal/oral	Forced performance of menial/trivial tasks
Knifing	Forced termination of pregnancy	Humiliation and degradation
Murder	Forced tying up during sexual activity	Isolation from family and friends/work
Punching	Rape	Jealousy and possessiveness
Scalding	Removal of sutures from perineum to facilitate intercourse	Sleep deprivation
Scratching	Sexual assault using objects	Targeted abuse of children, relatives or pets
Slapping	Urinating/defecating on abused	Threats
Starving	Withdrawal of contraception	Verbal abuse

In the Scottish crime survey (2000) 62% of people reporting crimes of threatened or actual domestic abuse said the perpetrator had been drinking alcohol. This may mean that the perpetrator needs help to tackle alcohol problems. Nevertheless alcohol abuse is never a cause, or an excuse, for domestic violence.

National policy framework

The Scottish Executive is strongly committed to raising awareness amongst professionals and the public concerning domestic abuse, improving information about the scale and nature of the problem and ensuring that women and their children get the protection and support they need.

A great deal of cross agency work is already being undertaken in the UK to prevent abuse and to support women and their families who are experiencing domestic abuse. This work emphasises the importance of changing the balance between the ‘powerless’ nature of the abused against the ‘powerful’ abuser. Campaigning and pressure groups, research findings and increased public awareness

of the problem have brought about a significant change in attitudes, and have directed government's attention to the need to address domestic abuse effectively in partnership with local agencies and survivors.

Awareness raising

Domestic abuse must become unacceptable in Scottish society so that there is widespread acceptance that responsibility lies with the perpetrators of abuse and that those who are abused are in no way to blame. It is also important to create a climate of belief, so those women experiencing abuse will come forward and receive the support and services they require.

The Scottish Partnership on Domestic Abuse was established in November 1998. It produced *A National Strategy to Address Domestic Abuse in Scotland*, which includes an Action Plan, supported by *Good Practice Guidelines and Service Delivery Standards*. The Executive is committed to implementing the Action Plan.

The National Group to Address Domestic Abuse in Scotland

Implementation of the *National Strategy and Action Plan* is overseen by a National Group of stakeholders, chaired by the Deputy Minister for Social Justice. Its remit is to:

- Oversee the implementation of *A National Strategy to Address Domestic Abuse in Scotland*
- Review and monitor progress against the Action Plan
- Identify and disseminate good practice
- Identify key issues and develop a coherent national response
- Provide advice in relation to monitoring data and the identification of the research required
- Establish and oversee a structure of specific issue-based groups and local multi-agency groups working within a coherent framework
- Consider links between domestic abuse and the wider issues of violence against women.

The Scottish Executive has allocated a budget of £4.5 million over three years, from 2001-2004, for the implementation of the Action Plan.

The Government's commitment to ensuring the NHS in Scotland provides a responsive, high quality service to anyone experiencing domestic abuse is stated in a number of policy statements:

- The Scottish Needs Assessment Programme (SNAP) (1997)
- *A Framework for Mental Health Services in Scotland* (1997)
- Scottish White Paper *Towards a Healthier Scotland* (1999)
- The audit report of maternity services *Maternity Care Matters* (1999)
- *The Priorities and Planning Guidance for the NHS in Scotland 1999-2002 NHS MEL* (1998)
- *Our National Health: A plan for action, a plan for change* (2001)
- *A Framework for Maternity Services in Scotland* (2001)
- *Nursing for Health* (2001)

The role of the health service

The health service is in a unique position to contribute to helping people who suffer violence at home get the support they need. Virtually every women in Britain will use the health care system at some point in her life, whether for routine health care, pregnancy and childbirth, illness, injury, or in the role of carer for children or older people. Health services may often be a woman's only contact with professionals who might recognise domestic abuse and intervene. The health service may become a lifeline for women whose freedom is being restricted by a violent partner, or who is reluctant to become involved with the police or the criminal justice system. Health services also have a strong contribution to make to changing public attitudes.

Therefore health services have a pivotal role to play in the identification, assessment and response to domestic violence, in promoting health and through the provision of support and services for women and their children. Any health care professional may have the opportunity to identify someone experiencing domestic violence, and to empower women to get help and support. Early intervention can prevent an abusive situation becoming worse and the level of violence becoming more intense.

In particular, health care workers have a responsibility to:

- be educated and trained in how to best help;
- be aware of a woman's often tentative attempt to seek help – this includes children presenting with a variety of illnesses;
- be sympathetic, non-judgemental and show empathy;
- be responsive within a co-ordinated health service, with links to multi-agency help as required;
- value racial, cultural or religious diversity and be sensitive to women's needs.

Domestic abuse may present in any area of practice and clinical provision and therefore health care workers need to be alert to, and develop the skills to respond effectively to any signs and indicators. Those who experience domestic abuse may be patients or staff. Many may be very reluctant to tell anyone about abuse. Practitioners should be mindful that women currently experiencing domestic abuse may also have experienced other forms of abuse including childhood abuse. If a household includes children there may also be child abuse.

These guidelines should assist a more consistent and comprehensive response. In addition the national helpline service, NHS 24, will provide support for women in future by ensuring that when women call for advice, their needs are properly identified and that they are directed to the most appropriate advice or service.

Effective inter-agency working

Some women experiencing domestic abuse decide to leave their abusive partner, while some decide to stay. No one service or agency can deal with all problems related to domestic abuse in isolation. A *National Strategy to Address Domestic Abuse in Scotland* includes standards for inter-agency working, which describe what services a women experiencing domestic abuse has a right to expect from the agencies to whom she turns for help. Whatever their circumstances they need access to a range of

services and support, medical, social and practical. To meet these needs, support services should be informed, efficient, pro-active, and multi-agency. Health care staff should familiarise themselves with the role and functions of the various statutory and voluntary organisations so that accurate information can be shared with women experiencing abuse, and appropriate referrals made.

The police

The police take cases of domestic abuse very seriously. Most police officers have received training in handling cases of abuse and most local forces have domestic violence liaison officers specifically to deal with such cases. All officers should be equipped to handle initial contact with women who have been sexually abused or subjected to domestic abuse, in an professional and sympathetic manner. Assault is a criminal offence and if a woman has been physically assaulted, the police may arrest the offender.

When the police are notified of an incident of domestic abuse the woman can expect them to:

- respond quickly to her call;
- talk to her separately from the violent person;
- arrest the perpetrator where there is sufficient evidence;
- arrest the perpetrator if they have broken the terms of an interdict with power of arrest or bail conditions;
- arrange for medical treatment for the woman if she needs it;
- keep records of all incidents of domestic violence against the woman.

If the woman decides to leave, the Police may accompany her back home and protect her if she wishes to collect any belongings.

Hitting Home (1997), a thematic study of eight Scottish police forces' response to domestic abuse, recommended that police forces should develop a common definition of domestic abuse for operational use by all forces so that:

- patterns of behaviour can be monitored and repeat incidents identified;
- consideration of further investigation can take previous incidents into account;
- future protection of the woman and any children can be considered by police and other interested agencies;
- police performance can be monitored at individual and organisational levels;
- strategy can be adjusted accordingly at local and force level.

The police definition now in operation is:

“Domestic violence is any form of physical, non-physical, or sexual abuse which takes place within the context of a close relationship, committed either in the home or elsewhere. In most cases this relationship will be between partners (married, co-habitant or otherwise) or ex partners.”

Police forces have collected statistics on incidents satisfying this definition since 1 April 1999, aided by the work of the Scottish Criminal Statistics Committee.

In an emergency, anyone experiencing abuse should dial 999 and ask for 'POLICE'. If a 999 call is made to the Police and interrupted, the Police will always trace the call and attend at the house.

The legal profession

A solicitor can provide information about a woman's legal options, her eligibility for legal protection and local court practice. Some solicitors provide a first consultation free of charge. Scottish Women's Aid (see part 5) can provide names and addresses of experienced solicitors that women have found helpful.

If the woman's partner is arrested, charged and goes to court, bail may be granted. In certain circumstances the court may decide to grant bail subject to conditions. Bail conditions may restrict the partner's movements and provide the woman with some protection, and time to consider what to do next. It is for the court to decide whether to impose conditions and what those should be.

Protection is available through civil law as well as criminal law. A woman can apply to the court, through a solicitor, for an Interdict. This is a court order, which prohibits her partner from doing anything set out in the order. It may, for example, prohibit him from coming within a certain distance of their home.

She may also apply, again subject to certain conditions relating to her own or her partner's occupancy rights, for a Matrimonial Exclusion Order, which requires her partner to leave the household and allows her and any children to remain in the family home. If she is married or cohabiting and is a joint owner or joint tenant or has been given occupancy rights by the court, in certain circumstances a woman can apply for a Matrimonial Interdict with a power of arrest attached. This allows the police to arrest her partner if he breaks the terms of the interdict.

The woman may need to apply for Civil Legal Aid to obtain an Exclusion Order or Interdict. Any income above the level of Income Support will be taken into account in assessing whether she should contribute to legal costs.

Anyone who is being harassed can apply to the Sheriff Court for a Non Harassment Order if an individual has done anything that causes alarm or distress on at least 2 occasions. The court can also be asked to award damages arising from the harassment. In addition, if a person is convicted of an offence involving harassment the Procurator Fiscal can ask the court to impose a Non-Harassment Order on the offender to protect against any future harassment in addition to the sentence imposed by the court. Breach of a non-harassment order (whether made by a criminal or civil court) is a criminal offence punishable by up to 5 years imprisonment, or an unlimited fine, or both.

The woman may be able to receive criminal injury compensation. For information on this and a fuller explanation of legal terms, see Glossary. (pg 40)

The local authority

Housing

A woman may be considered homeless if she has accommodation but it is probable that occupation of it will lead to abuse from someone else who lives there or who used to live with her. If found to be homeless a woman would be considered to have a priority need for housing if she had dependent children, was pregnant, was at risk of domestic abuse or otherwise vulnerable.

The *Code of Guidance on Homelessness*,³ which local authorities are required to take account of in exercising their function to house homeless people, sets out guidance on what might constitute such vulnerability.

Homeless people in priority need are entitled to permanent accommodation if they have not made themselves 'intentionally homeless' or other accommodation if they are considered intentionally homeless. Women escaping domestic violence or external violence should not normally be deemed intentionally homeless.

Placement in another local authority area, with the woman's consent, may be useful where there is a need to get away from the perpetrator of violence. The Housing (Scotland) Act 2001 amended the allocation provisions of section 20 of the Housing (Scotland) Act 1987 to ensure that in the allocation of their houses a social landlord shall take no account of whether an applicant is resident in their area if that applicant wishes to move into that area because he or she runs the risk of domestic violence. This applies equally to local authorities and registered social landlords. Local authorities also have the power to repossess and transfer council tenancies. In the case of a relationship breakdown, this could be used to transfer the tenancy to a woman at risk.

Social Work

Legislation relating to the 'local authority' does not only refer to Housing Departments, but to the whole council, including social services. Social services, and particularly the Emergency Duty Team, can be a vital resource and initial point of contact for many women. Their functions include help with emergency accommodation, benefits and finances.

The local authority social work service has statutory duties to protect children, and to safeguard and promote the welfare of children in need in their area.

