

Domestic abuse

June 2007



Domestic abuse

A report from the BMA Board of Science

June 2007

Editorial board

A publication from the BMA Science & Education Department and the Board of Science

Chair, Board of Science
Director of Professional Activities
Head of Science & Education
Editor & project manager
Research and writing
Editorial secretariat

Professor Sir Charles George
Professor Vivienne Nathanson
Dr Caroline Seddon
Nicky Jayesinghe
Sarah How
Luke Garland
Gemma Jackson
Joseph Kirkman
Joanna Rankin
George Roycroft
Simon Young

British Library Cataloguing-in-Publication Data.
A catalogue record for this book is available from the British Library.

ISBN: 1-905545-17-7
Cover photograph: Getty Images Creative

© British Medical Association 2007 – all rights reserved. No part of this publication may be reproduced, stored in a retrievable system or transmitted in any form or by any other means that be electrical, mechanical, photocopying, recording or otherwise, without the prior permission in writing of the British Medical Association.

Board of Science

This report was prepared under the auspices of the Board of Science of the British Medical Association, whose membership for 2006/07 was as follows:

Professor Parveen Kumar CBE	President, BMA
Dr Michael Wilks	Chair, BMA Representative Body
Mr James N Johnson	Chair, BMA Council
Dr Sam Everington	Deputy Chair, BMA Council
Dr David Pickersgill	Treasurer, BMA
Sir Charles George	Chair, Board of Science
Dr P B Maguire	Deputy Chair, Board of Science
Dr P H Dangerfield	
Dr G D Dilliway	
Dr G D Lewis	
Dr S Minkoff	
Dr O Moghraby	
Dr G Rae	
Dr D M Sinclair	
Dr A S Thomson	
Dr D M B Ward	
Dr D G Wrigley	
Dr C Spencer-Jones (by invitation)	
Dr S Chaudhry (Co-optee)	
Dr E F Coyle (Co-optee)	
Dr P Miller (Co-optee)	
Dr P Steadman (Co-optee)	
Dr S J Nelson (Deputy member)	

Approval for publication as a BMA policy report was recommended by BMA Board of Professional Activities on 23 May 2007.

Declaration of interest

There were no competing interests with anyone involved in the research and writing of this report. For further information about the editorial secretariat or Board members please contact the Science and Education Department which holds a record of all declarations of interest:
info.science@bma.org.uk

Acknowledgements

The association is very grateful for the help provided by the BMA committees and many outside experts and organisations, and would particularly like to thank:

- Professor Susan Bailey, Professor of Child and Adolescent Forensic Mental Health
- Dr Adrian Boyle, Consultant in Emergency Medicine, Addenbrooke's Hospital
- Professor Gene Feder, General Practitioner
- Caroline Harrison, BMA Ethics Department
- Dr Jo Nurse, Consultant in Public Health
- Professor Jonathan Shepherd, Professor of Oral and Maxillofacial Surgery and Director of the Violence Research Group, Cardiff University
- Professor Ann Taket, Head of School of Health and Social Development, Deakin University, Australia.

Abbreviations

A&E	Accident and Emergency
BAEM	British Association for Emergency Medicine
BCS	British Crime Survey
BMA	British Medical Association
BME	Black and other minority ethnic
CEMACH	Confidential enquiry into maternal and child health for England and Wales
CSA	Childhood sexual abuse
DAF	Domestic abuse forum
DH	Department of Health
DVEC	Domestic Violence Enforcement Campaign
GMC	General Medical Council
GPC	General practitioners committee
LGBT	Lesbian, gay, bisexual and transgender
MALE	Men's Advice Line and Enquiries
MHF	Men's health forum
NICS	Northern Ireland Crime Survey
PCT	Primary Care Trust
PHCT	Primary Healthcare Team
RCGP	Royal College of General Practitioners
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists
RCPsych	Royal College of Psychiatrists
STIs	Sexually transmitted infections
UK	United Kingdom
USA	United States of America
VVAPP	Victims of Violence and Abuse Prevention Programme
WHO	World Health Organisation
WMA	World Medical Association

Case studies are drawn from:

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

All names used in the case studies are pseudonyms

Foreword

The impact of domestic abuse can vary from person to person, but there is growing evidence to confirm that it has serious and long-lasting consequences on the health and wellbeing of the victim and family members. The British Medical Association (BMA) has a long-standing interest in the health of the public and believes that the occurrence of domestic abuse is a serious concern. In 1998 the BMA published *Domestic violence: a health care issue?*¹ which aimed to raise awareness of the nature and prevalence of domestic abuse, to break down some of the stereotypes that exist, and to discuss the role of healthcare professionals in identifying and dealing with the problem. The Board of Science has also produced the report *Growing up in Britain: ensuring a healthy future for our children* (1999)² which covers child abuse and highlights that this is a significant source of morbidity and mortality in children. The BMA publication *Child and adolescent mental health: a guide for healthcare professionals* (2006)³ explains that a child who has witnessed domestic abuse has an increased risk of experiencing mental health problems.

The BMA has a range of policies on domestic abuse. Much is detailed in its 1998 report. At the BMA's 2006 annual representative meeting, it was resolved that basic training in child protection is a crucial part of induction for doctors. In 1999 the BMA agreed policy that 'it is unethical for elderly people to be discriminated against in the provision of national health services'. Furthermore, the BMA has called not only for 'improved standards of accommodation for the examination of suspected victims of both rape and child abuse, but also women doctors to do these examinations'.

The BMA has also highlighted the ethical aspects of domestic abuse, and the matters surrounding the confidentiality of an abused patient. *Medical ethics today: the BMA's handbook of ethics and law* (2004)⁴ and *The medical profession & human rights handbook for a changing agenda* (2001)⁵ explain that the health system is the most likely place for evidence of abuse to be detected. Further, that ethical dilemmas can arise when the victim of abuse refuses to allow disclosure or discussion of the abuse.

Domestic abuse continues to be a major healthcare concern. By definition, domestic abuse is restricted to the adult population and consequently they remain the focus of this report. Children, however, can also be impacted by domestic abuse and are thus considered. This new report is intended to lead the way in encouraging the healthcare professions to raise awareness of the problem and makes recommendations for tackling domestic abuse.



Professor Sir Charles George
Chair, Board of Science

The Board of Science, a standing committee of the BMA, provides an interface between the medical profession, the government and the public. The Board produces numerous reports containing policies for national action by government and other organisations, with specific recommendations affecting the medical and allied professions.

Contents

Executive summary	1
Chapter 1 Introduction	11
Domestic abuse as a health concern	11
Chapter 2 The nature and prevalence of domestic abuse	12
Defining domestic abuse	12
The prevalence of domestic abuse	13
Barriers to measuring prevalence	15
The economic cost of domestic abuse	16
Chapter 3 Understanding domestic abuse	17
Types of domestic abuse	17
The perpetrator	19
The cycle of abuse	20
Reasons why adults stay in abusive relationships	22
The link between domestic abuse, drugs and alcohol	23
Chapter 4 Specific vulnerable groups	26
The impact of domestic abuse on children	26
Pregnant women	27
Lesbian, gay, bisexual and transgender individuals	28
Minority ethnic groups	29
Older people	30
Disabled people	31
Chapter 5 Detection of domestic abuse in healthcare practice	33
Behaviour and attitudes of healthcare professionals to domestic abuse	33
Patients' views of doctors	34
Enquiring about domestic abuse	35
The need for education and training	37
The role of the primary healthcare team	38
Chapter 6 Ethical considerations for healthcare professionals dealing with domestic abuse	40
Confidentiality and information sharing	40
If the perpetrator is registered with the same doctor	43
Meeting the healthcare needs of domestic abuse perpetrators	43
Chapter 7 Management of domestic abuse within healthcare specialties	45
The accident and emergency department	45
Obstetrics and gynaecology	48
Midwifery	49
Psychiatry	50
Nursing and health visiting	51
Chapter 8 Adopting a multi-agency approach	53
The need for a multi-agency approach	53

Chapter 9 Other services involved in domestic abuse	55
Voluntary and community services	55
Local authorities	57
Legal agencies	58
Chapter 10 Recommendations	59
Chapter 11 Useful contacts	61
Appendix 1	64
An illustration of the complex relationship and interaction between the causes and consequences of violence and abuse	
Appendix 2	65
Patient and healthcare professional opinion on routine enquiry for domestic abuse	
Appendix 3	66
Detecting domestic abuse during consultations with healthcare professionals	
Appendix 4	68
Actions required following a disclosure	
Appendix 5	72
An illustration of a preventative framework for violence and abuse	
Appendix 6	73
The police and legal profession's involvement with domestic abuse	
References	75

Executive summary

What is domestic abuse?

Defining domestic abuse

In this BMA report, domestic abuse is defined as 'any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners, or family members; regardless of gender, sexuality, disability, race or religion'.

Children are not the direct sufferers of domestic abuse, because by definition it occurs between adults, but they are commonly impacted upon in the family environment.

There are four main types of domestic abuse:

Physical abuse

Injuries are often sustained, especially among women, including bruising or a black eye, scratches, bleeding from cuts, internal injuries and broken bones or teeth. Death is ultimately the most severe consequence of domestic abuse.

Male victims of domestic abuse may have a weapon used against them, including stabbing by a knife or sharp object. They may also be kicked in the groin or attacked in their sleep or in bed.

Sexual abuse

Sixteen per cent of women and two per cent of men who have been a victim of any type of partner abuse since the age of sixteen have experienced sexual assault by a partner. In addition to the assault itself, women who suffer serious sexual assault suffer a range of physical and mental injuries.

Globally between six and 47 per cent of adult women report being sexually assaulted by intimate partners in their lifetime. Forced or coercive sexual intercourse with an HIV infected partner is one of the most common routes of transmission of HIV and other sexually transmitted infections (STIs).

Psychological abuse

Domestic abuse has long-term consequences on the mental health of its victims. Over a third of female victims and a tenth of male victims are likely to suffer (self-defined) emotional problems as a result.

The World Health Organisation (WHO) reported in 2000 that abused women are more likely to suffer from depression, anxiety, psychosomatic symptoms, eating problems and sexual dysfunction. Male victims of domestic abuse are also at risk of increased depression but at lower rates than in women.

Financial abuse

Financial abuse is more commonly seen in older people or people with disabilities as they may be reliant on carers to collect their pensions or organise their bank accounts.

Financial abuse can have a negative impact on an older person's health as it can lead to ongoing distress and if left with no access to their finances an older person could be without money, medications or transportation.

Why does domestic abuse happen?

The perpetrator

A common model of domestic abuse is one of male power leading to the abuse of a woman. A gender-neutral model applies to abuse perpetrated by either gender, including within straight, gay and lesbian relationships.

The link between domestic abuse, drugs and alcohol

Alcohol and drug abuse are frequently associated with domestic abuse. Alcohol and drug misuse do not cause domestic abuse, but it is acknowledged that they can both be contributing factors.

Alcohol consumption, especially at harmful and hazardous levels can be both a major contributor to the occurrence of domestic abuse and an outcome of being a victim or witness of abuse.

The cycle of abuse

Generally domestic abuse in intimate relationships does not take place continually. There are three phases which are repeated over time. First is the tension building stage which occurs before the violent eruption phase or crisis phase. Finally the honeymoon stage is reached, after the violence/crisis phase has ended.

Reasons why adults stay in abusive relationships

There are many emotional, psychological and practical reasons why a victim may not walk away from their abusive partner or family member. In the case of elder abuse the victim may feel entirely powerless to escape.

Abuse within relationships is not easily preventable. Domestic abuse mainly occurs behind closed doors and therefore, for it to stop, the victim must seek help or refuge.

How common is domestic abuse?

The prevalence of domestic abuse

Domestic abuse has been reported to affect over 350,000 people in England and Wales alone. Recently reported annual figures show 45,796 such incidents in Scotland, and 8,565 in Northern Ireland.

It has been estimated that as many as approximately half a million older people are being abused at any one time in the United Kingdom (UK). The majority of perpetrators of elder abuse are family members.

No accurate figures exist for the prevalence of domestic abuse in all its forms, as it is known to be grossly under-reported to authorities, such as the police, health service and social services.

The British Crime Survey (BCS) found that 34 per cent of women, and 62 per cent of men who had suffered domestic abuse since they were 16 years of age have probably never told anyone other than the survey in question.

Indicators of socio-economic status show that there is increased prevalence of domestic abuse in areas associated with relatively lower levels of socio-economic status. Domestic abuse can, however, also occur within professional families, and this includes healthcare professionals themselves.

Who are the victims of abuse?

In the UK 80 per cent of reported domestic abuse victims are women. It is estimated that one in four women and one in five men have experienced domestic abuse by a partner since the age of 16. Nearly a third of violent incidents against women are domestic abuse. One in three women seeking emergency medical care in UK inner city hospitals has suffered domestic abuse at some point in their lives.

Pregnant women

Around 30 per cent of domestic abuse begins during pregnancy. Abuse is more common for pregnant women than gestational diabetes or pre-eclampsia – both conditions for which pregnant women are routinely screened.

The impact of domestic abuse during pregnancy is recognised to be a significant contributory factor to maternal and fetal mortality and morbidity. The Royal College of Midwives (RCM) states that 'midwives are ideally placed to recognise and detect ongoing domestic abuse and to offer care, support and information to the woman'.

Lesbian, gay, bisexual and transgender individuals

Partner abuse is as common and as prevalent among same-sex couples as among heterosexual couples.