Perpetrators' programmes

As part of their preventive strategies, a number of local authorities criminal justice workers provide programmes for men convicted of domestic violence offences. Such programmes include intensive educational programmes based on behavioural therapy. The Scottish Office independently and positively evaluated two Scottish programmes, the Domestic Violence Probation Project in Edinburgh and the CHANGE Project in Stirling in 1996. The aim of such programmes is to encourage men to identify and re-think some of the beliefs, attitudes, expectations, and fears, which may underpin their use of violence. All programmes focus on the man's responsibility for his behaviour and on the impact on his partner and children.

³The Scottish Executive's *Code of Guidance on Homelessness 1998* can be downloaded from <http://www.scotland.gov.uk/homelessness/cog-00.asp>

To ensure that such programmes are effective and do not collude with perpetrators they should be compatible with the *Statements of Principle and Minimum Standards of Practice* issued by RESPECT, the National Association for Perpetrators Programmes and Associated Women's Support Services. This is a UK-wide body. Such programmes must have procedures for consulting confidentially with the partners of men on the programme and should have partner support services running alongside the men's programme.

Men on such programmes often attend as a condition of a Probation Order and their failure to attend or co-operate with the programme will result in them being returned to the court for an alternative sentence to be imposed.

DOMESTIC ABUSE – GOOD PRACTICE IN SCOTLAND

The Domestic Violence Probation Project is a probation project run by Edinburgh Council. It is designed to educate men to end their abuse and referrals are made by the Sheriff Court as part of the probation order. The Domestic Abuse Service Development Fund is funding a *Working with Men Partnership* to extend this service to men who have not been through the court system. The Fund has also supported partner working for those women in relationships with men on the DVPP.

The voluntary sector

Over the last two decades women's groups have campaigned vigorously on the issue of men's violence against women. These campaigns have succeeded in raising the profile of domestic abuse and in creating a less tolerant attitude towards abuse behaviour.

Scottish Women's Aid (SWA) is a key campaigning and support organisation run by women for women. It provides a network of independent, locally based services offering information, support and safe refuge for women, children and young people who are experiencing, or have experienced, domestic abuse. Scottish Women's Aid currently has 39 affiliated and 6 non-affiliated groups providing about 360 refuge places throughout Scotland. SWA also offer training to external agencies on domestic abuse and raising awareness.

DOMESTIC ABUSE – GOOD PRACTICE IN SCOTLAND

A multi-agency website is now available for information on domestic abuse, and strategies to tackle it, within Dumfries and Galloway – the first such regional site in Scotland. The address is www.dumgal.gov.uk/domesticabuse

PART 2: IDENTIFYING AND ADDRESSING DOMESTIC ABUSE – THE ROLE OF THE HEALTH CARE WORKER



This section provides information about the impact of domestic abuse and advice on how to approach the difficult task of talking about abuse. It outlines potential signs and indicators of domestic abuse and principles to inform effective practice. It provides guidance effective support.

Domestic abuse may result in physical injury, chronic physical ill health and ongoing emotional and mental health difficulties. It can lead to acute and chronic physical disability, miscarriage, loss of hearing or vision, physical disfigurement, and psychological injury leading to depression, drug and alcohol problems and sometimes suicide or attempted suicide. At the extreme end of the continuum, some women are murdered by their partners or ex-partners.

Violence not only has severe health consequences for the person directly affected. Children suffer the consequences of abuse too. They may show a number of the following symptoms: failure to thrive, development of anxiety and depression, withdrawal, asthma, eczema, disability caused by abuse of the mother during and after pregnancy, bedwetting and attempted suicide. Death from murder or suicide can also occur.

Barriers to accessing health service provision

Helping women tell others about abuse and obtain the help they need is not always easy. Patients may not disclose, or may not receive, the support they require, either through lack of information about available services, or because the service they seek help from lacks the skills or knowledge to provide an appropriate and effective response. NHS Scotland should offer a safe system and comprehensive support to which an abused individual can turn with confidence. This will require clear care pathways for women, well known to staff.

Women and children who have experienced abuse may not disclose what has happened to them because:

- they may not perceive what is happening as abuse;
- they may be ashamed and embarrassed about what has happened to them;
- they fear reprisals and serious escalation of abuse from their partner if outsiders get involved;
- they think they may receive an unsympathetic response or not be believed, particularly if the abuse is psychological or there are no physical symptoms;
- they fear that their children will be taken into care;
- they don't know what help might be obtained from health professionals;
- they are afraid of the police and other authorities, and fear deportation if a refugee, asylum seeker, or woman who has entered the country to get married;

- they feel trapped, degraded or humiliated; lacking self-esteem;
- they may be depressed and unable to make even basic decisions;
- they fear of insecurity, including financial;
- they do not realise that abuse is something they should not have to tolerate;
- children fear their mother will be blamed;
- of emotional dependence;
- of stigma of being without a partner;
- of lack of support from family & friends;
- they hope that their partner's behaviour will change.

Although it is important not to make assumptions about women based on their personal or social background, capabilities or living situations, certain circumstances may impact on a woman's ability to disclose abuse and create barriers to accessing services. The instances of these are even higher when the victim is from an ethnic minority group, male or homosexual. See table 2:

Health care settings should present information in ways that let women know that abuse is a subject that can be raised with their health care worker. Relevant addresses and telephone numbers should be made easily accessible to enable women to get help with or without the support or knowledge of health care staff.⁴ Displays, posters and information leaflets in reception and public waiting areas, consulting rooms, public and staff toilets and staff offices, may encourage some women to disclose.

Staff should be aware however that written material alone is not sufficient, as women may have difficulties with literacy or her first language may not be English, or it may simply not be noticed or read. In these cases the health care worker must be proactive in providing information.

DOMESTIC ABUSE – GOOD PRACTICE IN SCOTLAND

An information sticker offering advice on domestic abuse issues was developed and distributed throughout public toilets within the Forth Valley NHS Board area.

Table 2 Potential barriers to accessing provision

Common issues that create barriers to accessing provision	Women from minority ethnic/rural/travelling communities	Elderly/People with learning difficulties	Men/same sex couples and others
poverty homelessness isolation fear/mistrust of authority religious values literacy problems advocacy	language barriers immigration status racial or religious discrimination cultural values lack of interpreter threats of deportation (from family members)	deafness blindness mobility problems physical access self harm dependence on abuser who may also be care giver	embarrassment cultural expectations – men stronger than women women are the 'typical' victims of domestic abuse

⁴ The Scottish Executive's booklet *Domestic Abuse, There's no excuse* can be obtained free of charge from the Scottish Executive (Tel. 0131-244-3995).

Table 2 continued

Common issues that create barriers to accessing provision	Women from minority ethnic/rural/travelling communities	Elderly/People with learning difficulties	Men/same sex couples and others
fear of institutionalisation mental health depression illness previous childhood abuse confidentiality access to information finance self esteem reliance on abuser young person alcohol problem drug misuse stigma	threats of separation from children isolation from own relatives or friends family pressure unaware of the level of support and services available ethnic and rural communities tend to be male dominated travelling lifestyle distance from services lack of transport residency rights prevailing sense of being helpless	weak memory and/or alzheimers disease learning disability	men are expected to be able to look after themselves fear of not being taken seriously lack of service provision homophobia fear of 'coming out' limited legal representation afforded to gay couples perpetrators persuading their partner that their behaviour is an expression of masculinity rather than domestic abuse prostitution self blame

The Scottish Executive document on public involvement *Patient Focus and Public Involvement* (2001) states that appropriate interpreters should be made available where necessary. In domestic abuse cases, where interpreter facilities are required, female interpreters should be available where possible and family members **should not** be used as interpreters. Health care staff should be aware that the abusive partner might also be the carer, advocate or usual interpreter.

Providing the right environment

Health care workers should be sensitive to cues and warning signs, which might suggest domestic abuse. Women may approach a range of health services directly or indirectly when they experience abuse. Continuity of care, with women seeing the same professional at subsequent appointments, may be helpful in giving them confidence to discuss problems. Many health care contacts may take place in a private setting such as the home or surgery. Where health care professionals are approached in a *public* setting such as an outpatients' clinic, a quiet private space should be found where confidentiality can be assured. If time or private space is not available immediately, staff should arrange a further appointment for more detailed discussion as soon as possible afterwards.

If the woman is not alone, suitable arrangements should be made to offer privacy. If she has children with her, wherever possible, arrangements should be made for another member of staff to look after the children safely. Health care workers working with children and young people who are experiencing domestic abuse will also need to be sensitive to their needs.

Partners should generally be made welcome where women bring them along to health care appointments. Nevertheless if a woman is accompanied by her partner (or any person) at every appointment, an arrangement should be made to see the woman on her own at least once. If the appointment relates to physical injury, staff should seek an opportunity to see the woman alone to ask for information directly. This should be done tactfully, for example when obtaining a urine sample. During antenatal appointments, women should be seen first and the accompanying person invited in afterwards.

Recognising the signs

Women experiencing domestic abuse may often seek help for other complaints but be unable to disclose domestic abuse. In these instances, health care workers need to be able to recognise potential indicators of abuse and respond appropriately and supportively. It should be borne in mind that indicators of abuse are not sufficiently sensitive or specific to be used as definitive markers. These may also be attributable to other causes. Women experiencing abuse may show no signs or indications.

Many women try to conceal their abuse for their own survival. Where any suspicion exists in the mind of the health care worker, *they must act* either by broaching the subject directly with the woman, or by seeking advice from a senior colleague about what to do next.

Physical and emotional indicators

The following physical factors should raise the question of possible abuse in the mind of the health care worker and prompt further enquiry:

Table 3 Physical and emotional indicators

- The woman reports chronic pain, or there is pain due to diffused trauma, without physical evidence. Bruising may be present where the explanation does not fit with the description of the injury.
- Repeated or chronic injuries. Injuries that are untended and of several different ages, especially to the head, neck, breasts, abdomen and genitals.
- The woman minimises injuries and/or repeatedly gives the same explanation.
- The woman exhibits physical symptoms related to stress, other anxiety disorders or depression, such as panic attacks, feelings of isolation and inability to cope, suicide attempts or gestures of deliberate self-harm.
- There is frequent use of prescribed tranquillisers, anti-depressants or pain medications.
- There are gynaecological problems such as frequent vaginal and urinary tract infections, dyspareunia and pelvic pain.
- There is evidence of rape or sexual assault, such as injury to genitals.
- Dental emergencies and instances of facio-maxillary trauma occur.
- There is evidence of alcohol problems and/or substance misuse.

Behavioural indicators

Whether or not physical indicators are present, certain behavioural patterns may be a clue to the presence of abuse:

Table 4 Behavioural indicators

- The woman misses appointments and/or does not comply with treatment regimens.
- There are frequent admissions/appointments for apparently minor complaints e.g. backache, headache etc.
- The woman appears unable to communicate independently. The partner may accompany the woman at all times, and insist on staying close and answering all questions directed to her. He may undermine, mock or belittle her. She may appear frightened, ashamed, evasive, embarrassed or be reluctant to speak or disagree in front of her partner.
- The woman reports, or the partner expresses, intense irrational jealousy or possessiveness or conversely may appear overly concerned.
- The woman or her partner denies or minimises abuse. The woman exhibits an exaggerated sense of personal responsibility for the relationship, including self-blame for the partner's violence.