Domestic abuse experienced in same sex-couples is similar to that in heterosexual couples. In addition, lesbians, gay men and bisexuals who have not 'come-out' can be emotionally abused with threats of outing them at work, or to family or friends.

Lesbian, gay, bisexual and transgender (LGBT) individuals may also experience domestic abuse perpetrated by family members on grounds of their sexual orientation.

Minority ethnic groups

The risk of domestic abuse does not differ significantly by ethnic group. Women from black and other minority ethnic (BME) communities experience the same forms of domestic abuse as those women from all other communities.

Within the Asian community, some women are expected to uphold the honour of the family and this may even mean tolerating domestic abuse rather than leaving the family home. In extreme cases 'honour crimes' can take place, either in the form of assault or killings.

Domestic abuse can occur within a forced marriage, where duress, whether physical or mental, is used to force a marriage to take place (and indeed continue) without the free and valid consent of one or both parties.

People from minority ethnic groups may perpetrate domestic abuse on their family members or partners from the wider community, who may, for example, have a different skin colour or practice a different religion.

Older people

It has been estimated that as many as half a million older people are victims of domestic abuse in the UK, although only a minority of such cases will be recorded.

There are five main forms of elder abuse; physical abuse, sexual abuse, psychological abuse, financial or material abuse and neglect & abandonment. Neglect is the most common form of elder abuse compared with the other four types.

Disabled people

Disabled individuals can experience the same forms of domestic abuse as non-disabled individuals but may be more vulnerable.

Abuse specific to disabled people includes: the abuser withholding care or undertaking it neglectfully or abusively; removing mobility or sensory devices that are needed for independence; and using an impairment to taunt or degrade the individual.

Different types of impairment may make it more difficult to get out of the way of the perpetrator at the time of an attack, or to seek permanent refuge.

What is the impact of domestic abuse?

The economic cost of domestic abuse

The total cost of domestic abuse to services in England and Wales (Criminal Justice System, health, social services, housing, civil legal) amounts to £3.1bn, and a loss to the economy of £2.7bn per annum. This adds to a total tangible cost of £5.8bn. Pain and suffering (which are not counted in the cost of services) have been estimated at a further £17bn.

Health impact of domestic abuse

The direct health impact of domestic abuse can include suffering from chronic pain, fractures, arthritis, hearing or sight deficits, seizures or frequent headaches. The indirect health outcomes are hypothesised to be caused through stress, and these include stomach ulcers, spastic colon, frequent indigestion, diarrhoea, constipation, angina, and hypertension.

Domestic abuse during pregnancy increases the rate of miscarriage, low birth weight, premature birth, fetal injury and fetal death. Domestic abuse can have an indirect effect on the health of the developing fetus, whereby there is an increased likelihood of maternal smoking and alcohol consumption, in connection with maternal stress. The fetus may also be indirectly harmed by women being prevented from seeking or receiving proper antenatal or postpartum medical care by their abusive partners.

Self-harm is an indirect health outcome for victims of domestic abuse.

The impact of domestic abuse on children

A minimum of 750,000 children a year witness domestic abuse, equivalent to about three-quarters of UK domestic abuse incidents. Approximately half the children in such families have themselves been badly hit or beaten. Neglect is another form of child abuse which may result from domestic abuse.

How can victims of domestic abuse be detected and helped?

The World Medical Association (WMA) statement on family violence (including domestic violence) (2006) holds several recommendations for doctors dealing with cases of such abuse. It recommends that national medical associations should encourage a multi-agency approach to facilitate coordination of action against family abuse.

Doctors' education and training

Doctors in training must be aware of alcohol and drug abuse, domestic abuse and abuse of the vulnerable patient. They are required to identify signs of possible patient abuse and alert the appropriate colleagues and agencies in a timely fashion, as well as maintain a strong and consistent focus on the needs of the patients.

Different medical royal colleges produce their own independent guidelines on domestic abuse within their specialist curricula.

All healthcare professionals and staff working in healthcare settings should ideally receive training on enquiring about domestic abuse.

Behaviour and attitudes of healthcare professionals to domestic abuse

Primary care doctors believe it is their responsibility to treat victims of domestic abuse.

Healthcare professionals report patient non-disclosure and fear of offending the patient as two of their key barriers to asking patients about domestic abuse.

Doctors who have received training are much more likely to ask patients about domestic abuse. Additionally, doctors who ask more regularly about domestic abuse are more likely to have patients who disclosed the abuse.

Detection of domestic abuse in healthcare practice

Medical providers are well placed to identify and intervene on behalf of patients who are experiencing domestic abuse. All healthcare professionals should practise selective enquiry, and routine enquiry should be considered in a number of different settings.

Selective enquiry involves asking women directly about their experiences, if any, of domestic abuse where there are concerns or suspicions, including visible signs/symptoms.

Routine enquiry about domestic abuse (within vulnerable groups), commonly known as 'screening', may help increase the rates of identification.

Victims' views of how doctors can help

Victims of domestic abuse are most likely to have told their own friends, relatives or neighbours. Only a minority of victims approach the health service.

Patients want their doctor to offer referral to appropriate specialist services (and feel strongly that the services should be individualised to a victim's specific situation) and 24-hour access to professional advocates who understand domestic abuse.

The role of the primary healthcare team

Victims of domestic abuse use health services frequently and require wide-ranging medical services. They are likely to be admitted to hospital more often than non-abused victims and are issued more prescriptions.

Identification of domestic abuse falls largely to the Primary Healthcare Team (PHCT); and as well as GPs includes practice nurses, midwives and health visitors, all of whom may identify domestic abuse through their contacts with families with young children.

GPs' waiting rooms are ideal locations for highlighting that domestic abuse is wrong by displaying posters and educational leaflets containing this message. Information about seeking help, including helpline phone numbers, should also be displayed in private areas such as on the back of toilet doors.

It is critical that there is a joined-up approach to dealing with domestic abuse across the whole PHCT.

What are the ethical considerations?

Confidentiality and information sharing

Respect for confidentiality is an essential requirement for the preservation of trust between patients and healthcare professionals. Providing that consent is gained from the patient there is no problem in disclosing information to a third party.

The right to confidentiality, however, is not absolute and may be countered when the rights of others to be protected from harm are jeopardised in a serious way. All healthcare professionals must therefore understand and be honest with patients about the limits to confidentiality.

Disclosures in the public interest

Disclosures in the public interest are made where disclosure is essential to prevent a serious and imminent threat to public health, national security, the life of an individual or a third party or to prevent or detect serious crime.

If the healthcare professional has reason to believe that a child or a vulnerable person is at risk, then protection must take precedence over confidentiality.

Balancing benefits and harms

The BMA's advice is that, where feasible, healthcare professionals should try to envisage the seriousness of the potential harm from the viewpoint of the person likely to suffer it.

Where a healthcare professional becomes aware that a patient has been a victim of domestic abuse and is at risk of serious harm or death from an abusive partner, they may decide, (after considering all the available evidence, the probable outcome from disclosure and the wishes of the patient), to disclose this information to an appropriate third party.

Where disclosure is made without the consent of the patient the healthcare professional must be prepared to justify his or her decision before their regulatory body.

If a decision is made to disclose then this must be to a reputable agency and only directly relevant information should be provided.

If the perpetrator is registered with the same doctor

Following a disclosure of domestic abuse from a patient, the doctor would be breaching confidentiality by initiating a discussion about the abuse with the perpetrator.

It is the responsibility of a GP to direct patients who do disclose that they are perpetrating domestic abuse, to appropriate specialist support services. Respect is the UK association for domestic abuse perpetrator programmes and associated support services.

Meeting the healthcare needs of domestic abuse perpetrators

Healthcare professionals have a duty to meet the healthcare needs of their patients who are perpetrators of abuse. A GP is ethically obliged to ensure that the perpetrator receives ongoing care and should refer them on to another doctor if there is a conflict of interest or of conscience.

Protecting staff

In some circumstances the fear of violence from the perpetrator towards members of the PHCT may be justified and a risk assessment should be carried out to ensure that staff are protected from such an individual. GPs have a right and a duty to protect themselves, their staff and any other individuals on their premises.

How can specialist healthcare services help victims?

Dealing with domestic abuse is not the sole responsibility of PHCT. Given that victims of domestic abuse will present in numerous different healthcare settings, such as a hospital accident and emergency (A&E) department, an obstetrician appointment, or a midwifery home visit, it is certainly a multidisciplinary concern.

Staff working in all areas of the health service who are likely to encounter domestic abuse should be educated about it and trained to help victims.

In addition to meeting the specific medical needs of their patients they must take a consistent approach to the referral of patients to specialist domestic abuse services.

The accident and emergency department

Over one per cent of A&E department visits are due to domestic abuse. To put this in context, an A&E department with 55,000 patients of all ages attending during one year would see over 500 adult patients suffering due to domestic abuse.

There are presently no guidelines in the UK to implement routine enquiry for domestic abuse in patients visiting A&E departments.

While routine enquiry for domestic abuse is not recommended in A&E departments, it is still important that emergency doctors know how to create the opportunity and environment for a patient to disclose domestic abuse, so that self-reported victims can be offered help.

Following a disclosure of domestic abuse a healthcare professional should carry out specific enquiry into suicidal ideation, drug and alcohol use, and the presence of children in the home.

The first priority with a patient who has suffered from domestic abuse would be to treat the physical injuries. It is crucial that these are meticulously recorded and photographs taken if appropriate. It must be explained to victims that domestic abuse is unacceptable and against the law.

While police contact must be offered, the healthcare professional must not influence the patient to make any decisions about disclosure.

Obstetrics and gynaecology

Obstetricians are the key healthcare professionals in contact with women with, or at high risk of, complications during pregnancy, and therefore in an opportune position to identify victims of domestic abuse.

Domestic abuse is associated with numerous negative health outcomes for both the mother and unborn child. Physical violence during pregnancy is the second leading cause of trauma during pregnancy, after motor vehicle accidents.

Conception may occur as a result of rape. Victims of domestic abuse are significantly more likely to describe their pregnancy as unplanned.

To encourage the disclosure of sensitive information, all pregnant women should have at least one consultation with the lead healthcare professional during the pregnancy which is not attended by the partner or any family member.

Gynaecologists are likely to encounter women suffering from STIs, and therefore due to the association between STIs and domestic abuse, are in an important position to identify cases of domestic abuse.

Midwifery

Pregnancy may trigger or exacerbate domestic abuse; hence midwives should play a pivotal role in its detection and management.

All Trusts should be working towards routine enquiry in maternity services and midwives see routine enquiry as important, and acknowledge their key role to play within it.

The RCM proposes that domestic abuse is best challenged by a multidisciplinary approach, in which professionals work in partnership with local service providers, police, the voluntary sector and the woman herself.

Psychiatry

Domestic abuse can have long-term consequences on the mental health of its victims. Over a third of female victims of domestic abuse and a tenth of male victims are likely to suffer (self-defined) emotional problems as a result.

Psychiatric disorders in victims of domestic abuse are generally the consequence of the trauma; however it is also possible that individuals currently suffering from depression, anxiety or phobia may be drawn to, or attract, dominant or aggressive partners.

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

Screening by interview should be introduced as part of a sensitive clinical enquiry as it is the safest and most effective method of detecting domestic abuse.

Understanding the psychology of both the perpetrator and the victim is critical for effective treatment and additionally psychiatrists must be aware of the potential impact of domestic abuse on children's mental health.

The psychiatrist must support the victim through a process of empowerment so that they feel capable of seeking further help and putting an end to the cycle of abuse.

Nursing and health visiting

Nurses may often be the first people, outside of the family to discover that domestic abuse is occurring.

Community nurses, including district nurses, health visitors and community psychiatric nurses, are ideally placed to deal with cases of domestic abuse mainly due to their ongoing relationship with their patient. The nurse is usually welcomed into the home and so has the opportunity to see the interactions between other family members as appropriate.

Practice nurses working within GP surgeries are largely involved with well-women care and are therefore in a position to see a female patient without the presence of a family member or partner.

School nurses must be aware of the impact domestic abuse can have on children. Aside from the possible physical injuries, there may be a psychological impact.

Which services help victims and how do they collaborate?

The need for a multi-agency approach

The 'Inter-Ministerial Group on Domestic Violence' is leading the implementation of the Government's strategy, focused on education and awareness raising, early identification and intervention, the response from the authorities, safe accommodation choices for victims and relationships between the civil, criminal and family law courts.

In Scotland there is a comparable arrangement with a national group of stakeholders, chaired by the Deputy Minister of Social Justice, which oversees the implementation of the *Scottish Executive's Action Plan on Domestic Abuse (2000)*.

The Northern Ireland Office's report *Tackling violence at home (2005)* details the 'strategy for addressing domestic violence and abuse in Northern Ireland'.

The Victims of Violence & Abuse Prevention Programme (VVAPP) in England ensures that services and professionals in all sectors and settings are equipped to identify and respond to the needs of domestic abuse victims whose mental and physical health have been affected.

Due to the multi-agency approach to tackling domestic abuse, the numerous services available to support a victim may be overwhelming and often difficult to navigate. The Home Office promotes the importance of domestic abuse advocates who should be independent and act on behalf of the victim.

Healthcare professionals have a responsibility to refer patients disclosing domestic abuse to an expert domestic abuse agency which can offer specialised help and support.

Voluntary and community services

The voluntary and community sector is a major provider of specialist services to victims and perpetrators of domestic abuse. Helplines are also a vitally important service. The *National Domestic Violence Helpline* is a 24-hour free-phone number for women victims. There is also a helpline number for male victims of domestic abuse.

Voluntary and community organisations can also provide advocacy and outreach responses to domestic abuse. Outreach services support victims of domestic abuse in their homes and communities and, provide accessible and flexible points where information about service provision, and follow-up contact, are available.

Local authorities

An individual may be considered homeless if they live in accommodation where it is probable that living there will lead to abuse from someone else who lives there or used to live there. A local authority's housing department is obliged to provide advice about finding somewhere else to live, and the domestic abuse victim may be entitled to emergency accommodation.

Following disclosure of domestic abuse, a GP may refer the case to social services with (or sometimes without) the consent of the patient. Social services primarily become involved in cases of domestic abuse when children are at risk.

As part of a local authority's domestic abuse preventive strategy they may provide programmes for perpetrators of domestic abuse. Such programmes are designed to help change the behaviour of the perpetrator and to enable them to develop respectful, non-abusive relationships.

Legal agencies

Prosecutors striving to gain protection for domestic abuse victims may rely heavily on a doctor's medical records. Such medical reports must be written promptly and must contain all the facts. Doctors must record what they saw, observed and heard.

Recommendations

As the major professional organisation representing doctors in the UK, the BMA through this report, aims to lead the way in encouraging all healthcare professionals in all disciplines to raise awareness of the problem of domestic abuse. Developing strategies to identify and reduce the substantial impact upon the health and wellbeing of adults and children is equally important.

A list of recommendations can be found at the end of this report.

Chapter 1 Introduction

Domestic abuse as a health concern

Domestic abuse affects over 350,000 people in England and Wales alone.⁶ In 2005/06 there were 45,796 incidents of domestic abuse reported to the Scottish police,⁷ and in Northern Ireland 8,565 domestic abuse offences were responded to by the police in 2003/04.⁸ Domestic abuse is a challenging crime to tackle as it occurs within relationships, where emotions are highly entwined. For this reason, as well as others described later in the report, it is a crime that is largely under-reported. The high prevalence of such criminal acts and the large-scale impact they have on the individual, their families, the health service and the country's economy mean that this is a problem to which healthcare professionals need to be alert and know how to intervene effectively.

The government's consultation paper *Safety and justice* (2003)⁹ sets out the new strategic approach to domestic abuse, building on the domestic abuse proposals laid out in the 2002 *Justice for all*¹⁰ white paper. The 2003 consultation paper brought domestic abuse into the limelight in England and Wales and it resulted in the Domestic Violence, Crime & Victims Act 2004;¹¹ the most comprehensive piece of legislation on domestic abuse for over 30 years. In March 2005 the government produced *Domestic violence – a national report*,¹² which provided an overview of its achievements in implementing the proposals outlined in *Safety and justice* (2003),⁹ as well as setting new objectives for dealing with domestic abuse through early identification, prevention and improved response. To date, the most recent document issued by the government on domestic abuse is the *National domestic violence delivery plan – progress report (2005/06)*¹³ which outlines the progress made in tackling domestic abuse using the methods described in the 2005 report.

Domestic abuse has risen up the political agenda over the last decade and it has been recognised as a cross-government priority. This is demonstrated by the formation of an Inter-Ministerial Group for Domestic Violence, which has been responsible for managing the National Delivery Plan. The Department of Health (DH) has also done a large amount of work on this topic in recent years and in the last two years alone has produced the following reports; *Responding to domestic abuse: a handbook for health professionals* (2005),¹⁴ *Tackling the health and mental health effects of domestic and sexual violence and abuse* (2006),¹⁵ and *Interventions to reduce violence and promote the physical and psychosocial wellbeing of women who experience partner violence: a systematic review of controlled evaluations* (2005).¹⁶

The WMA issued a statement on family violence (including domestic violence), which was last updated in October 2006. The policy holds several recommendations for doctors dealing with cases of such abuse. The policy recommends that national medical associations should encourage a multi-agency approach to facilitate coordination of action against family abuse, and to encourage and facilitate research to understand the prevalence, risk factors, outcomes and optimal care for victims of family abuse.¹⁷

This report aims to further publicise domestic abuse as a highly important healthcare concern that must be tackled from many different angles, not just by the health service.

Chapter 2 The nature and prevalence of domestic abuse

Defining domestic abuse

There is no single official definition of domestic abuse, and it is important to point out at the outset that there are several terms for such types of behaviour. The most commonly used alternative is domestic violence. Domestic violence can be misleading because violence is defined as involving the use of physical force against another individual.¹⁸ Abuse however, can also include psychological abuse, which involves no physical force. This report uses the term domestic abuse because it clearly encompasses both the physical and psychological aspects of abuse. Other terms used which are associated with domestic abuse include family violence, intimate partner violence/abuse, elder abuse, and sexual abuse.

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

1. domestic abuse defined as being about the use of coercive control within an intimate or family relationship
2. domestic abuse defined as covering a much wider field of difficulties within an intimate or family relationship.

Both positions recognise the existence of female perpetrators of domestic abuse, and the existence of domestic abuse in homosexual relationships (both gay and lesbian). The first position is exemplified in the definition of domestic violence used by Women's Aid¹⁹ and in the Respect guidelines, which state the following:

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

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

Social and institutional power structures support some groups using abuse and violence in order to control other groups in our society eg institutional racism, heterosexism, and parents' violence to children. The unequal power relations between men and women account for the fact that the vast majority of domestic violence is perpetrated by men against women rather than vice versa.²⁰

The government's definition falls into the second position, and is explicit in the psychological research literature.^{21,22} For the purpose of this report, domestic abuse is defined in accordance with the government's definition (of domestic violence), which is 'any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members,³ regardless of gender or sexuality'.²³ In addition, the BMA would extend this definition to include 'disability, race or religion'.

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

Domestic abuse can take many forms; however, despite these differences they are all interconnected and have an impact on the family as a whole. Domestic abuse is rarely a one-off incident, and should instead be viewed as a pattern of abusive and controlling behaviour often used by one person to control and dominate another with whom they have, or have had, a close or family relationship.²⁴ Domestic abuse can be either active or passive. Active abuse is when there is anger directed at the victim, for example executing non-accidental injury, intimidation or rape. Passive abuse is when the anger felt by an abuser is shown by a lack of concern for the victim, for example providing poor care, emotional neglect or a failure to protect.

The types of domestic abuse, as described by the Crown Prosecution Service,²⁵ are as follows:

- physical abuse
- verbal or non-verbal abuse (psychological abuse, mental abuse, emotional abuse)
- sexual abuse
- stalking or cyber-stalking
- economic abuse or financial abuse
- spiritual abuse.

It is important to note, however, that the boundaries between these different types are not clear cut, and further that it is rare for one form of abuse to occur in isolation.

The prevalence of domestic abuse

The BCS is the largest source of data on crime and victimisation in the UK. It measures the extent of crime in England and Wales by asking people about crimes they have experienced in the last year, including crimes which are not reported to the police. The most recent survey, published in July 2006,⁶ interviewed over 50,000 people aged 16 or over and reported the occurrence of nearly 2.5m violent incidents over a one-year period. Fifteen per cent (363,000) of these incidents were domestic abuse. It is important to note that not all people regard domestic abuse against themselves as a crime, and this is a view most commonly held by young men. This means that crime statistics are highly likely to be an under-representation of domestic abuse crime, especially against young men.²⁶ In 2005/06 41.8 per cent of BCS domestic abuse incidents were reported to the police.

The BCS 2005/06 reports a 64 per cent decrease in domestic abuse between 1995 and 2005/06, however this figure must be interpreted with caution. The most recent BCS included a self-completion module on domestic abuse and (as shown by the 2004/05 BCS) the prevalence rates of domestic abuse were five times higher when individuals completed this, compared with the previously used face-to-face interviews. When the BCS calculated percentage changes in crime, they used only the figures collected from face-to-face interviews. The vast majority of domestic abuse cases will have been recorded via the self-completion module. Consequently it is difficult to compare the results obtained from these different methods.

The 2003/04 Northern Ireland Crime Survey (NICS) findings suggest that overall victimisation rates of domestic abuse in Northern Ireland are consistently below those identified in England and Wales. Fifteen per cent of the 2003/04 NICS respondents^b have been victims of domestic abuse at some point in their lives, while six per cent have been victims within the year prior to completing the survey.⁸

^b Respondents of the computer-assisted self interviewing domestic abuse module included within the 2003/04 NICS.

Of all the BCS violence in 2005/06, domestic abuse had the highest rate of repeat victimisation, with 43 per cent of victims being victimised more than once, and 23 per cent being victimised three or more times. In January 2007 a Home Office report confirmed that for the year 2005/06 in England and Wales there were 766 homicides initially recorded, and currently 746 still exist as a homicide crime. Thirty-three per cent of the 248 total female homicide victims were killed by a partner, ex-partner or lover, and 23 per cent of all male homicide victims (498) were killed by a partner, ex-partner or lover.²⁷ In Scotland 90 homicides took place in 2005/06 where one or more accused persons had been identified; 18 per cent of victims were presumed to have been killed by a partner and 11 per cent by a relative.²⁸

Domestic abuse prevalence is uneven and varies by demographic group and socio-economic and lifestyle characteristics.²⁹ It is a crime which is perpetrated upon both men and women, and research has shown that 29 per cent of women and 18 per cent of men have reported experiencing domestic abuse from a partner since the age of 16 years.²⁷ In Northern Ireland, research findings reveal 19 per cent of females and 11 per cent of males have been victims of domestic abuse at some point in their lives, equating to approximately one in five females, compared to one in nine males surveyed.⁸ The 2005/06 BCS found that 80 per cent of domestic abuse victims were women and as reported by Walby and Allen (2004) 'among people subject to four or more incidents of domestic violence from the perpetrator of the worst incident (since age 16), 89 per cent were women'.³⁰ This high figure coupled with the greater severity and health consequences of domestic abuse perpetrated by men against women helps to explain why the majority of domestic abuse literature concentrates solely on this. The BCS 2005/06 also shows that nearly a third of violent incidents against women were domestic abuse. Domestic abuse was the only category of violence^c for which the risks for women were higher than those for men.⁶ As reported in the *Emergency Medicine Journal*, one in three women seeking emergency medical care in UK inner city hospitals has suffered domestic abuse at some point in their lives.³¹

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

Source: BCS 2005/06

Children and older people are two groups of the population that are often overlooked when discussing domestic abuse. Children are not the direct sufferers of domestic abuse, because by definition it occurs between adults, but they are commonly impacted upon in the family environment (see chapter 4 for further discussion). It has been estimated that half a million older^d people are being abused at any one time in the UK,³² and that the majority of the perpetrators are family members.

A report from the Home Office²⁹ explains the various trends in domestic abuse, and like all crimes, it is one with an uneven prevalence. The prevalence of **reported** domestic abuse was found to decrease relatively consistently with the victim's age. This marries with the findings from a survey by Women's Aid³³ which reported that women aged between 26 and 35 years were the most common (37%) to turn to them for refuge from domestic abuse. This figure then decreases to 0.3 per cent of the surveyed women being over 65 years old. It should be noted, however, that older people are likely to have more difficulty accessing refuge services and therefore the low percentage of older women seeking help must not be interpreted as a representation of the prevalence of elder abuse (see chapter

^c Sexual offences are not included in the BCS violent crime figures.

^d Defined as men and women aged 60 and over.

4 for further information on the abuse of older people). The BCS 2001 confirmed that young people are at a high risk of suffering domestic abuse as women and men aged 20-24 years were the highest risk age group for becoming a victim and 16-19 year olds were a close second.³⁰ The BCS 2004/05 states that marital status is a determining factor of how 'at-risk' an individual is to domestic abuse. The same Home Office²⁹ report found that separated, divorced, cohabiting or single women were at a higher risk of suffering domestic abuse than married women. Among men, married men have the lowest risk of suffering domestic abuse, however there is less variation in the risk of domestic abuse by marital status than there is among women.

The Home Office report also states that 'it is the more vulnerable groups that are more likely to experience intimate violence or abuse'. This is demonstrated by the finding that indicators of socio-economic status such as household income, vehicle ownership, and tenure type and council/non-council areas show that there is increased prevalence rates of domestic abuse in areas associated with relatively lower levels of socio-economic status. Domestic abuse can, however, also occur within professional families, and this includes healthcare professionals themselves. There has been minimal research published on this topic. One American study in 1999 into domestic abuse and sexual abuse of female healthcare professionals reported that '3.7 per cent of women healthcare professionals report domestic abuse histories, 4.7 per cent report sexual abuse histories and approximately one in 13 report having experienced either or both at some point in their lives'.³⁴

Barriers to measuring prevalence

It has been suggested that there are four main barriers to assessing the true prevalence of domestic abuse.³⁵ They are:

- the hidden nature of the problem, caused by the stigma associated with domestic abuse, results in the problem remaining low in the public's awareness and thus a lower priority at both a national and local level
- many people do not regard the abuse they are suffering as a crime. The major domestic abuse statistics stem from the BCS yet, of those women who had experienced domestic abuse (non-sexual threats or force), only half (51%) thought their worst incident was a crime. Even more concerning is that 13 per cent felt that it was just something that happens³⁰
- domestic abuse may be incorporated into statistics and reports on violence in general, as opposed to being specifically singled out. Domestic abuse, however, stands far apart from violence perpetrated by strangers as it largely occurs behind closed doors and in a family environment
- 'domestic violence research is hampered by lack of an accepted definition.'³⁶ There are numerous terms and definitions used to describe domestic abuse. This can lead to major differences in the prevalence figures reported. For example, in one study on domestic violence in a UK emergency department the definition used for domestic violence is 'illness or injury resulting from the deliberate actions of an intimate partner'. This would rule out some forms of domestic abuse, such as abuse of an older person by their adult child.³⁶

The BCS found that 34 per cent of women, and 62 per cent of men who had suffered domestic abuse since they were 16 years of age have probably never told anyone other than the survey in question. Victims do not report the abuse to the police due to a range of feelings, with the most common perception being that the abuse is too trivial to disturb the police.³⁰ One survey of men found that just under half never sought help from the police after an incident of domestic abuse as they felt that the police would be unsympathetic or disbelieve them. When male victims had contacted the police for help, 89 per cent reported a feeling that they were not being taken seriously.³⁷

Gareth's story ...