The *Confidential Enquiries into Maternal Deaths in the UK (CEMD)* estimates that over a third of domestic abuse incidents start during pregnancy. Pregnancy may trigger or exacerbate male abuse in the home. Pregnancy may indeed be a *consequence* of abuse and an indication that the pregnant woman is in a coercive relationship, and health care staff should be particularly alert to this possibility where she is under 18. To investigate the possibility of abuse, the health worker should talk to the young woman about how she feels about her pregnancy. In the case of admission for abortion, gynaecological staff should never assume that the teenager or older woman has consented to unprotected intercourse.

There are strong links between domestic abuse and adverse pregnancy outcomes and maternity services should be particularly alert to the possibility of abuse and proactive in its detection and management. Service providers should consider routinely printing on the bottom of hand held records and co-operation cards, local information on services, emergency helplines and sources of help concerning domestic abuse.

The woman should have the opportunity to establish a good relationship with a midwife or doctor. Midwives in particular during assessment and antenatal care, may have the opportunity to support and empower the woman to escape abuse (See part 2).

Table 5 Indicators related to pregnancy

- Late booking.
- Unplanned or unwanted pregnancy.
- General unhappiness about the birth of the baby.
- Frequent visits with vague complaints or symptoms 'of an unknown clinical cause' and without evidence of physiological abnormality.
- Recurring admissions usually for reduced fetal movements/abdominal pain/investigation of UTI (although these are common in pregnancy).
- A high incidence of stillbirth, miscarriage and termination of pregnancies.
- Fetal injury and fetal deaths.
- Intrauterine growth retardation/low birth weight.
- Pre-term labour/prematurity.
- Evidence, or a history, of Postnatal depression
- Post-natally, removal of perennial sutures.

Research and practice has identified both the need for routine enquiry during maternity care and to see every woman on her own at least once during the antenatal period, to enable disclosure (RCOG (1997) and *Confidential Enquiries into Maternal Deaths in the UK* (2001)). Women who have disclosed domestic abuse are poor clinic attendees and there is a need for active outreach services.

DOMESTIC ABUSE – GOOD PRACTICE IN SCOTLAND

- Midwives at Forth Park Maternity Hospital are encouraged to ask women whether they are experiencing abuse at home.
- Aberdeen Maternity Hospital has established a group to address domestic abuse issues relating to midwifery.

Introducing the subject

Having had cause to suspect possible abuse, the health care worker must be prepared to broach the subject with the woman. Research evidence indicates that a substantial number of women do not tell agencies about abuse, but want the agency to enquire or prompt discussions. With training, staff should be aware of their responsibility to give women permission to speak out about their experience.

Challenging fears and concerns

Health care workers may be reluctant to confront a woman about the possibility that she is being abused, or acknowledge that it is a feature of a particular case, for a number of reasons. These include:

- concern about being seen to be intrusive or causing offence;
- concern that there may not be adequate time or resources to deal with the issue;
- belief that this is not the province of the NHS;
- belief that other local services will deal with abuse;
- fear of not knowing what to do next;

- fear of making things worse;
- fear of 'taking the lid off' something which will get out of control;
- fear of personal attack;
- personal identification with abuse, either as someone who is experiencing abuse or as a perpetrator;
- fear of involvement (i.e. as a witness).

It is important to be direct but tactful. No form of abuse can be considered acceptable or insignificant.

Asking questions

Discussing domestic abuse can be difficult and embarrassing. It is important to introduce the subject with open-ended, non-threatening questions so that the woman has a choice about how to respond and therefore remains in control of the interview. An abused woman's circumstances are almost certainly too complex to reduce to YES/NO responses. More open questions may include:

- How are things at home?
- How are you feeling generally?
- How are things with your partner?

If responses to open questions suggest that all is not well, the worker should ask more probing questions.

- What kinds of things are going wrong at home?
- What sorts of things are bothering you?
- Has anyone ever done anything to you to hurt you... is that happening now?

It may be helpful to say that it is important to ask such questions as in some cases women have mentioned problems. This will indicate that, where the woman is experiencing abuse, she is not alone. It should also reduce the likelihood of offence to those who are *not* experiencing problems in their relationships. Staff should not assume that women will be hostile or offended at being asked. If she is angry, that does not mean that the subject should not have been raised. The woman may come back later and want to discuss it when she is more able to do so. NHS Boards and Trusts should consider arranging training for key staff in counselling

More detailed prompt questions are included in Annex D.

Perpetrators as patients

An abused woman and the perpetrator of the abuse may be registered at the same medical practice. The GP, nurse or other health care worker may be aware that domestic abuse is occurring and may have discussed it with the woman. However, it is not likely that a woman who has made a disclosure will wish the issue of domestic abuse to be raised with her partner: fear of the perpetrator finding out is a common reason for women not disclosing. For example a GP discussing domestic abuse with a perpetrator may breach medical confidentiality and could be dangerous.

The perpetrator may also be in need of counselling and medical care in the same way as any other patient. The medical practice must ensure that the appropriate medical care is available. However, the health of the perpetrator, mental or otherwise, is not an excuse for abuse. Health care workers must guard against collusion, particularly if they know the perpetrator personally and find it difficult to accept the potential for abuse. It should always be made clear that abuse is unacceptable regardless of the other problems that the perpetrator might have.

Staff should also be ready to deal with the topic of abuse should disclosure occur, but should not put themselves in danger. Fear of violence towards members of the primary health care team may be justified. Managers of GP practices or LHCCs should assess the risk presented by any individual and ensure that staff are adequately protected. Removal of the alleged perpetrator from the doctor's list without robust evidence that the patient represents a real threat to staff at the surgery, or to other patients, is unacceptable. GPs may need to discuss this with the General Medical Council, the British Medical Association or Medical Defence Unions (see part 5).

Responding effectively

The subject of domestic abuse having been opened up, it is important that the health care worker manage the ensuing discussion appropriately. The following table gives guidance for staff on conducting interviews with women regarding the domestic abuse they are experiencing. Employers should provide appropriate training to support this guidance.

There are basic principles involved in talking with women experiencing abuse:

Table 6 Talking with women

- **Listen carefully.** The woman may talk around the subject before getting to the point. Often requests for help are veiled or oblique and must be identified and amplified. If necessary, clarify that you have understood she is talking about domestic abuse.
- **Believe her and say so.**
- **Reassure her** that she was right to disclose. Be careful not to make her feel inadequate for not having sought help sooner: remember, she may have sought help and been rebuffed. Reaffirm that she is a valuable person and that her needs are as important as anyone else's.
- **Affirm** the strength the woman has shown in enduring continued abuse, and the courage she has displayed in asking for help. Acknowledge her experience and accept her evaluation of the danger of her current situation. Stress that she does not have to continue in her situation and that you want to help.
- **Be honest and sympathetic.** Explain why questions are being asked so that the woman has a concrete focus, and avoid making her feel judged or defensive. At this stage it is useful to ask direct questions that require direct answers. *Under no circumstances should the woman be led to believe that she is in some way to blame for what has happened.*
- **Let her control the discussion.** Talking about abuse may be very difficult, so allow her to go at her own pace. She may only reveal a proportion of the abuse she has experienced.

- **Respect confidentiality.** Remind the woman that anything she chooses to tell you will be confidential, but also explain the limitations of your confidentiality, for example if there are children involved who may be at risk from the abuser. (See section 2.7)
- **Be constructive.** In addition to being supported and believed, the woman may need accurate information on the law, benefits, local resources and local support groups, and the worker should have these to hand. Be realistic about what help can be offered and be aware that giving inaccurate information such as wrong telephone numbers, addresses or times of opening could further discourage or endanger the woman.
- Be prepared to **deal with the disclosure over several contacts.**
- **Avoid saying ‘why don’t you?’** – it’s never that simple.
- Don’t try to solve everything. **Every woman has the right to make her own decisions.** She should be allowed to ignore the advice of health care workers if she wishes, or cease contact, without being judged. Women whose lives have been controlled by abusive men need time and space to learn to take control of their own lives again.
- Make sure she knows she **can approach NHS staff again in future.**

Health care workers can help and provide support by listening sympathetically. It is not always necessary to do something to be helpful. However, local arrangements should be in place for any referral on to specialist services or support.

Documenting and recording abuse, confidentiality and sharing information with others

Any member of staff within the health service may have cause to treat women, children and young people who have been abused. All may be asked to provide evidence to support legal actions. Careful recording and documentation is crucial.

Documenting injuries

In 1994 the British Association of Accident and Emergency Medicine issued guidelines on domestic violence to A&E Departments in the UK, recommending that attending staff be thorough in their examination of injuries, stressing that injuries should be documented meticulously and legibly, and highlighting that the presenting complaint may be only part of the picture.

Documenting disclosure of abuse

It is important that health care workers discuss with the woman as early as possible that:

- it **will** be necessary to record accurately all information given
- that it **may** be necessary to share this information with other agencies such as social work and police if staff fear that there is a risk to life

They should seek the woman’s consent to document the disclosure of abuse in her patient record, and the woman should see and have the opportunity to correct if necessary any information written about her. The woman should be informed of the importance and possible benefits of abuse being properly documented. Increasingly, a woman seeking legal help is likely to be asked to prove that she has been

abused and medical evidence can be a most useful way to strengthen her case, especially in court. It can also help in applications for an Interdict, Exclusion Order, Non-Harassment Order or for child custody purposes.

If there is objection to staff documenting the disclosure then they cannot care for the patient properly and this should be explained sensitively and carefully to the patient. If there is any information which the patient does not want to be readily accessible in her case notes, then she can request that this information is stored in a sealed envelope, only available to specified staff, except in an emergency. Staff should record these arrangements in the notes.

If an individual, especially a child may be at risk of significant harm, this will override a professional or agency requirement to keep information confidential. All health care workers have a responsibility to act in a manner which ensures the safety and welfare of an individual, especially children. This should be explained to the patient.

It should also be noted that under the Data Protection Act, the perpetrator may also have the right to see any information held which refers to him or her in the victim's casenotes. However in practice, the perpetrator might not be allowed to exercise this right if this might be harmful to others. Clinicians and other health care staff should consult with their agency's adviser on domestic abuse (see part 4) and their local Caldicott Guardian before deciding to disclose any information to an alleged perpetrator.

Sharing information

Medical and other health care professionals should provide written reports of their findings when asked to do so by the police, the local authority or the Reporter, as these agencies may need to take action on the basis of medical findings. Medical reports should normally be provided with the patient's consent unless there are special circumstances which require disclosure without the patient's consent, for example a Court orders disclosure, or disclosure is required to protect a child or other vulnerable person.

Staff should keep up-to-date case records of their involvement in any domestic abuse case, especially when child protection issues are involved. Records should include:

- details of any concerns about the woman, child and family;
- details of any contact or involvement with the family and any other agencies;
- the findings of any assessment;
- any decisions made about the case within each agency or in discussions with other agencies;
- a note of information shared with other agencies, with whom and when;
- a statement that the woman has been asked about sharing information and has given or withheld consent.