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

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

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

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

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

A further barrier to accurate prevalence figures for domestic abuse is the attitudes and action of healthcare professionals. It is of utmost importance to detect and address domestic abuse in the healthcare setting and thus crucial that healthcare professionals are equipped with the skills to do so. Barriers preventing doctors from enquiring about and reporting of domestic abuse include uncertainty of what to do following a disclosure and fear of offending the patient when enquiring about an individual's personal life.³⁸



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

The economic cost of domestic abuse

The WHO report *The economic dimensions of interpersonal violence (2004)*³⁹ explains that the costs attributable to such things as domestic abuse can be grouped into direct and indirect costs. Direct costs are costs incurred directly from acts of abuse and include the cost of legal services, medical costs, perpetrator control costs, policing and the costs of emergency housing. Indirect costs include lost earnings and lost time for victims, lost investments in human capital, life insurance, and psychological costs.

There are relatively few studies on the economic effects of domestic abuse. The Women and Equality Unit report *The cost of domestic violence (2004)*⁴⁰ states that the total cost of domestic abuse to services in England and Wales (Criminal Justice System, health, social services, housing, civil legal) amounts to £3.1bn, and a loss to the economy of £2.7bn per annum. The Criminal Justice System spends around £1bn a year on domestic abuse cases, which is equal to nearly one quarter of their budget for violent crime. The cost to the NHS of physical injuries from domestic abuse is around £1.2bn, and for mental healthcare it equals £176m. This adds to a total tangible cost of £5.8bn. The report also highlights the additional human and emotional cost of domestic abuse. Pain and suffering (which are not counted in the cost of services) have been estimated at a further £17bn.

Chapter 3 Understanding domestic abuse

Types of domestic abuse

Domestic abuse falls into four main types, each being significant but for different reasons and all known to have a long-term impact on the victims. These are physical abuse, sexual abuse, psychological abuse and financial abuse. Physical injury is likely to be the most life threatening, but this however does not imply that the other impacts cause any less harm to an individual's wellbeing. It has been found, for example, that female victims of domestic abuse have an increased use of all forms of medical care, in addition to trauma and mental health services.⁴¹

Physical abuse

Findings from the BCS (2004/05)²⁹ show that injuries are often sustained as a result of domestic abuse, especially among women. During victims' worst incident of domestic abuse within the last year, 46 per cent of women sustained a minor physical injury, 20 per cent a moderate physical injury and six per cent severe injuries. Among men 41 per cent sustained a minor physical injury, 14 per cent a moderate physical injury, one per cent severe injuries. Minor injuries include minor bruising or a black eye and scratches; moderate injuries are severe bruising and bleeding from cuts; and severe injuries are internal injuries and broken bones or teeth. Death^e is ultimately the most severe consequence of domestic abuse.

One study has shown that of the more serious violent incidents reported by female victims of domestic abuse, 10 per cent reported being punched in the face, 10 per cent punched or kicked in the body, arms or legs, and nine per cent choked.⁴²

A survey of male victims of domestic abuse has found that 66 per cent said that their partner used a weapon, and 22 per cent said they had been stabbed by a knife or sharp object. Thirty three per cent of men had been kicked in the groin and the same number had been attacked in their sleep or in bed. The latter appears to be a characteristic of male abuse, much more than with female abuse.³⁷

The physical health consequences of domestic abuse can be described as either direct or indirect. The direct health impact can include suffering from chronic pain, fractures, arthritis, hearing or sight deficits, seizures or frequent headaches. The indirect health outcomes are hypothesised to be caused by domestic abuse through stress, and these include stomach ulcers, spastic colon, frequent indigestion, diarrhoea, or constipation, angina, and hypertension. A study from the United States of America (USA) of female victims of domestic abuse found that they are more likely than women who have not suffered domestic abuse to report their physical health as fair to poor, to have more doctor attendances, irritable bowel syndrome and frequent dyspepsia, chronic pain and migraine and other headaches.⁴³

Sexual abuse

The BCS 2005/06 found that 16 per cent of women and two per cent of men who had been a victim of any type of partner abuse since the age of 16 had experienced sexual assault by a partner.²⁷ In addition to the assault itself, women who suffered serious sexual assault^f suffered a range of physical and mental injuries. This group are particularly prone to depression and other emotional problems (52%), attempted suicide is seen in five per cent of cases, and four per cent have to deal with an unwanted pregnancy. Other physical impacts include difficulty sleeping, minor bruises and scratching. As the prevalence for male sexual assault is comparatively low the same analysis is not possible.

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

^f That is, involving unwanted penetration of the body (vagina, anus or mouth).

Research has also been conducted to discover how the coercion leading to serious sexual assault without consent is carried out. In 62 per cent of cases physical force was used, mainly in the form of being held down and in 27 per cent of cases the woman was drugged, unconscious or incapable of consent.²⁹ Long-term sexual abuse may increase a woman's risk of urogenital infections and chronic pelvic pain.⁴³

The WHO reported in 2004 that half or more of the 40m individuals infected with HIV in the world are women, a statistic that has brought into sharp focus the problem of abuse against women, as the two are dramatically linked. Globally between six and 47 per cent of adult women report being sexually assaulted by intimate partners in their lifetime. Forced or coercive sexual intercourse with an HIV-infected partner is one of the most common routes of transmission of HIV and other sexually transmitted diseases. The risk of transmission is increased with the degree of trauma inflicted on the victim. Abuse from an intimate partner can also indirectly result in HIV transmission because it reduces the woman's ability to negotiate condom use. In addition, the abuse and associated fear of abuse acts as a barrier to women seeking HIV testing and thus decreases the number of women receiving treatment for the disease.⁴⁴

Psychological abuse

The mental health impact of domestic abuse is likely to be overlooked as it does not present itself as openly as the physical signs of abuse. It is known, however, that domestic abuse has long-term consequences on the mental health of its victims. It has been reported by the Home Office (2004)³⁰ that over a third of female victims of domestic abuse and a tenth of male victims are likely to suffer (self-defined) emotional problems as a result. It is known that depression, psychological symptoms of somatisation, anxiety, obsessive compulsive symptoms, and the tendency to be paranoid are commonly found in women victims of domestic abuse.⁴⁵ The WHO reported in 2000 that abused women are more likely to suffer from depression, anxiety, psychosomatic systems, eating problems and sexual dysfunction.⁴⁶ Male victims of domestic abuse are also at risk of increased depression but at lower rates than in women.⁴⁷

A meta-analysis of research into the causal relationship between domestic abuse and mental health disorders concluded that 'although absolute prevalence rates varied a great deal across studies, the magnitude of association between intimate partner violence and mental health problems was substantially more consistent'. The literature suggests that the prevalence of mental health disorders among women who have suffered domestic abuse is high, which is consistent with the hypothesis that domestic abuse serves as a risk factor for mental health problems. The prevalence and severity of depression and post-traumatic stress disorder are suggested to have dose-response relationships with the severity or duration of the abuse.⁴⁸ It has been reported that the psychological impact of continued abuse often results in numbing and habituation such that successive violent episodes do not have any new psychological effects.⁴⁹

Self-harm is an indirect health outcome for victims of domestic abuse. Research published in the *Emergency Medical Journal* (2004) showed that women who deliberately self-harm are 75 times more likely to report physical and/or verbal abuse from a partner than women who do not harm themselves. For male victims of domestic abuse, they are twice as likely to self-harm when compared to men who have not suffered from domestic abuse.⁵⁰

Financial abuse

Financial abuse is more commonly seen in older people as they may be reliant on someone to, for example, collect their pension or organise their bank accounts. Financial abuse can have a negative impact on an older person's health as it can lead to ongoing distress and if left with no access to their finances an older person could be without money, medications or transportation. The older population may suffer more serious consequences from financial abuse than younger people as they are often more vulnerable to be taken advantage of. Following a period of financial domestic abuse, older people are less likely to recover their financial situation than younger people. It has been found that elder victims of financial abuse have a three times higher mortality rate than non-victims.⁵¹ Financial abuse may involve the loss of a home through deceit, loss of beloved personal assets through theft, or loss of money from improper use of a 'power of attorney'. Loss of money and/or property is likely to result in an adult having fewer resources to take care of their own health, housing and good nutrition.⁵² In the USA it has been estimated that financial abuse accounts for half of all types of elder abuse as other types of abuse such as psychological abuse, deception and intimidation are commonly accompanied by financial exploitation.⁵³ Elder financial abuse is very difficult to diagnose due to the lack of physical symptoms and therefore it is thought that it remains heavily under-reported. Signs of financial abuse include unusual bank account activity, sudden changes to beneficiaries or advance directive documents, and the worsening of medical conditions due to lack of unfilled prescriptions.⁵⁴ Despite the devastating effects of financial abuse on older victims, doctors may not, however, recognise, diagnose and assist such people. This may be simply because they are not witnessing the impact, or because they are not trained to recognise the signs.⁵⁵

The perpetrator

There is no typical perpetrator of domestic abuse. They come from different backgrounds, have had different life experiences and have different reasons for this behaviour. It is a commonly held view that despite their individual motives to abuse, all choose to abuse, and it is not accidental. Mitchell and Gilchrist (2004)⁵⁵ provide a contrasting hypothesis that some incidents of domestic abuse can be understood in terms of a panic/anger attack directed at the family member. There are numerous reasons why an individual may choose to abuse someone. Some perpetrators learn to abuse from their childhood years. They may have been the victims of abuse themselves or witnessed one of their parents being abused. As a consequence a child may grow up believing that abuse is part of the normal way of life, and that it is natural for a person to become either the 'in-control' abuser or the 'out-of-control' victim. The term 'cycle of abuse' can be used to describe the pattern whereby a victim of abuse develops into a perpetrator in later life. This explanation is based on social learning theory, in that as an adult such people rely on learned behaviour and release their frustration in abusive behaviour.⁵⁶ It must also be noted, however that, conversely, a child may grow up appreciating the devastation abuse can cause and therefore reject such behaviour.

The desire to control the way an individual acts, feels and thinks is a common motive for abuse of a family member. Perpetrators are also sometimes described as lacking empathy and being unable to relate to other people's perspectives and feelings. They may treat their victims as though they are there solely for their convenience and do not deserve their independence. Jealousy can often play a part in such domestic abuse so that if the perpetrator is able to control their partner it will help to reduce their own feelings of jealousy.⁵⁷

Untreated mental or emotional health problems may in some cases result in domestic abuse. Evidence exists to show that the 'rates of violence toward family members by a relative with a psychiatric disorder is between 10 per cent and 40 per cent', which is significantly higher than in the general population.⁵⁸ It must be noted, however, that individuals with mental or emotional health problems have an increased vulnerability to being subjected to many forms of abuse, including domestic abuse. A common model of domestic abuse is one of male power leading to the abuse of a woman. Merrill proposed a gender-neutral model in 1996⁵⁹ which would apply to abuse perpetrated by either gender, including within straight, gay and lesbian relationships. This model encompasses some of the previously discussed causative factors. Merrill gives three underlying aspects of domestic abuse, the first being that individuals learn how to abuse from their family or friends and second they must have the opportunity to abuse. The third is that the perpetrator must choose to abuse. This may reflect a belief that resorting to violence or emotional abuse is the only option when dealing with distorted ideas about gender roles, or the need to control their partner.⁶⁰



Alcohol and drug abuse are frequently associated with domestic abuse. Please see the final section of this chapter for further discussion.

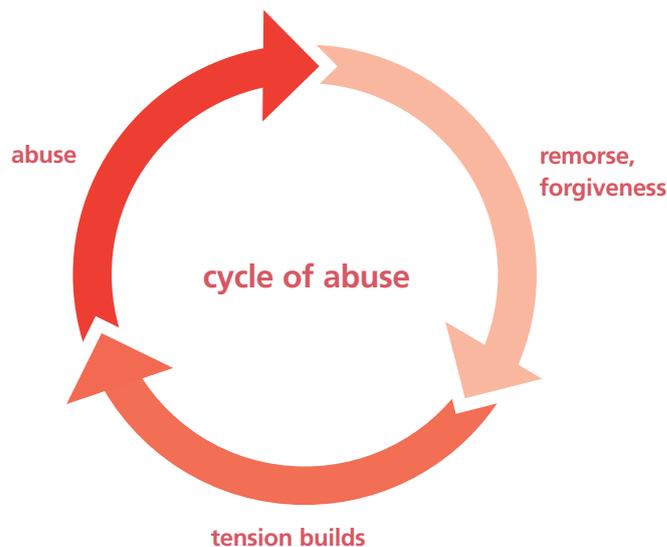


For further information about meeting the healthcare needs of domestic abuse perpetrators see chapter 6.