Recording referrals and disclosures

Any information about or alleging domestic abuse in a referral or disclosure should be written down accurately and in detail, either at the time or immediately afterwards with the woman's consent. Records should note the date and time that any incident occurred and the date when the record was made. They must also be signed.

Any documentation of disclosure of domestic abuse must clearly and accurately record the woman's history. These records must be maintained in strict confidence and never in her hand held notes. An agreed plan of action, which can be followed up by the health care worker at a later date, may also be useful. If the woman does not keep to the agreed action, the health worker needs to document this in the records and ask her about this in a non-challenging way. If the woman feels she will be judged negatively because of failure to follow the plan, she may default on further appointments. If there is no follow up, the woman may feel that she has not been listened to.

Documenting domestic abuse can be difficult and time consuming, but health care workers should endeavour to offer a supportive service, which may or may not need the intervention of others. Any child protection concerns should be shared with the social work Department and the police in line with local child protection guidance, without delay.

Recording systems should meet the requirements of legislation on access to files and data protection. Storage arrangements should be adequately secure and protect client confidentiality.

Guidance for the retention and destruction of Health Records is set out in NHS MEL (1993) 152, Appendix A, paragraph 6 and Appendix B, 1b.



“Children’s and Young Adults’ Records (persons aged less than 16 on date of admission) shall be retained for a minimum until the person reaches 25 or 3 years after death if this is earlier. At the conclusion of the period, the records may be destroyed, but there is no obligation to do so”

Confidentiality of personal health information is the cornerstone of the patient/health professional relationship. In Scotland, guidance on handling personal health information rests on the *Code of Practice on Confidentiality of Personal Health Information*, issued to the NHS in 1990. The Code, which is due for revision in 2002, sets out the main principles that have to be followed by all NHS staff. The overriding principle of the Code is that information about the health and welfare of a patient is confidential in respect of that patient and such information should not be disclosed to other persons without the consent of the patient, except in certain well defined circumstances, for example where a child is at risk.

It is a matter for the health professional with overall responsibility for clinical care to determine whether the wider public interest outweighs the rights of a patient to confidentiality and warrants the disclosure of information. In reaching a decision, all relevant circumstances should be taken into account including the need to protect the public and any rights of the patient to have confidentiality of personal information about him or her protected.

Doctors' professional accountability

The General Medical Council's advice to doctors is that where they believe a patient to be experiencing neglect, or physical or sexual abuse, and that patient cannot give or withhold consent to disclosure, information should be disclosed to the appropriate responsible person or agency where it is felt to be in the patient's best interests. This has particular implications for those women who may be recognised by the Incapacity (Scotland) Act (2001). Where such circumstances arise in relation to children, concerns about abuse need to be shared with other agencies such as social work services. It will usually, but not necessarily, be appropriate for those with parental responsibility to be informed.

Nurses' and midwives' professional accountability

All nurses and midwives should be familiar with the Nursing and Midwifery Council's *Code of Professional Conduct*, which came into effect on 1 June 2002. The designated, named or senior nurse/midwife should encourage staff to refer to the document and ensure that the Code is covered in in-service training. The *Code of Professional Conduct* makes sure that nurses, health visitors and midwives promote the interests of their patients and clients, respect the client's autonomy and are accountable for their own practice.

Caldicott Report on Review of Patient-identifiable Information

Each NHS Board and NHS Trust has appointed a 'Caldicott Guardian' who is responsible for the way that the organisation handles and protects patient-identifiable information. The Caldicott Guardian is a senior health professional, most usually the Director of Public Health at NHS Board level and the Medical or Nursing Director within NHS Trusts. Any queries about the disclosure of personal health information should be referred to the Guardian.

Safety assessments

Once any response to the patient's immediate needs has been made, it is important to make an assessment of safety. Conducting a safety assessment with the woman may help her to think through her situation and make decisions about what she needs to do.

It should be determined whether the woman is afraid to go home and if necessary she should be referred to the local Scottish Women's Aid or other agencies (see Part 4) where experienced help and support is available.

A full safety assessment should address:

- The history of abuse of the woman and her children, considering any escalation in frequency, intensity or severity.
- Whether the abuser is:
 - Making verbal threats
 - Physically violent
 - Threatening to harm or abduct the children
 - Physically harming the children
 - Frightening/disturbing/threatening friends and neighbours
 - Frequently intoxicated on drugs/alcohol and more abusive in this state
- The woman's current fear of the situation and her beliefs about her immediate danger.
- Self-harm or suicide threats/attempt by the woman.
- The woman's attempts to get help – from police, courts or Women's Aid groups during the past 12 months.
- The availability of emotional support and practical support from friends and family.

A decision to leave

If the woman is returning to a living situation that may expose her to abuse in the future, the health care worker should provide information about services and offer practical advice. Preparing a safety bag to keep hidden in a secure place, such as a friend's house should be recommended. Practical advice about what should be contained in the safety bag is available from local Women's Aid groups.

Where possible the woman should arrange alternative accommodation before leaving, by contacting for example local Scottish Women's Aid or a friend. However, the most dangerous time for a woman and children is when she is planning to leave her abuser, as her partner may escalate the intensity of the abuse if he becomes aware of her intention. Her first priority is get herself and the children away from danger and to a safe place where she can call for help and advice. This may require the assistance of the police (see part 1).

A decision to stay

It is important to understand that leaving an abuser is not a single act but a process. It should be remembered that many women face multiple obstacles in escaping abuse, often the same obstacles that make disclosure difficult (see part 2).

Women stay for many reasons ranging from love for the abusive partner (though not the abuse), fear of reprisals against her or her children and lack of money. Leaving and staying both require strength and resourcefulness. A woman may hope that her partner will change and that the family can stay together. An abusive partner may exhibit periods of loving behaviour and express remorse. Support services for women fleeing domestic abuse vary widely around the country. Well resourced in some areas, in others options may be more limited. Difficulties with housing and money, as well as a range of emotional pressures, may force a woman to return to an abusive partner.

The decision to leave or stay rests with the woman. The health care worker must respect and support her, regardless of the decision she makes. However, when children are exposed to risk, health care workers will need to notify agencies with statutory responsibility for child protection (see Part 3).

Referral to other specialist services

Women who are experiencing, or have experienced, domestic abuse or child abuse may experience severe psychological consequences resulting in depression, drug misuse and alcohol problems and sometimes suicide or attempted suicide. Women with learning difficulties or mental health problems may require referral to psychological or psychiatric services.

All staff should have access to information about alcohol/substance misuse and treatment services. Antenatal staff should routinely ask for information at booking about alcohol and drug use, problems in relation to substance misuse, psychiatric history, and be aware of the links between these problems and domestic abuse.

Psychological interventions should be delivered by skilled personnel trained specifically in domestic abuse, in an appropriate professional context, with regular supervision. Many patients will need long term help and support.

Advocacy

Some women may benefit from an advocacy service to ensure their needs are understood and are clearly and sensitively expressed, so that they can contribute to the decision making. The Adults with Incapacity (Scotland) Act 2000 must also be considered in terms of decision making and consideration of the person's future.

PART 3: PROTECTING CHILDREN

This section is based on national guidance on child protection
*PROTECTING CHILDREN – A SHARED RESPONSIBILITY:
Guidance on Inter-agency Co-operation (1998)*

Research indicates that many children at risk of harm live in families in which domestic violence, social exclusion, mental illness or misuse of drugs or alcohol are significant factors. Good health care, education and family support are essential services to safeguard and promote children's welfare and strengthen the capacity of families under stress to meet the needs of their children before problems escalate to abuse or neglect.

It is estimated that in around 90% of cases, children will be in the same or adjacent room to where domestic abuse is occurring. They may try to intervene and there may be a high risk that they may also be assaulted. Children and young people suffer in many ways when living with and witnessing domestic abuse. They may experience emotional disturbance, physical disorders and disruptions to lifestyle, such as:

- feelings of anger, guilt, isolation, fear;
- anxiety, self harm, low self esteem, depression, withdrawal;
- asthma, eczema, bedwetting, tiredness, injury;
- homelessness, poverty, disruption to schooling, social exclusion;
- loss of family, friends, pets, possessions.

Some groups of children are particularly vulnerable or have additional needs, and agencies should consider their circumstances with special care. These include children affected by disability, children from minority ethnic groups or who do not have English as a first language and children in homeless families.

Working together to protect children

Child abuse and neglect have implications for child welfare, criminal justice and other agencies' responsibilities. Each agency makes a distinctive contribution to safeguarding children's welfare within a context of collaboration and shared understanding. No one agency should be seen as solely responsible for the protection of vulnerable children. Child protection is one aspect of services geared towards meeting children's wider developmental needs and should not be seen as a separate activity.

Co-operation in child protection is underpinned by joint procedures prepared by inter-agency Child Protection Committees, to which all relevant agencies contribute, and appropriate inter-agency training. These procedures should deal with the arrangements for responding to and sharing of information about allegations of child abuse, and accessing specialist advice or expertise. All agencies should have

arrangements in place for selecting suitable staff, and for supervising, training and supporting them to carry out their tasks.

- Agencies need to understand the causes and be alert to signs of child abuse and neglect, and be willing to provide help and support at an early stage.
- Informed responses to reports of abuse from a child or any other person should not pre-empt or prejudice child protection inquiries or criminal investigation.
- Local authorities should plan child protection inquiries in close consultation with the police and other agencies, in particular health and education.
- Evidence should be gathered in ways which ensure the effective prosecution of crimes against children.
- Legal measures to protect children are available through the Courts in emergencies or when families are unwilling to assist.
- All agencies should contribute to assessments and decisions about how to protect children from abuse, and give priority to helping children recover from the trauma of child abuse or neglect.
- Agencies should work in partnership with families, by informing and involving them in decisions and enabling them to participate actively in plans.

When information is received which suggests a child may be in need of compulsory measures of supervision, the local authority social work service will make inquiries and pass their findings on to the Reporter to the Children's Panel. Some children who experienced abuse or neglect will need continuing support from their local authority, including specialist services and counselling. Some may need to be looked after by the local authority.

Providing practical and emotional support is a major factor in influencing how children survive and cope with abuse. There are specially trained people who can help children and young people to talk about their experiences, make sense of their fears and worries, gain mutual support and self esteem and feel happier.

Agencies should provide sufficient help at an early stage to reduce the need for compulsory intervention in families' lives. But where a family is not able to care for their child safely, agencies must act promptly and with skill, to protect the child. In doing so they should avoid causing the child undue distress or adding unnecessarily to any harm already suffered by the child. The welfare of the child is the paramount consideration when his or her needs are considered by Courts, Children's Hearings and local authorities.

Sharing information to protect children

Personal information about children and families given to professional agencies is confidential and should be disclosed only for the purposes of protecting children. Nevertheless the need to ensure proper protection for children requires that agencies share information promptly and effectively when necessary. Ethical and statutory codes for each agency identify those circumstances in which information held by one professional group may be shared with others to protect a child. Agencies should not disclose information given in confidence for any other purpose without consulting the person who provided it.

In child protection cases where children are at risk or alleged to have been harmed, when recording their intervention and activity, health care staff should take contemporaneous notes wherever possible, and should complete records as soon as possible after an event or interview. Original notes and case records, drawings or other written material should be retained even if information is condensed into summary reports, as these original notes are regarded as ‘best evidence’ by the courts. All maternity records need to be retained for 25 years.