The cycle of abuse

Domestic abuse does not generally take place continually. It is described as being cyclic with three phases which are repeated over time (see figure 1). The cycle of violence was originally described in *The battered woman* (1979)⁶¹ by Walker and has been used as a reliable theory to describe the cycle of domestic abuse between partners. Each stage lasts a different amount of time, with the total cycle taking from just a few hours to complete, to over a year. The cycle commonly speeds up as time goes on.

Figure 1: The cycle of abuse: diagram illustrating the cyclic nature of domestic abuse



Source: *Sex Info at University of California at Santa Barbara*
(www.soc.ucsb.edu/sexinfo/?article=violence&refid=004) (accessed May 2007)

Stage one

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

Stage two

Stage two is the violent eruption phase or crisis phase, and it begins with some form of explosive outburst with significant violence. The behaviour of the victim is rarely the trigger for this phase; it is more commonly an external initiator, such as problems at work or money worries. It is a common misconception that violent couples live repeatedly within this stage, as this is normally when help is called for, or the abuse is detected by outsiders. The abuse in this stage is largely physical and occurs as a result of the build up of the uncontrollable tension from stage one. The perpetrator can often cause very serious harm to the victim, and in a family environment, this is when the children are at their highest risk of being impacted, both physically and emotionally. The victim during this stage may often experience fear and shock. Often they may be forced to use self defence, and may try to leave the relationship. It is during this stage that the violence may result in permanent injury or even death of the victim.⁹ It is at this stage that healthcare professionals are most likely to be made aware of the abuse.

Stage three

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

The honeymoon stage will nearly always come to an end and the cycle will then be repeated. It can be hard for both the perpetrators and the victims of domestic abuse to see the cyclic nature of the abuse. This, therefore, makes it harder for the victim to seek help and leave the relationship. For the perpetrator this will delay the time when they may choose to seek help for themselves.^{62, 63, 64}

⁹ Of the homicides currently reported in 2005/06, 33 per cent of female victims, and 23 per cent of male victims were killed by a partner, ex-partner or lover. (Source: Homicides, Firearm Offences and Intimate Violence 2005/06, Home Office 2007.) (Please refer to page 14.)

Reasons why adults stay in abusive relationships

Asking the question ‘why do adults stay in abusive relationships?’ implies blame of the victim for the domestic abuse which is occurring. It is a commonly held misconception that if the abuse is so severe then the victim should choose to leave their abusive partner, and therefore if they do not leave they are not blameless. Abuse, however, is not the victim’s fault and there are many emotional and practical reasons why a victim may not walk away from their abusive partner or family member. In the case of elder abuse (see page 30) the victim may feel entirely powerless to escape.

The cycle of abuse (tension building – violence – honeymoon) as previously described is partly the reason why victims find it such a struggle to walk out on a domestic abuse perpetrator. During the tension building stage the victim will often grasp onto a sense of hope that the next abusive stage will not be reached. This is a time therefore, when they may put effort into trying to prevent the abuse from being triggered, thus distracting them from thinking about leaving. The violent stage is the most obvious time to seek refuge, but due to the often very physical nature of this stage it can frequently be impossible to get away. The defining factor of the honeymoon stage is the manifestation of love and affection, displayed by the perpetrator towards their partner, and the frequent promises to never hurt them again. This often causes the victim to feel renewed love toward their partner and in this context, victims often rationalise that they are not really being abused. Victims are motivated to find excuses for the perpetrator and they think of the most recent episode of abuse as a one-off event. For all of these reasons, a victim will find it very difficult to leave the relationship as they will be unmindful of the reasons for escape.

There are other reasons that deter victims of abuse from seeking help and refuge from domestic abuse perpetrators, all of which work either within or alongside the cycle of abuse. Practical reasons are commonly what stop a victim from leaving. Being financially dependent on the perpetrator, or not having any property which is solely theirs, makes leaving often an unthinkable option for a victim. Some victims will not have access to cash or bank accounts and would therefore find themselves living in far more basic conditions if they left. When children are involved these practicalities become more apparent as the victim would often find themselves not only trying to independently support themselves, but also their children. Older people may be fully dependent on a family member to provide their care needs, resulting in leaving being an impractical and highly daunting option.

Victims, who are or were in an intimate relationship with the perpetrator, often prolong the time they stay in an abusive relationship because they feel it is in the interest of their children. Some believe it would be more detrimental to the upbringing of their children if they lived within a single parent family compared with a two parent family, despite the abuse within it. Perpetrators will go to great lengths to stop their victim from leaving and this will often involve threatening to harm the children or threatening to deny the victim access to them. A victim can also be afraid that following the disclosure of domestic abuse, social services may remove their children from the family home.

Religious and cultural pressures can stop victims from leaving. For example, traditionally the Catholic Church disapproves of divorce and thus for a victim with those beliefs, choosing to end their marriage may cause them to feel shame and social exclusion. Women from Asian communities are often expected to uphold the family honour and therefore leaving could result in being ostracised by their family and friends. Other external pressures which can influence whether victims of abuse seek help include the worry that if they approach the police they may not be taken seriously. Police may dissuade them from pressing charges or treat the abuse as a ‘domestic dispute’ which implies that both partners are equally guilty.^{57, 65, 66}

In 2005 the *Journal of Family Violence*⁶⁷ reported that 'there is a considerable body of evidence demonstrating that survivors of childhood sexual abuse (CSA) are at an increased risk of experiencing subsequent episodes of victimisation'. Individuals with a history of CSA may have difficulty recognising or responding to the threat of relational abuse or negotiating relationship boundaries.⁶⁸ It has also been found that early abuse may play a critical role in the difficulty that many women victims of domestic abuse have in terminating abusive relationships in adulthood.⁶⁹

Sufferers of domestic abuse will to a certain extent live in fear of the next attack. It is a natural response to try to prevent it from happening, or if this is not possible, to reduce the severity of the attack. This helps explain one common reason why many victims do not leave, and this is because if they try to, but are caught in the process, then the abuse may escalate into something much worse than what it would have originally been. The perpetrator may feel they need to punish their victim for trying to flee the home. This tactic is likely to work because many victims would decide that the risk would not be worth taking in the future. Additional to this, victims who do successfully escape will often find themselves always worrying whether the perpetrator of the abuse will find them. This may be a worse alternative to living with their abusive partner.

Victims of domestic abuse frequently suffer with low self-esteem, often exacerbated by the abusive relationship. They fear being alone and tolerate the abuse, or believe they do not deserve a better partner, and are torn between a need for love and support and the fear of not having that. These individuals therefore have a higher tendency to excuse their partner's abuse.⁷⁰

Abuse within relationships is not easily preventable. Domestic abuse mainly occurs behind closed doors and therefore, for it to stop, the victim must seek help or refuge. Every time a victim forgives the perpetrator of the abuse it reinforces that it is an acceptable behaviour, as such it is more likely to be repeated.⁵⁷



Please refer to appendix 1 for an illustration of the complex relationship and interaction between the causes and consequences of violence and abuse.

The link between domestic abuse, drugs and alcohol

Alcohol and drug misuse do not cause domestic abuse, but it is acknowledged that they can be contributing factors. The BCS 2005/06⁶ found that 46 per cent of domestic abuse offenders were under the influence of alcohol and in 12 per cent of domestic abuse cases the victim judged their offender to be under the influence of drugs. The NICS 2003/04 found that 55 per cent of the worst incidents of domestic abuse took place while the perpetrator was considered to be under the influence of alcohol.⁸ Victims of domestic abuse have also been found to have increased alcohol consumption compared with non-victims. Additionally, the risks of suffering domestic abuse rise with increasing levels of drinking for both male and female victims.⁷¹

Gillian's story...

(Age 45)

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

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

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

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

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

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

Alcohol consumption, especially at harmful and hazardous^h levels can be both a major contributor to the occurrence of domestic abuse and an outcome of being a victim or witness of abuse. In an evidence review, the WHO recognises the links to include the following:

- alcohol use can directly affect cognitive and physical function, reducing self-control and leaving individuals less capable of negotiating a non-violent resolution to conflicts within relationships
- excessive drinking can exacerbate, for example, financial difficulties, infidelity or childcare problems, resulting in tension building and conflict within a relationship, thus increasing the risk of abuse
- individual and societal beliefs that alcohol causes aggression can encourage violent behaviour after drinking and alcohol consumption can be used as an excuse for violent behaviour
- experiencing violence within a relationship can lead to alcohol consumption as a method of coping or self-medicating
- children who witness domestic abuse are more likely to display harmful drinking patterns later in life.⁷²

It has been found that domestic abuse characterised by the perpetrator's pre-assault alcohol use is associated with more serious outcomes, with perpetrator alcohol use being related to approximately 1.5 times greater risk of victim injury and medical attention. On this basis, attempts to combat alcohol abuse in perpetrators may have an impact on reducing the severity of the abuse.⁷³ Healthcare professionals should be aware that alcohol and drug misuse can be linked with perpetrating and suffering domestic abuse, but it should not be assumed that they coexist in all situations. As suggested by the WHO, it is important, however, to raise public awareness of the links between alcohol consumption and domestic abuse.

For a more in-depth analysis of alcohol and domestic abuse, please refer to the WHO report *Intimate partner violence and alcohol* (2006).⁷²

For a worldwide perspective on understanding domestic abuse see the WHO report *World report on violence and health* (2002).⁷⁴

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

Chapter 4 Specific vulnerable groups

The impact of domestic abuse on children

Child abuse usually takes place within the immediate family circle; it is, however, not within the remit of this report because by definition, domestic abuse only involves abuse between adults. Nevertheless, as reported by the Royal College of Psychiatrists (RCPsych) in 2004,⁷⁵ children witness about three-quarters of abusive incidents occurring within relationships where there is domestic abuse.

Approximately half the children in such families have themselves been badly hit or beaten. The DH (2002) found that a minimum of 750,000 children a year witness domestic abuse. Nearly three-quarters of children on the child protection register live in households where domestic abuse occurs, which in England (2002) would equate to nearly 19,275 children.^{76,77} ChildLine receives almost 2,000 calls a year from children who are experiencing problems with domestic abuse.⁷⁸

Children can witness domestic abuse in a variety of ways and suffer a broad range of both physical and psychological consequences as a result. In nine out of 10 cases of domestic abuse, children are in the same or next room when the abuse is taking place.⁷⁸ All children witnessing domestic abuse, whether they are in the same room, caught in the middle of an incident, or simply witnessing the physical injuries inflicted on a parent, are being subjected to emotional abuse. Edleson (1999)⁷⁹ reviewed several studies on the impact on children who witness domestic abuse, and reported some robust underlying themes. A child's behavioural and emotional functioning can be severely influenced by living within a household where domestic abuse is occurring. Children from such environments can exhibit more aggressive and antisocial behaviour as well as fearful and inhibited characteristics. Many children may want to protect the parents from abuse, thus putting themselves at risk in the process and experiencing feelings of guilt when they are unable to help.⁸⁰ They show signs of anxiety, depression, anger and behavioural difficulties. Younger children may demonstrate their anxiety with physical problems, such as complaining of tummy-aches, wetting the bed, having difficulty sleeping and having temper tantrums.⁷⁵ Children who witness abuse may also learn to use it, but this effect has been found to differ between boys and girls. Boys have been shown to express their distress more outwardly with hostility and aggression, whereas girls are commonly found to show evidence of more internalised problems. They may withdraw from other people, become anxious or depressed. There are also long-term effects seen in these children. Adults who witnessed domestic abuse as children have been found to experience depression, trauma-related symptoms and low self-esteem.⁸¹ In addition to these emotional wounds, children who have witnessed abuse are more likely to be either abusers or victims themselves.⁷⁵ It is natural for children to learn from their parents and this can therefore lead to a child falling into an abusive adult relationship. It is, however, also the case that children who witness domestic abuse may reject such behaviour, and will try not to repeat it.⁷⁵

Neglect is a form of child abuse which can result from domestic abuse. When a parent is suffering abuse they will almost certainly strive to continue to provide love and support for their children yet this may be extremely difficult in such circumstances. Children living in abusive family environments may be left to look after themselves at an age where hands-on parenting would normally still be occurring.⁷⁸

It is recognised that educating children about domestic abuse is a key step in the process of eliminating domestic abuse. Women's Aid believes that 'the most positive way to reduce and eliminate domestic violence and its effects on children and young people is through a strategy of preventive education work' and 'all children and young people should have access to domestic violence preventive education programmes'.⁸² Working within schools to build awareness and change attitudes towards domestic abuse is decreed by the Home Office⁸³ as a primary prevention method. Research by Hague et al (2001)⁸⁴ indicates that violence prevention programmes may change attitudes, however, it is less well known whether there is a link between raised awareness and any long-term domestic abuse reduction.

Education at a young age should catalyse a change in the public perception of domestic abuse. The role of friends, relatives, neighbours and colleagues in helping victims of domestic abuse is underestimated. Educating the public about domestic abuse would help to reduce cases such as that described by Channel Four television programme 'Dispatches'; 'When did you last beat your wife?' where a woman ran from her home as her partner was violently abusing her, calling for help, while her neighbours watched and did nothing. She was subsequently dragged back in and subjected to further physical abuse.⁸⁵ It is vital that the public are aware that there are domestic abuse helplines that can be contacted should they suspect domestic abuse. Both family and friends of the victim are also well placed to encourage and support the victim to seek help.