The Child Protection Register

Registration is an administrative system for alerting workers to the fact that there is sufficient professional concern about a child to warrant an inter-agency child protection plan. It ensures that the plans for these children are reviewed at least every six months. Local authorities are responsible for maintaining a Register of all children who are the subject of an inter-agency child protection plan, which provides a central point of rapid enquiry for professionals who are concerned about a child’s development, welfare or safety. The decision to place a child’s name on the Child Protection Register is taken by a multi-disciplinary case conference.

Joint investigation

Joint investigation describes the process whereby social work, police and health professionals plan and carry out their respective tasks together when responding to complex or substantial child protection referrals. All referrals of child sexual abuse should be considered for joint investigation.

The police and social work service should share and jointly evaluate all relevant information at an initial planning meeting or discussion, involving health services wherever possible. Planning should consider the needs of and risk to the child, as well as the conduct of child protection inquiries and any criminal investigation. Medical information and assessment may assist the planning and management of any inquiries.

National guidance on child protection

The executive has issued national guidance on inter-agency co-operation in child protection and agency specific guidance for health professionals.⁵ These should help agencies and professionals to understand each other’s roles and functions, and make the best use of their experience and expertise in safeguarding children.

DOMESTIC ABUSE – GOOD PRACTICE IN SCOTLAND

In Fife the Child Protection Training Programme has also begun to incorporate women’s protection.

⁵ Protecting Children, a shared responsibility – Guidance for Health Professionals in Scotland, Scottish Executive, January 2000.

Fig 1: AN OVERVIEW OF THE CHILD PROTECTION PROCESS

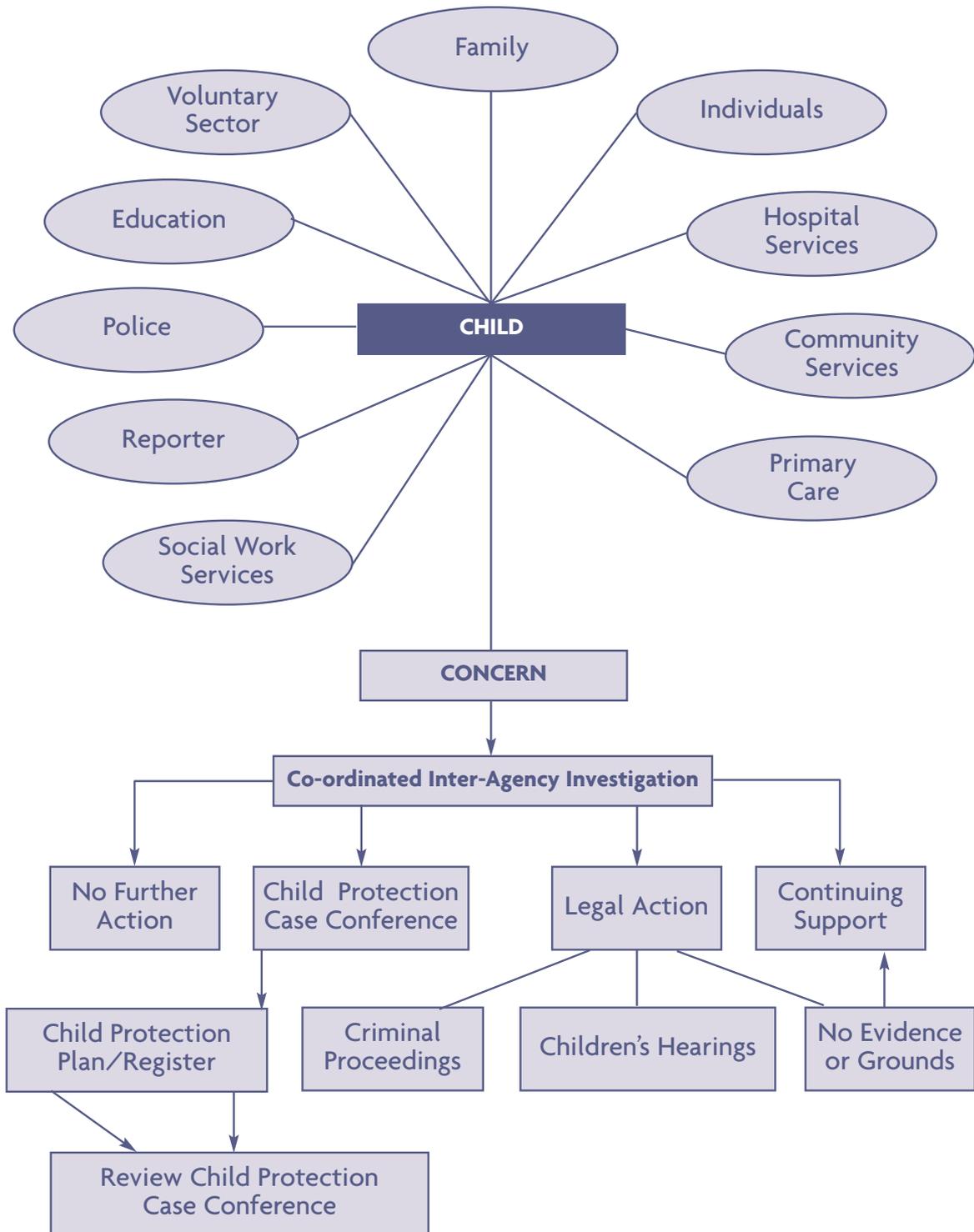
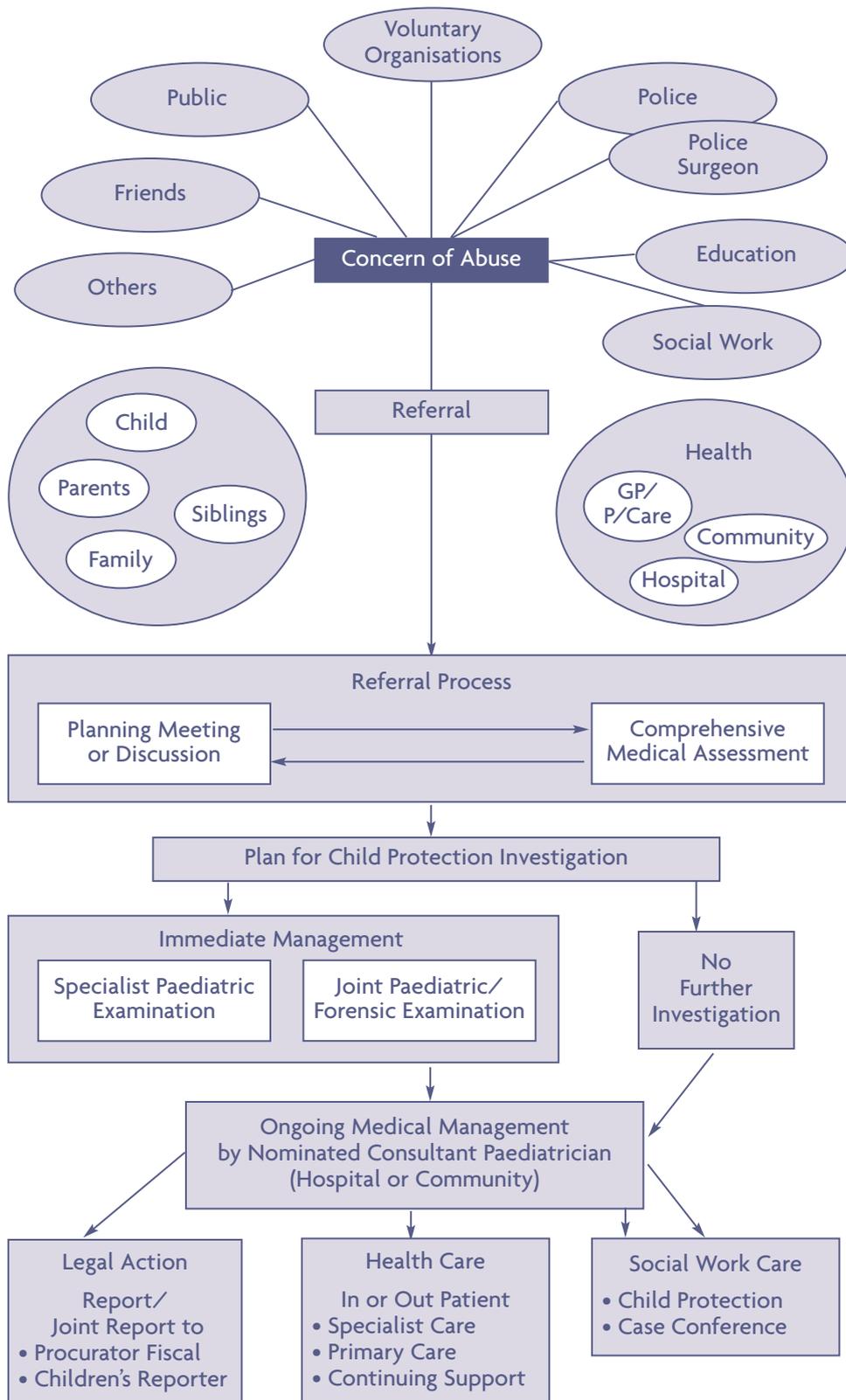
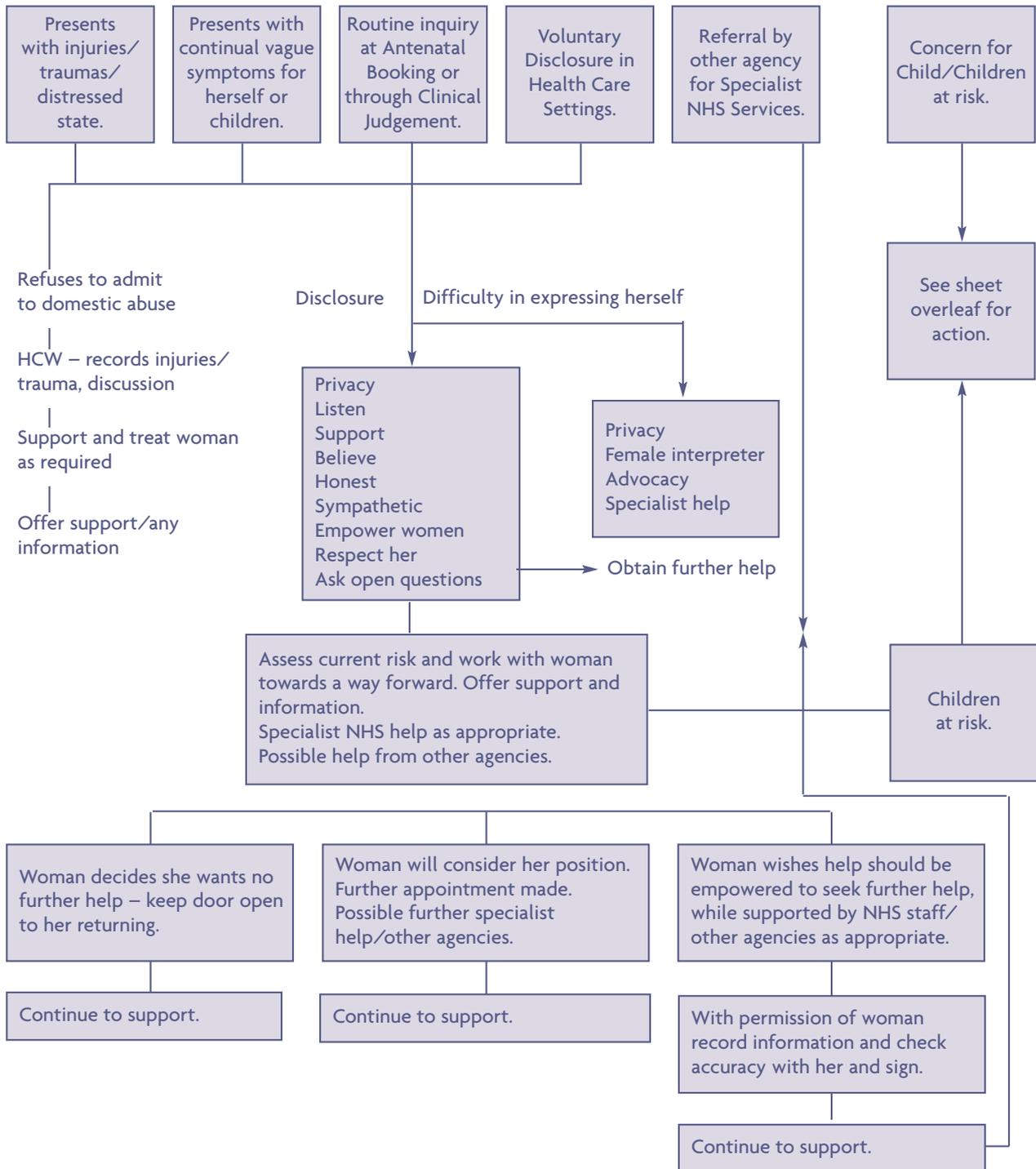