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

- children and young people want and value lessons on relationships and on abuse
- following a primary prevention project, pupils had increased awareness of factual information regarding domestic abuse
- training for teachers is important and teachers who do not feel supported are likely to feel under-confident in using the materials and dealing with domestic abuse
- education in schools can make both primary and secondary school pupils think more deeply about domestic abuse⁸³
- in line with the recommendations stated by the Home Office in 2001, the BMA would support implementation of domestic abuse education programmes in all primary and secondary schools.

Pregnant women

It has been estimated by the Confidential Enquiry into Maternal and Child Health for England and Wales (CEMACH) that around 30 per cent of domestic abuse begins during pregnancy.⁸⁶ Studies, however, have shown a variable incidence of domestic abuse of pregnant women. In the WHO worldwide survey, it was reported that in the majority of settings, between 11 per cent and 44 per cent of pregnant women who had been abused in the past, were assaulted during pregnancy, and that in 90 per cent of all settings this abuse was carried out by the father of the unborn child.⁸⁷ An American study found that each year approximately 324,000 pregnant women in the country are abused by their intimate partner, which makes abuse more common for pregnant women than gestational diabetes or preeclampsia – both conditions for which pregnant women are routinely screened.⁸⁸ The impact of domestic abuse during pregnancy is recognised to be a significant contributory factor to maternal and fetal mortality and morbidity.⁸⁹ The CEMACH reported that in its 2000/02 study *Why mothers die?* 14 per cent of maternal deaths occurred in women who have either self-reported a history of domestic abuse to a healthcare professional caring for them, or the abuse was already known to health and social services.⁹⁰

Research has found that in comparison with other victims of domestic abuse, pregnant women are more likely to have multiple sites of injury, including the breasts and abdomen, implying that the fetus as well as the woman herself is the focus of the perpetrator's anger.⁹¹ The RCM has produced guidance for midwives dealing with cases, or suspected cases, of domestic abuse in pregnant women.⁹² The RCM advises midwives to look for a number of possible indicators of domestic abuse, which include a high incidence of miscarriage and termination of pregnancies; stillbirth; preterm labour/prematurity; smoking; alcohol and drug abuse; gynaecological problems; repeated chronic injuries; physical symptoms related to stress or depression and signs of rape or sexual assault. The RCM states that 'midwives are ideally placed to recognise and detect ongoing domestic abuse and to offer care, support and information to the woman'.⁹³



For further information about midwifery and domestic abuse please see chapter 7.

Lesbian, gay, bisexual and transgender individuals

When domestic abuse is discussed in a healthcare, political or even an informal setting, it is highly likely that its occurrence among LGBT individuals will be overlooked. It is a commonly held belief that domestic abuse does not happen within same-sex couples. The misconception that women are not perpetrators means that it is thought unlikely for a lesbian to experience domestic abuse from a partner. Mounting evidence is available which demonstrates that partner abuse is as common and as prevalent among same-sex couples as among heterosexual couples.⁹⁴ The organisation Broken Rainbow provides support for LGBT individuals who are experiencing domestic abuse. The Broken Rainbow annual report 2004/05⁹⁵ reported that around one in four lesbians, gay men, bisexual and transgender individuals will experience domestic abuse at some point in their lives. A survey of lesbians and gay men in 2003⁹⁶ found that almost a quarter (22%) of women, and almost a third (29%) of men, had suffered physical, sexual or mental abuse or violence from a regular partner, within their lifetime. The most common forms of abuse experienced by LGBT individuals are similar for men and women. These are emotional abuse, such as being regularly insulted or put down, and secondly being physically attacked.

In many ways domestic abuse in same-sex couples is the same as in heterosexual couples. The abuse can take many forms (emotional, sexual, physical, financial), occurring in a cyclic fashion, and is a way for an individual to maintain control and power over a family member/partner. There are, however, some aspects of domestic abuse that are specific to LGBT individuals. Lesbians, gay men and bisexuals who have not 'come-out' can be emotionally abused with threats of outing them at work, or to family or friends. The services available to victims of domestic abuse are rarely geared to accommodate LGBT individuals. Broken Rainbow reported in 2003 that only 20 dedicated emergency refuge spaces were available for gay men in the UK.⁹⁵ This lack of resources coupled with the lack of training, sensitivity and expertise of staff in refuge centres makes it all the more difficult for sufferers of domestic abuse who are LGBT individuals to seek help and protection from their abuser. The attitudes of the police may also create barriers for LGBT individuals, because they worry that they may not be taken seriously. Research has found that of those women in same-sex couples who have experienced abuse from a partner, only 13.1 per cent had reported the abuse, and for men who have experienced abuse from a regular male partner, only 18.8 per cent reported this abuse to the police.⁹⁶

Domestic abuse in same-sex couples is not restricted to just the abuse between the partners or ex-partners. LGBT individuals may also experience domestic abuse perpetrated by family members on grounds of their sexual orientation.⁹⁷

There is a clear need to raise awareness of the scale of domestic abuse among LGBT individuals. Breaking down the barriers for such individuals to access the services and protection they need, as well as the reporting of the abuse to the police will not only help get a better understanding of how many individuals are suffering, but it will also reduce the damaging consequences for the victims. With reference to legislation, in England and Wales some progress has been made over the last five years with the Domestic Violence, Crime and Victims Act 2004,¹¹ which recognises domestic abuse within same-sex relationships. The introduction of the Gender Recognition Act 2004, gave transgender individuals the legal right to live in their acquired gender. This needs to be further developed, for example, in female refuges to accommodate the needs of trans women.

Minority ethnic groups

Research has shown that the risk of domestic abuse does not differ significantly by ethnic group.³⁰ Current research is very limited, however, in the main it relates to domestic abuse inflicted on women from ethnic minority communities, by either their partner or family.

Women from BME communities experience the same forms of domestic abuse as for those women from all other communities. There are, however, elements that are specific to this group of women, and these must be taken into consideration when designing services which can be effective in helping all sufferers of domestic abuse.⁹⁸ There are many specialist services for women from BME communities which they may prefer to use.¹⁹ Within the Asian community, some women are expected to uphold the honour of the family by being the 'dutiful wife', and this may even mean tolerating domestic abuse rather than leaving the family home. A woman who leaves the family may make herself vulnerable to being treated as a social outcast by her extended family and wider community, something many would feel is worse than accepting the domestic abuse. In extreme cases 'honour crimes' can take place, either in the form of assault or killings, and these are justified as punishment for bringing shame on the family honour.^{98, 99}

Forced marriage is another area where domestic abuse occurs. Duress, whether physical or mental, is used for a marriage to take place without the free and valid consent of one or both parties. Some cases of forced marriage may be interlinked with the concerns held for women who are at risk of deportation if they end their marriage. If an individual has entered the UK to join their British spouse they are subject to a one-year probationary period, at the end of which they may remain permanently in the UK. If the marriage breaks down in under a year then the individual would be at risk of deportation. There are, however, certain immigration rules to protect sufferers of domestic abuse within this one-year rule. If they can provide supporting evidence for their claim of domestic abuse then they should be able to gain permanent citizenship. Individuals who have entered the country with asylum seeker status are a high risk group because they are not eligible for many social security benefits or council housing, and this makes leaving an abusive partner a much harder prospect. Refugees are at risk of domestic abuse and are increasingly likely to suffer in silence if they have previously lived in oppressive regimes, where there is little or no help from the police or local government.⁹⁹

Racism is a significant problem for many women from BME communities. Many women suffering from domestic abuse fear that when seeking help they will be subject to racist treatment. This may be further exasperated if the woman had been subjected to racism when previously having sought help. This would inevitably lead to increased under-reporting of domestic abuse in such communities and thus reduce the number of domestic abuse cases which can be stopped or treated.⁹⁹

It is not only individuals from minority ethnic communities who can be victims of domestic abuse on the basis of cultural, religious or racial differences. People from minority ethnic groups may perpetrate domestic abuse on their family members or partners from the wider community who may, for example, have a different skin colour or practise a different religion. The Home Office acknowledges the concern about domestic abuse among minority ethnic groups. *Tackling domestic violence: providing advocacy and support from black and other minority ethnic communities* states that 'being sensitive to, and aware of, the specific issues that affect black and other minority ethnic women should be integrated into the delivery of all support services'.⁹⁸

Migrant domestic workers are a further group of people vulnerable to abuse within the home. Migrant domestic workers are individuals who have entered the UK legally on a domestic worker visa to work in a private household. These individuals can face physical, psychological and sexual abuse similar to that of domestic abuse victims. While this is acknowledged as an important problem, it is however, not a concern within the remit of this report as typically an employer does not have an intimate or family relationship with the victim. The charity Kalayaan provides advice, advocacy and support services in the UK for migrant domestic workers – further information is available at www.kalayaan.org.uk.

Older people

There is no standard definition of elder abuse in the UK, however the charity Action on Elder Abuse¹⁰⁰ provides the following clear description: ‘A single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person’. Note, however, that this definition takes it out of the domestic abuse context as it includes relationships of care, such as one between a healthcare professional and an older person. If the perpetrator of elder abuse is the carer this would only be defined as domestic abuse if the carer is an intimate partner or family member of the victim.

Domestic elder abuse refers to the maltreatment of an older person by someone who has a special relationship with the older person, which occurs in either their home, or in the home of a caregiver. It has been estimated that roughly two-thirds of all elder abuse perpetrators are family members.¹⁰¹ Research has found that their own adult children are the most frequent perpetrators.¹⁰²

The WHO has predicted that by the year 2025, the global population of those aged 60 years and above will more than double from 542m in 1995 to around 1.2bn.¹⁰³ Elder abuse is a growing problem that must be taken seriously. There is a disappointing amount of research published on the prevalence of elder abuse. The statistics used by the government in the report *Elder abuse (2003/04)*¹⁰⁴ originate from a research study by Ogg and Bennet (1992)¹⁰⁵ which stated that there are approximately half a million older people being abused in the UK at any one time. This, however, is an extremely outdated figure, and the BMA recommends that research should be completed to update this. It is also widely reported that this figure cannot be relied upon to give the full picture, due to difficulties defining elder abuse, the methodology of the study and more importantly the well-documented concern that elder abuse is the most commonly under-reported form of domestic abuse.¹⁰⁶

The reasons behind elder abuse, the many forms of elder abuse and the resulting consequences overlap significantly between domestic and institutional elder abuse.

There are five main forms of elder abuse.

1. Physical abuse – this involves the use of physical force, with acts such as hitting, slapping, pushing, kicking or burning. In addition to these, physical force includes the misuse of medication, physical restraints and force-feeding.
2. Sexual abuse – this is when sexual contact is made with an older person without their consent. This includes, rape, unwanted touching, coerced nudity and sexually explicit photography.
3. Psychological abuse – this involves the infliction of anguish, pain or distress through verbal or non-verbal acts. It includes emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, harassment, verbal abuse, and isolation from family, friends, services or supportive networks.
4. Financial or material abuse – this is the illegal or improper use of an older person’s money, property or assets. This includes fraud, exploitation, forging of signatures, stealing, and the pressurising or deceiving of an elder to sign important documentation, such as a Will or contract.

5. Neglect and abandonment – neglect occurs when the person trusted to care for the older person ignores the medical or physical care needs of that person, fails to provide access to appropriate healthcare, social care or educational services, and the refusal or failure to provide the necessities of life (such as food, water, clothing, personal hygiene, personal safety). Abandonment is defined as the desertion of an older person. Research has found that neglect is the most common form of elder abuse (55% of reported cases in the USA in 1996)¹⁰² compared with the other four types.

Defining an elder abuse perpetrator is as much of a challenge as it would be to describe the defining characteristics of a perpetrator of any other type of abuse. Studies have discovered some common causal factors, which vary depending on the relationship the perpetrator has with the older person. The domestic abuse may have simply continued from a younger age, whereby habitually one member of a couple had always exerted power and control over the other. Now with one or both members being older, this is classed as elder abuse. Primarily in the case of adult children, the abuser is commonly dependent on their victim for either financial support or housing. In some cases, strained family relationships may worsen when a family member becomes stressed as an older person may gradually become more dependent on their care giver. Cultural and socio-economic factors, such as the depiction of older people as frail, weak and dependent; restructuring of the basic support networks for older people; and the migration of young couples to other areas can also have an impact on the likelihood of elder abuse.^{101, 104, 107}

Disabled people

Findings from the 2004/05 BCS state that ‘having a limiting illness or disability is independently associated with all types of intimate violence for men and women and is strongly associated with family violence (non-sexual) among men and women and stalking among men’. Disabled women have three times greater odds of experiencing domestic abuse than non-disabled women and for disabled men the odds are two times greater.²⁹ Disabled individuals can experience the same forms of domestic abuse as non-disabled individuals but may be more vulnerable. Certain forms of abuse which may be specific to disabled people include the abuser withholding care or undertaking it neglectfully or abusively; the abuser may remove mobility or sensory devices that are needed for independence; they may be claiming state benefits on behalf of the disabled individual thus making it easier for them to control the disabled person’s finances; and using an impairment to taunt or degrade the individual.¹⁹ Disabled people are likely to experience abuse over a longer period of time and can suffer more severe injuries as a result of the violence. They may have to rely on family members for their care and this puts them at risk of being abused by a person with whom they place so much responsibility and trust.

If a person has a mobility impairment, it may be more difficult for them to get out of the way of the perpetrator at the time of an attack, or to seek permanent refuge. If they require specialised transport to leave the home, which often would be arranged or provided by a carer, then they are effectively trapped. Having a communication impairment would mean that accessing helplines and making appointments for example may be very difficult. A further barrier preventing disabled people from escaping their abuser is that they may be socially isolated from friends and family either due to their impairment or due to the control of their carer. This makes reporting domestic abuse extremely difficult as they have no one to turn to and often no opportunity to see health or social care professionals without the carer being present.¹⁹ Individuals with learning difficulties are vulnerable to domestic abuse as they may, for example, have impaired speech or are too cognitively impaired to report domestic abuse, or to realise that a crime has been committed.