Fig 2: MEDICAL ASSESSMENT AND CARE OF CHILDREN WITH SUSPECTED ABUSE/NEGLECT



CARE PATHWAY FOR RESPONDING TO A WOMAN EXPERIENCING DOMESTIC ABUSE



PART 4: PLANNING AND MANAGEMENT

NHS Boards and NHS Trusts must play their part in raising awareness of domestic abuse as a significant social and health problem and ensure effective participation in local frameworks to implement *A National Strategy to Address Domestic Abuse in Scotland*. Each NHS board should ensure that the health component of their local strategy to address domestic abuse is included in their Local Health Plan. Boards will be held accountable for the quality of strategy and performance through the Performance Assessment Framework for the NHS in Scotland.

Planning

Each NHS Board should develop a policy for women's health improvement as an overarching framework in which domestic abuse/violence is addressed. The health service is one partner in a multi-agency response to domestic abuse and should contribute effectively to the development of multi-agency strategies. Local Domestic Abuse Forums will oversee development of a multi-agency strategy to address domestic abuse and ensure that local agencies develop appropriate links. Each NHS Board should identify a lead officer at Director level to co-ordinate the planning of a local strategy for local NHS organisations, and an operational adviser to provide advice and support for front line practitioners.

The development of guidelines for each health service setting should be linked to clinical governance and to a robust system of audit. Systems must be put in place in order that guidance for staff is cascaded to all health care settings.

Locally appropriate systems should be devised to involve women who have experienced domestic abuse, and Scottish Women's Aid and local Women's Aid Groups, in service planning and delivery.

DOMESTIC ABUSE – GOOD PRACTICE IN SCOTLAND

- The Scottish Executive Domestic Abuse Development Fund, has funded Domestic Abuse Training Co-ordinators in Forth Valley NHS Board.
- Lanarkshire NHS Board has contributed to the staffing costs associated with the establishment of a Domestic Abuse Co-ordinator's post in North Lanarkshire

Implementing the guidance

NHS Boards and NHS Trusts should put in place a local strategy for implementation of these national guidelines on domestic abuse and how to identify and respond to it.

DOMESTIC ABUSE – GOOD PRACTICE IN SCOTLAND

NHS Greater Glasgow has included tackling domestic abuse in its local health plan and identified dedicated resources for development in this area.

When putting together local policies and guidance, NHS Boards and Trusts should:

- adopt the Scottish Executive's definition of domestic abuse;
- base guidance on best available current evidence, audit and risk management;
- ensure professional and user experiences and views are taken into account;
- include prevention as well as intervention;
- take into account codes of professional conduct and professional guidelines on best practice and advice from trades unions such as Unison.

In addition, any guidance produced should take into account local child protection processes, as domestic abuse may be an indicator of child abuse. The policy should also link across to other policies such as the Framework for Mental Health, the Drug Action Team's Corporate Action Plan and any plans developed by the Alcohol Misuse Co-ordinating Committees and local WellWoman services and support services for children.

Education and training should be addressed, including issues regarding the potential for litigation, negligence, breach of duty of care and breach of confidentiality. Documents explaining these should be included in the guidance. Policies must also be regularly evaluated.

DOMESTIC ABUSE – GOOD PRACTICE IN SCOTLAND

The EVA project is currently funded by Motherwell North Social Inclusion Partnership (SIP) and is managed by Motherwell LHCC. It has a number of objectives including direct service delivery, research and staff training. In relation to training, the project has worked with the LHCC to provide multi-agency training to groups of nursing staff, police, Procurator Fiscal staff, social workers and voluntary sector staff. Subject to a positive evaluation, this will be rolled out to other SIP areas.

Service provision

Specific services may need to be developed, or existing services adapted, to create a comprehensive service for women, children and young people who have been abused. Screening for domestic abuse during antenatal care should be introduced and advocacy offered for those who need it, such as women with a mental illness or a learning disability who are experiencing abuse, as outlined in *Our National Health* (2000), *Independent Advocacy* (2001) and *Patient Focus and Public Involvement* (2001). Resources, including time, must be made available for implementing NHS guidance on domestic abuse.

Normally, women experiencing abuse should have the option of access to female staff in any setting, at all levels of the service, including cervical screening and post rape screening. A female interpreter service should also be available where possible (see *Fair for all: working together for culturally competent services*, NHS HDL (2002)). Professionals who understand the needs of children and young people who are experiencing domestic abuse should be involved as appropriate.

Staff development

Effective staff development must be in place, and education and training should be updated regularly. All health care workers should be made aware of the services and resources available locally to women, children and young people experiencing domestic abuse, and should use this guidance to help them create health care environments that give women confidence to disclose.

As part of the partnership approach, Ayrshire and Arran NHS Board is taking the lead in mapping a woman's journey through the various services available. This will enable seamless and integrated provision for a person suffering the consequences of domestic abuse.

Advanced training of key staff should create a network of link contacts who could act as local 'experts' on issues such as referral, support and advice.

Staff support

Domestic abuse is an emotive issue. NHS employers, through line managers, must ensure that staff are appropriately supported when involved in any aspect of domestic abuse, irrespective of whether they are supporting others or are experiencing abuse themselves. Where health care workers are involved in criminal proceedings, for example in a child abuse case, it is the responsibility of the NHS employer to ensure that staff are given support, time and supervision to prepare statements and that they have appropriate legal advice. The NHS employer should make sure that the staff member:

- Is familiar with local court procedures.
- Has the opportunity to discuss statements or evidence with a lawyer.
- Is supported by being accompanied to court when giving evidence.
- Has the opportunity, following court proceedings, to discuss the case and receive further clinical supervision.

Education and training

Education and training for all health service staff on domestic abuse should be available in order that they have the opportunity to gain an awareness and understanding of domestic abuse and familiarise themselves with NHS Board or Trust guidance on the detection of abuse and response to it. While domestic abuse crosses all sectors of society and is not confined to certain groups, specialist training will be required on some issues, such as the specific needs of people who use drugs and/or work in the sex industry. More detailed training for specialist staff e.g. in obstetrics and gynaecology, accident and emergency, primary care and paediatrics should be available.

NHS employers, with Higher Education Institutions, should ensure that domestic abuse is included in pre-registration, post registration, undergraduate and postgraduate education and training programmes of all health related disciplines, with particular emphasis on health care practice. Staff should be instrumental in raising awareness of the issues of women and children experiencing domestic abuse. Staff should emerge from training confident in asking safe questions appropriately and understanding the link with child protection.

Where possible shared learning should be available on ethics, legal issues and interpersonal/communication skills for doctors, nurses, midwives, social workers etc, using a variety of educational approaches. The use of voluntary organisations to 'train the trainers', should be explored as a means of taking this forward, such as Scottish Women's Aid staff, and their training pack which will be available at the end of 2002.

As part of the educational process, health care workers must have had the opportunity to examine their own beliefs and attitudes towards domestic abuse. Education and training programmes must emphasise that:

- Domestic abuse is a serious problem, as well as a criminal offence; it is not a private matter between partners.
- Abuse is not an inevitable part of 'normal' relationships.
- Women do not provoke or 'ask for it'.
- Women can be supported if they decide to stay with an abusive partner.
- Misuse of alcohol or drugs is not an excuse for domestic abuse and does not exonerate the abuser from responsibility for his behaviour.

DOMESTIC ABUSE – GOOD PRACTICE IN SCOTLAND

Training to change attitudes and raise awareness has been taken forward as part of the organisational response in Ayrshire and Arran NHS Board. Several members of staff have already completed the training and awareness raising with Scottish Women's Aid and the Strathclyde Police.

Employers' responsibility for staff and the development of an employee policy

NHS employers should be aware that health care workers may experience distress in working with cases where abuse has occurred and they may need extra support (see section 4.7).

Furthermore, health care workers are not immune to abuse themselves and may be experiencing it outside the work environment. In such situations, staff members may be reluctant to approach their employer due to fear of the response or concern for the impact on their employment and promotion prospects. It is generally acknowledged that such cases are under reported.

It is essential that a climate of belief is created whereby staff can approach their employer for support. This needs to be addressed by producing an employee policy, which should be discussed with trade unions. Domestic abuse policies constitute an essential part of the NHS employers' strategy to achieve equal opportunities in the workplace. Support for employees should be available from the Occupational Health Service and employee counselling programmes.

Support and security at work play a vital part in the well being of any organisation. Staff should feel fully supported and confident in approaching their employer for help. This can also increase their commitment to their organisation. A workplace policy is a good investment, helping to retain skilled and experienced staff, and contributing to motivation and job satisfaction. Employers who have a policy on domestic abuse are demonstrating a powerful commitment to the principles of equal opportunities and community investment.

Human Resources staff or contact officers must be suitably trained and equipped to support and advise health care workers who are experiencing distress over a domestic abuse case, who are themselves experiencing abuse or who are perpetrators of abuse.

A checklist for negotiating a policy for staff is available in Annex C.

PART 5: SOURCES OF SUPPORT AND INFORMATION

This section discusses sources of advice and support for health care workers who are responding to domestic abuse cases. It provides information on other agencies and bodies which play a role in tackling the issues and which provide services.

VOLUNTARY ORGANISATIONS AND HELPLINES FOR WOMEN;

DOMESTIC ABUSE HELPLINE

A National Helpline is available for anyone who is experiencing domestic abuse, or knows someone who is. Run by North Ayrshire Women's Aid, it operates between 10am and 10pm, 7 days a week and currently averages 50 calls per week.

Tel: **0800 027 1234**.

SCOTTISH WOMEN'S AID

If a woman needs to leave her home because of abuse, Scottish Women's Aid can help her find somewhere else to stay. They may offer a place in a Women's Aid refuge, which provide safe temporary accommodation run by women for women. Refuges are usually ordinary houses where women and their children have their own room and share the rest of the house with other families, or self contained flats with common areas. Women's Aid has refuges throughout Britain if a woman is afraid to stay in her own area. They can provide women with information about the options available to them, and offer someone to listen if they need to talk.

A woman does not commit herself to anything by contacting Scottish Women's Aid and the service is completely confidential. They would only pass information on to anybody else if the woman asks them to do so, *or if not doing so would place a child at risk*. Scottish Women's Aid also has children's workers.

Telephone numbers for local groups can be found in the telephone directory or from Scottish Women's Aid:

Tel. **0131 475 2372**

What Scottish Women's Aid offers?

- Someone to talk to confidentially.
- Time to decide what to do.
- Support to carry out decisions.
- Residential refuge for a short time for a break or time to think, or longer term, or for more than one occasion.

- A place to be safe – refuge addresses are not made public and are not accessible to male visitors. The local Scottish Women's Aid group can put women in touch with groups in other areas.
- The opportunity to stay in a refuge for as long as needed.
- Somewhere to come back to if things don't work out.
- Support from other women living in the refuge.
- Support from Refuge workers.
- Support for children and young people – a space for them to have fun, be listened to, etc.
- Help with school places.
- Children and young people's workers.
- Helplines, information, training and resources.

WOMEN'S AID NATIONAL HELPLINE

Tel: 08457 023 468 (referrals nation-wide)

REFUGE

24 hour national crisis line providing information, support and practical help to women experiencing domestic abuse. It can refer women and their children to refuges throughout the UK.

Tel: 0990 995 443

HEMAT-GRYFFE WOMEN'S AID

Hemat-Gryffe Women's Aid aims to provide safe temporary accommodation to women and their children primarily of Asian, black and ethnic minority background who have experienced abuse. They provide information and support on housing and help with arranging permanent re-housing. They also provide information on immigration, social security payments and other necessary help as needed.

Open 9am– 4pm, Mon-Fri.

Tel: 0141 353 0859 (24 hour answering machine service)

SHAKTI WOMEN'S AID

Shakti provides a service for Black and Asian women and children. They can help with immigration issues and laws concerning separation and divorce, and can give advice on what benefits are available. If the woman is still with her partner, they can give practical advice.

Tel: 0131 475 2399 (09.00-17.00)

RAPE CRISIS NETWORK

The Rape Crisis Network provides counselling and support to women who have been raped or sexually assaulted, or who are survivors of childhood sexual abuse. The phone number of the local Rape Crisis Centre is listed in the telephone directory and under 'Helplines' in the Yellow Pages, or is available from the police, Social Work Department or Citizen's Advice Bureau.

RAPE AND ABUSE LINE

Free helpline for men and women seeking help, advice and support as victims of rape and abuse.

Tel: 0808 800 0123

AGE CONCERN SCOTLAND

Abuse of the elderly is about more than violence and is not gender specific. Besides physical, emotional and sexual abuse it can include financial exploitation and neglect. There is however a gender dimension to ageing in that there are many more women than men in the age groups over 75. Advocacy services, such as Age Concern Scotland and Alzheimer's Scotland Action on Dementia offer one to one support and help to older people.

Tel: 0808 808 8141 (Mon-Fri 10.00-16.30)

WE'RE NO EXCEPTION

This is a campaign organisation raising awareness about and campaigning against violence against disabled women. They provide a service for young people to adults aged 16-65. They can give advice on rehabilitation services.

Tel. 0141 945 5662 (Mon-Fri 09.00-16.00)

LESBIAN AND GAY LINE

Provides support, practical help, and information on health issues, counselling and referral to specialist agencies.

Tel: 01387 261818

CARELINE

A national confidential counselling line for children, young people and adults on any issue including family, marital and relationship problems, child abuse, rape and sexual assault, depression and anxiety.

Tel: 0208 514 1177

SHELTERLINE

Shelter is a campaign organisation for homeless people and provides a freephone service offering information about emergency access to refuge services and general housing matters.

Tel: Shelterline 0808 800 4444

SAMARITANS

The Samaritans offer 24-hour confidential emotional support for anyone in crisis. Their number links up all their branches; or the number of a local branch, can be found in the local phonebook.

Tel: 08457 90 90 90

VICTIM SUPPORT

Victim Support provides emotional and practical support to all victims and witnesses of crimes: time to talk, confidential help, practical help, information about compensation, crime prevention and criminal justice procedures. They also provide help with attending court. Victim Support Scotland can be contacted 09.00-17.00 Monday to Friday. Outwith these hours, calls to any of their offices will be offered a helpline number to contact. Local numbers are in the phonebook and on their website www.victimsupportscotland.co.uk

ALZHEIMER'S SCOTLAND

Tel: 0808 808 3000 (24hours)

CITIZENS' ADVICE BUREAUX

Citizens' Advice Bureau, the local number for which can be found in the telephone directory and under 'Helplines' in the Yellow Pages, can offer advice and help on a whole range of matters and can refer women where appropriate to specialist services.

VOLUNTARY ORGANISATIONS AND HELPLINES FOR CHILDREN AND YOUNG PEOPLE;

CHILDLINE

Childline is the free national helpline for children and young people in trouble or danger. It is available 24 hours a day, every day of the year.

Tel: (free) 0800 1111.

CHILDREN 1st

Children 1st supports families under stress, protects children from harm and neglect, helps children recover from abuse and promotes children's rights and interests.

Tel: 0131 337 8539

PARENTLINE

A confidential helpline for parents.

Tel: 0808 800 2222

SUPPORT FOR HEALTH CARE WORKERS

Domestic abuse is an emotive issue and any member of NHS staff can experience distress in working with abused women. It may be difficult or painful for individual health care workers to confront the issue of abuse and to support others experiencing abuse. Staff expect, and should receive, assistance from their NHS employers. Counselling services are available from the Occupational Health Service and also in some areas from trained contact officers. Independent counselling support is available from several professional organisations, as outlined below.

Doctors

The British Medical Association (BMA) can be contacted for advice on legal issues and provides a Stress Service.

British Medical Association Tel: 0131 247 3000

BMA Counselling Services Tel: 08459 200169

Medical Defence Union (MDU) Tel: 0800 71 66 46

Medical and Dental Defence Union (MDDUs) Tel: 0141 221 5858

Medical Protection Society (MPS) Tel: 0113 241 0500

and 0207 399 1301 + 0845 605 4000

Midwives

A midwife should inform her/his supervisor of any complicated cases or instances where she is finding it difficult to deal with the situation. The supervisor can act as an independent advisor to the midwife but may also assist the midwife in accessing the appropriate support networks. The Royal College of Midwives (RCM) provides a helpline counselling service for its members.

Tel: 0845 605 0044

Nurses

Welfare advice and support is available to Royal College of Nursing (RCN) members on the RCN Nurseline and confidential support for members experiencing emotional distress is provided through the RCN Counselling Service.

Tel: 0845 769 7064 (local rate in the UK).

RCN Direct (24 hour helpline) Tel. 08457 726100 or their local representative

Union members

The trade union Unison has a helpline for members.

Tel: 0800 597 9750

GLOSSARY OF TERMS

The following provides an explanation of legal terms. It does not offer advice on which option a woman should pursue. This will depend on her individual circumstances and advice should be obtained from a solicitor.

Court order

This is the blanket name given to written instructions or decisions made by the court, some of which may give protection against domestic abuse. Some court orders can be granted on an emergency basis and a court can grant one or more order at the same time. For example, the court can be asked to grant an **Exclusion Order** on an emergency basis and at the same time as a **Matrimonial Interdict** is being sought.

Before considering applying for a court order, advice should be obtained from a solicitor, as this is a complex area of law. In order to obtain a court order, evidence will be needed in addition to the woman's own statement to satisfy the court that it is reasonable for the woman to be afraid of abuse or further abuse from the abuser. Evidence might come from a friend, a neighbour or relative who has witnessed or heard the abuse or seen the injuries, or can be provided from a medical report and police records.

Most court orders can be obtained quickly if the applicant is at risk. However, applications to the court must be prepared and also paid for. The woman may be eligible for Legal Aid to help with legal expenses, but this is only free for those in receipt of Income Support or income-based Job Seeker's Allowance, or whose income is below certain defined levels. If the woman's income is above this level she will be required to make a financial contribution, which can be high. The Scottish Legal Aid Board will allow contributions to be paid over 20 months.

Criminal Injuries Compensation

If a woman has contacted the police for protection against domestic abuse in the past, it is worth contacting **the Criminal Injuries Compensation Authority (CICA)** for information on making an application for compensation for any injuries sustained. It must be pointed out, however, that compensation is not available to anyone who continues to live in the same household as the abuser. CICA can be contacted as follows:

Criminal Injuries Compensation Authority (CICA)

Tay House

300 Bath Street

GLASGOW

G1 4JR

Tel: 0141-331 2726

Exclusion Order

This is a court order, which suspends the occupancy rights of the partner, against whom it is granted, to live in the family home. It is available to all married people and to some unmarried cohabitants. Unmarried women will need to ask advice from Scottish Women's Aid or from a solicitor to find out whether they might be entitled to an Exclusion Order. Exclusion Orders are not available to those in same sex relationships.

In order to obtain an Exclusion Order the court must be satisfied that it is necessary to protect the woman and/or her children from any behaviour of the partner which is potentially harmful, physically or mentally. The woman will be required to make a sworn statement about the way her partner has behaved in the past, and whether that behaviour is likely to occur again. She will need a medical report, or a sworn statement from another person, confirming what she says. The courts are cautious about making Exclusion Orders because it would be wrong to put someone out of their home without good reason. Exclusion Orders can be granted on an emergency basis, but usually take at least 2 or 3 weeks to be dealt with, because the partner must be given the opportunity to oppose the application.

Interdict

This is a court order, which prohibits a person from a particular action or behaviour and can prevent a person behaving unlawfully towards another. The unlawful behaviour can be of any kind and includes domestic abuse. This might include physical violence, threats and/or verbal abuse. Anyone who is affected by the unlawful behaviour of another person can apply to the court for an ordinary Interdict. It does not matter whether the applicant is married or unmarried, or in a same sex relationship.

After 6 February 2002, anyone applying for any Interdict for the purpose of protection from abuse or anyone who already holds one, can seek to have a power of arrest attached to that Interdict under the terms of the **Protection From Abuse (Scotland) Act 2001**. This enables the police to arrest an interdicted person without warrant, if he has breached the terms of the interdict and there would be a risk of further abuse if he were not arrested.

Matrimonial Interdict

This is a special type of **Interdict** granted in terms of the Matrimonial Homes Act, which prohibits abusive behaviour by a partner and allows police discretion to arrest if the Interdict is breached. It is available to married people and unmarried people living together as man and wife, if the court has given them **occupancy rights**. It is not available to people in same sex relationships.