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

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

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

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

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

Women’s Aid is organising a two and a half year research project, funded by the Big Lottery Fund, into disabled women’s experiences of domestic abuse, in tandem with an exploration into existing service provision for disabled women experiencing abuse. This started in September 2005 and is due to reach completion in April 2008.¹⁹ Research is equally required into disabled men’s experiences of domestic abuse.

Chapter 5 Detection of domestic abuse in healthcare practice

No accurate figure exists for the prevalence of domestic abuse as it is known to be grossly under-reported to authorities, such as the police, healthcare service and social services. There are numerous reasons for this, and it is important to identify what these are, not with the primary aim of achieving accurate prevalence figures, instead to try and combat the barriers to reporting. A Home Office report states that 'a true and accurate assessment of the real levels of domestic violence will not be possible until there is progress in changing attitudes so that all victims of domestic violence feel safe when revealing the violence they have experienced'.⁹ A UK study highlighted the extent to which domestic abuse is under-reported with the finding that only 17 per cent of women who had experienced domestic abuse disclosed this to their GP.¹⁰⁸ The health service has a dual role in tackling domestic abuse. It is a source of care for many of the injuries (both emotional and physical) of victims of domestic abuse, and it provides a key route to identification and risk assessment of domestic abuse victims.¹⁰⁹ This chapter will identify why victims of domestic abuse often go undetected in healthcare settings and provide advice on how identification may be improved.

Behaviour and attitudes of healthcare professionals to domestic abuse

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

A study of Australian doctors (2004)¹¹⁰ found that a doctor's perception could influence their identification and management of patients suffering from domestic abuse, which suggests that in some practices many victims were being overlooked. The study found that even doctors who expressed empathy for victims of domestic abuse found the work unrewarding and financially draining because of the long consultations. Doctors felt frustrated when patients were non-compliant with their advice or did not return for follow-up appointments, and some were discouraged because they got little feedback. Some doctors admitted occasional reluctance to acknowledge the problem, even when they had grounds for suspicion. Doctors' reactions to their victimised patients ranged from understanding, close identification, and distress to frustration with their inability to engender change. Healthcare professionals report patient non-disclosure and fear of offending the patient as two of their key barriers to asking patients about domestic abuse.¹¹¹

The gender of a doctor has been found to affect the likelihood of whether a patient will discuss domestic abuse with their doctor. The same study of Australian doctors¹¹⁰ found that overall, female doctors believe their gender is advantageous because women (statistically the most common victims of domestic abuse) would trust them more. They understood women's suffering, and they would identify with women's experiences. They also believe that male patients may find it easier to speak to them about emotional issues. Most male doctors agreed that their male patients would prefer to speak with a female doctor.

There is a lack of training among healthcare professionals on how to deal with domestic abuse (see later section within this chapter for more detail) and this results in them feeling a lack of confidence in knowing what to look for and what to do if abuse was disclosed. As a result of poor and/or no training, doctors will revert to their natural instincts and this may be to prioritise the preservation of the couple, or avoid intervening in an intimate relationship and thus ignore the abuse.¹¹⁰ Research has shown that doctors who have received training are much more likely to ask patients about domestic abuse. With training, 35 per cent 'almost always' ask, and without training only 13 per cent 'almost always' ask. Additionally, doctors who ask more regularly about domestic abuse are more likely to have patients who disclosed the abuse.¹¹² The Home Office reports that healthcare professionals find 'post-it' notes containing the phone number for the local domestic abuse support agency particularly helpful in prompting them to remember to ask.¹¹³

Care settings are often not appropriately structured to allow the privacy and time needed to explore a victim's problems with domestic abuse. A Home Office report states that women victims of domestic abuse have not had their needs met in a busy hospital A&E department.¹⁰⁹ Time constraints are a barrier to the disclosure of domestic abuse for all grades of doctors who operate a structured appointment timetable.

Although studies have shown that doctors have concerns about unearthing cases of domestic abuse, nearly all primary care doctors believe it is their responsibility to treat victims of domestic abuse.¹¹⁴ A study completed in the USA in 2003 has found that doctors who come across cases of domestic abuse are most likely to treat the emotional complaint (82%), document the abuse in the medical record (79%) and treat the physical complaint (67%).¹¹² Another study in the USA found a doctor's response to encounters with suspected victims of domestic abuse includes discussing their observations with the patient (80%), giving the patient information about community resources (80%), making a note in the patient's chart (76%), facilitating safety arrangements (65%), and encouraging the patient to report to the police (63%).¹¹⁵

Patients' views of doctors

It has been reported that women see the health sector as an appropriate site for intervention against domestic abuse and that they expect the health service to take an interest in understanding and acting on women's experiences of abuse.¹⁰⁹ This finding, however, does not correlate with the results from the BCS, which shows that one-third of women and just under two-thirds of men who have suffered domestic abuse since they were 16 years of age have probably never told anyone other than the survey about their worst incident. Victims of domestic abuse were most likely to have told their own friends, relatives or neighbours, and the next largest category to learn of the abuse was the police. Only 30 per cent of women and 14 per cent of men who sustained injuries in their worst incident of domestic abuse said that they approached the health service as a result. Of those who did seek medical help for domestic abuse, the service most frequently used by women was the GP (65%), followed by the A&E department (35%).³⁰ Research carried out by Women's Aid in 2005 found that only 19 per cent of female victims of domestic abuse approached a doctor for help.³³

Surveys have identified a number of barriers that prevent victims of domestic abuse from disclosing it to a doctor during a healthcare visit. These include embarrassment, lack of trust in the healthcare professional, fear of retaliation from their partner, concerns about police involvement,¹¹⁶ feeling disempowered and denying the abuse, denying that it is a health concern or denying its seriousness.¹¹⁷ An American study found further reasons why victims do not report domestic abuse to their doctor. These included humiliation, cost of medical services, risk of having social services remove their children, abuse being too personal to discuss, lack of confidentiality, and doctors' inability to provide what victims really need because of limited training, interest or resources.¹¹⁸ An additional fear preventing disclosure of domestic abuse is that the healthcare professional may act as if the victim is an equal partner in provoking a violent encounter.¹⁰⁹

A 2005 study was completed in Texas on adult primary care patients, both men and women (those who were abused, not abused or had been the perpetrators). Respondents were asked 'What advice do you have for doctors who want to help patients with severe family problems?' The results revealed the following strong themes, which were communication, assistance, and cautions:

- good communication will build a robust doctor-patient relationship, and it must include asking about family concerns, as well as listening

- assistance: the majority of respondents advised doctors to make referrals (to therapists, counsellors, refuges etc) but additional recommendations were to offer advice (give advice, discuss the options, suggest solutions), provide help (offer help if they cannot go to anyone else, the provision of follow up appointments) and both emotional and medical support
- finally, respondents advised doctors to be cautious with the advice they give, ensure they have received adequate training on how to deal with domestic abuse, get involved and be prepared to deal with whatever comes up.¹¹⁹

The outcome of a disclosure of domestic abuse to a healthcare professional is dependent on many factors such as whether the healthcare professional has been trained to deal with domestic abuse, their attitude towards domestic abuse, the services available for them to refer patients to and the time available to discuss the problem further. When patients were surveyed to find out what services they want their doctor to offer, referral to appropriate specialist services was the preferred outcome. Respondents felt strongly that the services should be individualised to a victim's specific situation and that there was a need for 24-hour access to professional advocates who understand domestic abuse.¹¹⁸ Patients are known to value emotional support from healthcare professionals, careful and non-judgemental listening,¹²⁰ and reassurance that the abuse is not their fault and that negative feelings are understandable.

Enquiring about domestic abuse

Medical providers are well placed to identify and intervene on behalf of patients who are experiencing domestic abuse. The signs and symptoms of abuse are often easily concealed from the doctor or nurse, and the victim may not choose to broach the subject. In cases such as this, routine enquiry about domestic abuse, commonly known as 'screening', may increase the rates of identification. Many research projects have been completed to ascertain the views of patients (abused and not abused) and of doctors on routine enquiry for domestic abuse. There is no official regulation that doctors in the UK must routinely question all patients for domestic abuse but it is recommended in the USA. It is important to note here that as it is mainly women who experience domestic abuse, routine enquiry is generally discussed in the context of asking women patients only.



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

The Home Office report *Tackling domestic violence: the role of health professionals (2004)*¹¹³ explains that there are two methods of enquiry which can be used to identify domestic abuse in the primary care setting. *Routine enquiry* refers to asking all women who are using the service direct questions about their experiences, if any, of domestic abuse regardless of whether there are any signs of abuse, or whether abuse is suspected. *Selective enquiry* involves asking women directly about their experiences, if any, of domestic abuse where there are concerns or suspicions, including visible signs/symptoms. The report states that all healthcare professionals should practise selective enquiry and routine enquiry should be considered in a number of different settings, for example, in maternity services where the risk of domestic abuse is far greater than average. Routine enquiry needs to be implemented flexibly and must take account of local factors, including the availability of private space and the staff based in the setting. Routine enquiry has several advantages over selective enquiry. It ensures all women are provided with basic information about domestic abuse, including the existence of specialist services that can provide support, and with clear messages that it is unacceptable and can present in many different forms. It also should help to reduce the stigma associated with abuse and gives women victims a clear message that they are not alone in their experience.

Sarah's story ...

(Age 27)

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

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

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

The American Medical Association guidelines on domestic abuse advise that doctors should 'routinely enquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care'.¹²¹ The American College of Obstetricians and Gynaecologists recommends that doctors routinely enquire about intimate partner violence with all patients. This recommendation is valid for both women who are not pregnant and for those who are.¹²² The guidelines in the UK are far less supportive of introducing a blanket rule to routinely enquire about domestic abuse in all patients. The DH states that routine enquiry in ante-natal care and sensitive enquiry about domestic abuse should be included in taking a social history.¹²³ This is endorsed by the Royal College of Obstetricians and Gynaecologists (RCOG).¹²⁴ The DH report explains the importance of adopting routine enquiry about domestic abuse in conjunction with appropriate protocols, and training and support for the staff involved. Routine enquiry should not be treated as a one-off episode. Examples of this include that a victim of abuse may need to hear the questions several times before gaining the confidence to disclose the information, and that it is important to ask at different stages of a woman's pregnancy. The DH does not recommend that routine enquiry should be carried out on all patients outside antenatal care, instead it states that 'the extension of routine questioning to other health settings [also] requires further development and research validation prior to wholesale introduction'.¹²⁵ The RCPsych recommends that due to the association between domestic abuse and poor mental health, enquiry about domestic abuse in the past and present should be included as part of the clinical assessment of all patients and families.¹²⁶

For further information and guidance on asking about domestic abuse refer to *Responding to domestic abuse: a handbook for health professionals* (2005) published by the DH¹⁴ and *Responding to domestic abuse: guidelines for healthcare workers in NHS Scotland* (2003)¹²⁷ published by NHS Scotland.

The need for education and training

Information on the extent of training received by doctors on domestic abuse is limited and mainly consists of guidelines as opposed to accounts of what happens in practice. Within the General Medical Council's (GMC) recommendations for undergraduate medical education it states that medical students 'must be aware of issues such as alcohol and drug abuse, domestic violence and abuse of the vulnerable patient'.¹²⁸ The curriculum for the foundation years in postgraduate education and training makes several points related to domestic abuse. The curriculum states that a trainee must demonstrate the knowledge, skills and attitudes to be able to take a history and examine patients, including being able to take a history in non-routine circumstances such as possible child abuse/neglect and elder abuse. Trainees are required to identify signs of possible patient abuse and alert the appropriate colleagues and agencies in a timely fashion as well as maintain a strong and consistent focus on the needs of the patients. Finally, the curriculum states that a trainee must be capable of dealing with ethical and legal situations, including seeking appropriate, timely advice where patient abuse is suspected while respecting confidentiality.¹²⁹ Different royal colleges produce their own independent guidelines on the training of the specific type of healthcare professional. An example of this is the Royal College of General Practitioners (RCGP) who incorporates domestic abuse into the curriculum for the training of GPs, but only in relation to the healthcare of women. It states that a GP should be familiar with local support services, referral services, networks, and groups for women (eg family planning, breast cancer nurses, domestic abuse resources), as well as recognise the prevalence of domestic abuse and question sensitively where this may be a concern.¹³⁰

Studies have been carried out which demonstrate the importance of training healthcare professionals about domestic abuse. The research displays the positive impact training can have on the detection and treatment of victims. The research is largely from the USA as it is there that guidelines for dealing with domestic abuse in a healthcare setting are more extensive. It has been found that training of healthcare providers leads to an increase in ability to identify and help partner abuse victims, as well as other attitudes and values thought to be important to aid healthcare providers to both identify and help such victims.¹³¹

Unfortunately, however, the presence of domestic abuse training in the curriculum for undergraduate medical students does not necessarily equate to all junior doctors becoming competent at dealing with such a complex problem. Additionally, it has been found that medical school curricula are not always closely followed. A study in the USA found that while 86 per cent of USA medical school deans report teaching about domestic abuse, only 57 per cent of medical students report learning about it.¹³² A survey of final-year residents from across the USA into their perceived preparedness to counsel about preventative and psychosocial subjects found that, less than half of respondents felt well prepared to counsel patients about domestic abuse.¹³³ There are significant barriers preventing medical students from carrying skills related to domestic abuse in the classroom into early experiences in primary care.¹³⁴

All healthcare professionals and staff working in healthcare settings should ideally receive training on enquiring about domestic abuse. The Home Office stated in *Tackling domestic violence: the role of health professionals* (2004)¹¹³ that 'given the importance of domestic violence as a factor impacting on health, training about enquiry should be part of pre-registration curricula and post-registration on-the-job training for all health professionals. Basic awareness training is also useful for administrative staff with patient contact, eg GP receptionists, A&E receptionists'. It has been recommended by the Home

Office that training of healthcare professionals in preparation for enquiry about domestic abuse should include the following key aspects:

- be at least one day in length
- explain the nature and extent of health problems caused by domestic abuse
- include information about how to ask direct questions about a victim's experience without compromising their safety
- training on how to respond when domestic abuse is disclosed
- information on the local availability of services for victims
- coverage of safety planning for those experiencing abuse
- information about the safe documentation of domestic abuse.¹¹³

Domestic abuse training

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

General Practitioner

The role of the primary healthcare team

Identification of domestic abuse falls largely to the PHCT, and this involves a broader range of professionals than solely GPs. Practice nurses are heavily involved with well-women care and are often responsible for completing new patient screening appointments. Nurses are in an ideal position to offer advice and support if domestic abuse is suspected or disclosed. Midwives come in direct and regular contact with pregnant women, whose incidence of domestic abuse is higher than average, and they are able to provide an enabling environment for the disclosure of domestic abuse during pregnancy. Midwives can make referrals and provide ongoing support.¹⁴ In addition, health visitors may identify domestic abuse through their contact with families with young children.