Matrimonial Interdicts are often granted along with **Exclusion Orders**, but they can stand alone. Exclusion Orders can be used to order the partner not to come near the family home, to prohibit the removal or destruction of furniture from the home, and to prohibit violence, verbal abuse, threats and harassment.

The advantage of a Matrimonial Interdict over ordinary Interdicts is that a power of arrest may be attached, at the discretion of the court. Powers of arrest make interdicts more effective in deterring abusive behaviour. Powers of arrest are available to married people but unfortunately they are not always available to unmarried people, unless the court has given the occupancy rights. Matrimonial Interdicts under the Matrimonial Homes Act can only be granted to those who qualify under the Act. An unmarried woman will need to ask advice from Scottish Women's Aid or from a Solicitor to find out whether she might be entitled to powers of arrest.

Non-Harassment Order

This can be obtained to prevent a person from behaving in a way which is not on the face of it unlawful, but which is designed to cause fear or distress to another person. This might include following a person, sending letters or unsolicited gifts, telephoning repeatedly, etc. There must have been at least two incidents of harassment before the order can be made. It can be made either in a civil court on the application of the woman, or in a criminal court on the application of the Procurator Fiscal.

A Non-Harassment Order may be more complicated and difficult to obtain than an interdict, because a breach of a Non-Harassment Order is a criminal offence, punishable by up to 5 years in prison or an unlimited fine. This type of order can be made in favour of anyone who has been harassed. It may therefore be of use to people who are not able to obtain **Exclusion Orders** and **Matrimonial Interdicts**, such as couples in same sex relationships, former partners or other relatives.

Occupancy rights

These are the legal rights established in **the Matrimonial Homes (Family Protection) (Scotland) Act 1981** (the “Matrimonial Homes Act”) which entitle people to live legally in their home. Occupancy rights are important because the right to stay in or return to the home is dependent on them. Occupancy rights also entitle a person to return to and live in the home, even after having left for any reason or for any period of time up to 5 years.

If a woman is married, she has an automatic right to stay in her house and it does not matter if she does not own or rent the house. Even if her name is not on the title deed or lease, she cannot be evicted without a court order. However, occupancy rights of married couples end on divorce.

If the woman lives with her partner and they both own or rent the house, they both have occupancy rights and if the house is owned or rented in one name only, the other partner does not have any occupancy rights and would have to go to court to get these.

Matrimonial Interdicts with powers of arrest attached can only be granted to persons qualified in terms of conditions laid down in the Matrimonial Homes Act. For further information please see *A Guide to the Matrimonial Homes (Family Protection) (Scotland) Act 1981*.

People in same sex relationships can only get occupancy rights if they own or rent the house either in their own name or jointly with their partner. They cannot go to court to have occupancy rights established.

Protection from Abuse (Scotland) Act 2001

This allows the power of arrest to be attached to any interdict for the purpose of protection from abuse. It enables the police to arrest an interdicted person without warrant, if he has breached the terms of the interdict and there would be a risk of further abuse if he were not arrested. However, a person cannot be subject at the same time to powers of arrest attached to both a Matrimonial Interdict and any other interdict under the Protection from Abuse (Scotland) Act. Attaching a power of arrest to an interdict to protect against abuse can be applied for by anyone at risk, regardless of his or her relationship with the potential abuser.

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ANNEX A: DOMESTIC ABUSE HEALTH GUIDANCE SHORT LIFE WORKING GROUP

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Dr Anne Cunningham	representing British Medical Association
Ms Dot Fall	Scottish Women's Aid Representative
Ms Citty Finlayson	UNISON Nominee
Ms Dawn Giffen (Practitioner)	Scottish Women's Aid Representative
Dr Mary Hepburn	representing Royal College of Obstetricians and Gynaecologists
Ms Sue Laughlin	Greater Glasgow NHS Board
Ms Kate Munro	GGNHSBoard
Ms Susan Moffat	Lothian Health Board
Ms Diane Norris	Project Manager The Highland Domestic Abuse Forum
Ms Sandra Robb	representing Royal College of Midwives
Dr Penny Watson	representing Royal College of General Practitioners
Mrs Joan Wilson	Healthcare for the Homeless Perth, representing Royal College of Nursing
Ms Emma Witney	HEBS, Programme Manager – Community
<i>Scottish Executive</i>	
Mrs Lorna Belfall	Domestic Abuse Unit, Justice Department
Mrs Fiona Dagge-Bell (until April 2002)	Project Midwife, Health Department
Ms Fiona March (until June 2001)	Primary Care Division, Health Department
Jackie McRae	Women and Children's Unit, Health Department
Alexandra Simpson (from Oct 2002)	Women and Children's Unit, Health Department
Mrs Jean Swaffield	Nursing Adviser, Nursing Directorate

ANNEX B: CHECKLIST FOR NEGOTIATING A WORKPLACE POLICY ON DOMESTIC ABUSE

A workplace policy on domestic abuse will need to be tailored to your particular workplace and employer. The following checklist identifies the major points, which should be considered. It is based on the model policy developed by UNISON's Southern Region and the policy introduced by City of Edinburgh District Council.

1. Policy statement

- Recognise that domestic abuse is a serious issue in society.
- Ensure that those who are experiencing domestic abuse can raise the issue confident that it will be dealt with sympathetically and seriously.
- Recognise that domestic abuse can affect an individual's work performance.
- The policy is part of the commitment to promoting dignity at work and responsibility for health, safety and welfare at work.

2. Aims of the policy

- To assist and support employees requesting help in addressing problems arising from domestic abuse.
- Remove fears of stigmatisation.
- Ensure confidential and sympathetic handling of the situation.

3. Identifying domestic abuse

- Domestic abuse is abusive or violent behaviour perpetrated by a partner or ex-partner. It can take place within heterosexual or same sex relationships.
- Overwhelmingly the abuser is a man, the abused a woman. Children are often involved. The abuse will often be physical or sexual, its effects ranging from bruising to permanent injury, and it may even result in death. However, it is often emotional, mental and verbal, involving threats, belittlement, isolation or control of money and activities. Less visible but equally damaging effects include diminishing self-esteem, fear, guilt, insomnia, depression, agoraphobia and difficulty in trusting other people.
- The majority of those affected are women, but this policy applies equally to men and women.

4. Identifying the problem

- It must be for the individual concerned to recognise they are experiencing domestic abuse and to decide to take action.
- However, managers should be aware of signs which may indicate that an employee may be experiencing domestic abuse. These may include: visible bruising; loss of self-confidence; frequent absenteeism; lower quality of work; out of character conduct.

5. Raising the issue

- Because of the sensitivity of the situation, normal reporting procedures may not be adequate.
- Allow for informal approach for advice and assistance.
- Recognise that staff may not wish to go through normal line management to discuss this issue.
- Specially trained, designated contacts may be appointed who can be approached in confidence by staff to discuss problems relating to domestic abuse.
- These contacts can advise staff of the provisions of this policy and procedure to assist in resolving the problem.
- Contacts will be supportive and sympathetic.
- An employee may require support on a number of occasions as they go through the process of leaving a violent relationship. The same standard of support should be provided throughout.
- It is for the employee to decide their course of action at every stage.

6. Providing information

- The employee should be enabled to select a suitable course of action for themselves.
- Contacts should provide information to ensure that employees seeking assistance have immediate access to appropriate professional assistance – including access to appropriate aid agencies, police etc.
- Contacts should provide information on local refuges and/or helplines.
- It is for the employees to decide their course of action.

7. Confidentiality

- Issues raised under this policy will be treated in confidence.
- Disclosure of information will only occur with the employee's permission.
- Unauthorised disclosure of details concerning confidential records will be taken seriously and dealt with under disciplinary procedures.
- Records of employees who are experiencing domestic abuse will be treated as strictly personal and confidential.
- A change of work location should not be disclosed.

8. Counselling

- Provide access to appropriate, confidential, independent professional counselling.
- Provide for referral to an appropriate aid agency, if requested.

9. Time off

- Special paid leave should be provided for appointments where necessary, e.g. with support agencies, solicitors, for re-housing, to alter childcare arrangements.
- Other requests for paid leave and extended unpaid leave should be considered sympathetically.
- The reasons for such absences should be recorded separately from the main employee record.
- Periods of absence during this period, including sickness absence, should not adversely effect employee's employment record.

10. Other provisions

- Requests for advance of pay should be considered sympathetically.
- Flexible working arrangements may assist an employee in this situation.

11. Re-location/re-deployment

- Threats of domestic abuse may carry over into the workplace. Where an employee requests a change of workplace this should be treated sympathetically.

12. Information, training and publicity

- The employer should publicise this policy widely.
- Line Managers should receive awareness training.
- Specialised training should be provided for designated contacts.
- The issue of domestic abuse should be included in induction and other training courses as appropriate.
- Since domestic abuse can affect self-esteem, confidence building or assertiveness training should be available to staff experiencing domestic abuse.
- Information on local advice and aid agencies and helplines should be readily available.

Fife NHS Board and Argyll and Clyde NHS Board also have helpful examples of workplace policies.

ANNEX C: QUESTIONS TO ASK

The following are examples of follow-up questions to ask when domestic abuse is suspected. The questions are intended as prompts – it will not be necessary to ask all of them and they should not be used as a checklist. In particular, the questions tend to focus on evidence of physical assault and injury, but many women, who routinely access health care services and who are experiencing domestic violence, will not have physical evidence of injuries at the time.

- I noticed a number of bruises/cuts/scratches/burn marks: how did they happen?
- Do you ever feel frightened of your partner or other people at home?
- Does your partner ever treat you badly, such as shout at you, constantly call you names, push you around or threaten you?
- Have you ever been in a relationship where you have been hit, punched, hurt in any way? Is that happening now?
- Some women tell me that their partners are cruel, sometimes emotionally and sometimes physically hurting them – is this happening to you?
- We all argue at home. What happens when you and your partner argue or disagree?
- Has your partner ever destroyed things you cared about? Threatened you? Forced sex on you/or made you have sex in a way that you are unhappy with? Withheld sex/rejected you sexually in a punishing way? Used your personal fears to 'torture' you?
- Does your partner get jealous and if so, how does he then act?
- You mentioned your partner misuses drugs/alcohol. How does he act when drinking excessively or on drugs?
- Your partner seems very concerned and anxious. That can mean he feels guilty. Was he responsible for your injuries?
- Has your partner ever prevented you from doing things, for example leaving the house seeing friends, getting a job or continuing your education?
- Has your partner ever threatened or abused your children?

ANNEX D: LOCAL INFORMATION

Insert own local numbers into table:

Accident and Emergency Department	
Alcohol Groups	
Benefits Agency	
Citizens Advice Bureau (CAB)	
Family Planning Association	
Housing Department (Homeless Section)	
Local Domestic Abuse Forum	
Local Women's Aid Group	
Organisations for men tackling violent behaviour	
Police (Domestic Violence Unit)	
Rape Crisis Centre	
Social Work Department	
Scottish Women's Aid	
Solicitors	
Support/Counselling Groups	
Other Local Women's Aid Group	

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