Management and support staff in a GP's surgery are further examples of the PHCT members who may be able to play a part in identifying domestic abuse. They are well placed to convey the point that domestic abuse is wrong by displaying posters and educational leaflets containing this message. Reading information about domestic abuse is likely to be one of the first steps that a victim takes in acknowledging that what they are experiencing is not acceptable. Information must be publicly available for everyone to read, ie in the waiting room, as this not only educates the victims and the perpetrators, but it also works to change public perceptions of domestic abuse. Additionally information about seeking help, including helpline phone numbers, should always be displayed in private areas such as on the back of toilet doors. This will enable a victim to take a note of the information without anyone else knowing. It is important that all information sources whether verbal or written are available in languages other than English so as to dissolve the language barrier which may prevent individuals from ethnic minorities from disclosing domestic abuse.

It would be extremely valuable for all members of the PHCT to remember the freephone domestic abuse helpline numbers for women (0808 2000 247) and men (0808 801 0327) and to pass these on to their patients.

The Home Office guidance for healthcare professionals in tackling domestic abuse¹¹³ recommends that professionals use the mnemonic RADAR, modified from the original model proposed by the Philadelphia Family Violence Working Group, USA, to aid their approach. This is as follows:

RADAR

- R** Routine enquiry
- A** Ask direct questions
- D** Document findings safely
- A** Assess woman's [victim's] safety
- R** Resources; give woman [victim] information on resources available and respect their choices.

These different stages of dealing with domestic abuse are covered in more detail within this chapter.

The PHCT is an entity which is continually evolving. As explained by the RCGP¹³⁵ a PHCT 'refers to groups of professionals delivering health services in the community at "primary" or first points of contact with the health service'. Since the 1990s there has been an expansion of the PHCT to include a number of different professions working in primary care, and an emphasis on the different professions working together as a team. A PHCT consists of GPs, practice nurses, community nurses, health visitors, midwives, practice managers and administrative staff, as well as allied health professionals who include for example physiotherapists, occupational therapists, speech and language therapists, chiropodists/podiatrists, and dieticians. A further group of healthcare professionals that provide primary care are those working for GP out-of-hours care services. It is critical that there is a joined-up approach to dealing with domestic abuse across the whole PHCT for which in England the Primary Care Trust (PCT) is responsible for implementing, for example the use of training and good practice guidelines.

As explained by the DH, victims of domestic abuse use health services frequently and require wide-ranging medical services. They are likely to be admitted to hospital more often than non-abused victims and are issued more prescriptions.¹⁴ It is therefore critical that a PHCT has a mechanism in place to help identify patients who repeatedly seek medical treatment, and additionally those who frequently miss appointments, as both behaviours are symptomatic of domestic abuse. The former also applies to secondary care, for example identifying patients who repeatedly present to A&E departments with physical injuries. A study in 2004 compared the healthcare utilisation in family practice of abused women (not solely domestic abuse) to that of the average female population. It was reported that abused women had almost double the consultation rate together with a sevenfold prescription rate of pain medication in the youngest and middle age categories and threefold in the oldest age group.¹³⁶ Identifying 'repeat visitors' will enable more cases of domestic abuse to be unearthed, thus increasing the number of victims who are referred to agencies, that can subsequently reduce the chances of further harm.



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

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

Chapter 6 Ethical considerations for healthcare professionals dealing with domestic abuse

Confidentiality and information sharing

Respect for confidentiality is an essential requirement for the preservation of trust between patients and healthcare professionals. In addition to the traditional ethical obligation of medical confidentiality, there is also a strong public interest in maintaining confidentiality so that individuals will feel confident in sharing private information relevant to their health and wellbeing. Furthermore, an increase in public awareness of confidentiality may result in improved reporting rates of crimes such as domestic abuse, which in turn raises the number of people treated. In the case of victims of domestic abuse, confidentiality is essential in enabling them to disclose their experiences as their physical safety may be dependent on confidentiality being maintained. Providing that a healthcare professional gains consent from the patient then there is no problem in disclosing information to a third party.

The right to confidentiality, however, is not absolute and may be countered when the rights of others to be protected from harm are jeopardised in a serious way. When rights such as these collide, a balance must be struck between the importance of maintaining confidentiality and the harms that could be avoided if confidentiality was breached. For example, where there are reasons to believe that children are at risk of significant harm as a result of domestic abuse, protection must take precedence over confidentiality. All healthcare professionals must therefore understand and be honest with patients about the limits to confidentiality.¹⁴

Consent to information sharing

Increasingly, care is provided by multidisciplinary teams and following a disclosure of domestic abuse a healthcare professional may wish to discuss the matter with members of their team. The healthcare professional may also feel it is appropriate to report it to other agencies such as the police or social services. Provided that a healthcare professional gains consent from the patient then there is no problem in disclosing information to third parties. Consent can be defined as freely given, informed agreement. While disclosure with consent by an informed adult is unproblematic, it is generally advisable that evidence of the patient's consent to disclosure to third parties, is kept on the patient's file.

Patients do have the right to object to information they provide in confidence being disclosed to a third party in a form that identifies them, even if this is to someone who might provide essential healthcare. Where patients are competent to make such a choice and the consequences of that choice have been fully explained, if the patient does not wish the healthcare professional to share particular information with other healthcare professionals or agencies those wishes must be respected. It is particularly important in the context of domestic abuse that the patient is involved in all stages of the decision-making process, and that they retain as much control as possible over disclosures of information. They may feel threatened by the thought of others knowing about their situation. All medical members of a team receiving information in order to provide support or care for a patient are bound by a legal duty of confidence.¹³⁷

Disclosures in the public interest

When treating a patient who has disclosed domestic abuse it is the responsibility of a healthcare professional to emphasise that although information given to them by the patient is confidential, there are limits to this confidentiality. In the absence of patient consent, any decision as to whether identifiable information is to be shared with third parties must be made on a case-by-case basis and must be justifiable in the 'public interest'. Traditionally, disclosures in the 'public interest' are made where disclosure is essential to prevent a serious and imminent threat to public health, national security, the life of an individual or a third party or to prevent or detect serious crime. The GMC in its guidance *Confidentiality: protecting and providing information* (2004) states:

'Disclosure of personal information without consent may be justified in the public interest where failure to do so may expose the patient or others to risk of death or serious harm. Where the patient or others are exposed to a risk so serious that it outweighs the patient's privacy interest, you should seek consent to disclosure where practicable. If it is not practicable to seek consent, you should disclose information promptly to an appropriate authority or person. You should generally inform the patient before disclosing the information. If you seek consent and the patient withholds it you should consider the reasons for this, if any are provided by the patient. If you remain of the view that disclosure is necessary to protect a third party from death or serious harm, you should disclose information promptly to an appropriate person or authority. Such situations arise, for example, where a disclosure may assist in the prevention, detection or prosecution of a serious crime, especially crimes against the person, such as abuse of children.'¹³⁸

Similarly, the United Kingdom Central Council *Code of professional conduct* states that nurses or midwives should protect all confidential information, and make disclosures without consent only where required by order of a court, or where disclosure can be justified in the wider public interest.¹³⁹

Balancing benefits and harms

The decision to disclose is based partly on a balancing of several moral imperatives, including the risk and likelihood of harm if no disclosure is made, and the need to maintain the trust of the patient. There is no broad consensus of how harm to people should be evaluated or from whose perspective it should be judged. For the victim who suffers harm, it may be perceived in very different terms than by the decision maker outside the situation who is trying to weigh it up. The BMA's advice is that, where feasible, healthcare professionals should try to envisage the seriousness of the potential harm from the viewpoint of the person likely to suffer it.

Where a healthcare professional becomes aware that a patient has been a victim of domestic abuse and is at risk of serious harm or death from an abusive partner the healthcare professional may decide, after considering all the available evidence and the wishes of the patient, to disclose this information to an appropriate third party. The healthcare professional should ensure that the patient will not be put at increased risk following disclosure. Ultimately, the decision as to whether to disclose information about abuse to a third party rests with the healthcare professional responsible for the patient's care. However, discussion of the case on an anonymised basis with colleagues or with other agencies may assist.

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

Hamish Meldrum

Chairman, General Practitioners Committee, BMA

Knowledge or belief of abuse and neglect of a child or vulnerable adult is an exceptional circumstance which will usually justify a healthcare professional making a disclosure in the 'public interest' to an appropriate person or agency. If the healthcare professional has reason to believe that children or a vulnerable person are at risk, then protection must take precedence over confidentiality.

It is essential that healthcare professionals are aware of the risk factors and carefully weigh up evidence obtained from a victim concerning the alleged abuse of a child. It should not be assumed, for example, that simply because an abusive relationship exists between two adults in the household that any children are subject to abuse. Research has, however, found that children are negatively impacted from witnessing abuse and this should be taken into consideration.⁷⁹ The government report *Working together to safeguard children* (2006) states that all healthcare professionals working with children and families should 'understand the risk factors and recognise children in need of support and/or safeguarding, and contribute to planning support for children at risk of significant harm, eg children living in households with domestic violence or parental substance misuse'.¹⁴⁰ BMA guidance explains that 'no two cases are identical, and the needs of children and families vary from case to case. Decisions about how best to respond when there are concerns about harm to a child necessarily involve a degree of risk – at the extreme, of leaving a child for too long in a dangerous situation, or of removing a child unnecessarily from its family. In each case, these risks need to be weighed and advice may need to be taken from other professionals and local agencies'¹⁴¹ such as the Local Safeguarding Children Boards.

Involving the patient

Wherever possible, consent to disclosure of information should be sought from the patient. Disclosing information without consent of the patient would be the last resort. Victims may be concerned that the disclosure of what has occurred may lead to further maltreatment. There are no easy solutions but healthcare professionals must bear in mind whether other people in the family are also at risk and the possibility of continued or more severe abuse resulting in permanent damage. The patient may need time to come to a firm decision about disclosure. Persuasion may require time, counselling, and repeated consultations. Delay, however, is inadvisable in all cases when the risks are imminent, serious and foreseeable. Healthcare professionals who are unable to persuade a patient to voluntarily disclose information that could prevent serious harm to other people are likely to be justified in disclosing without consent.

Making a disclosure

Decisions to disclose information in the 'public interest' should be taken by the healthcare professional with overall responsibility for the patient's care. Information disclosed without consent should be the minimum necessary to deal with the risk and careful thought must be given to the question of to whom the information should be released. Where disclosure is made without the consent of the patient the healthcare professional must be prepared ultimately to justify his or her decision before the GMC or other appropriate disciplinary body.

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

For further information about confidentiality and guidance on how this can be adhered to please refer to the BMA publication *Medical ethics today* (2004).⁴

If the perpetrator is registered with the same doctor

Not uncommonly, the perpetrator will be registered with the same GP as that of the domestic abuse victim. It is stated in the GMC's *Duties of a doctor* that a doctor must 'Respect patients' right to confidentiality' and this would mean that following a disclosure of domestic abuse from a patient the doctor would be breaching confidentiality by initiating a discussion about the abuse with the perpetrator. It is unlikely that the victim who has divulged information about their abuse will wish the matter to be raised with their family member: fear of retaliation from a partner is known to be a common reason for victims not revealing a history of domestic abuse.¹¹⁶ In addition, many GPs would feel uncomfortable about engaging in a difficult and potentially confrontational situation with the perpetrator. The practice environment can, however, be helpful in conveying the message that domestic abuse is not tolerated, through the display of written materials, such as posters. The perpetrator may be in need of medical care in the same way as any other patient and the GP has a duty to ensure that the appropriate medical care is provided.

In some circumstances the fear of violence from the perpetrator towards members of the PHCT may be justified and some attempt should be made to assess the risk to staff and ensure that they are protected from such an individual. Removal of the alleged perpetrator from the doctor's list without good evidence that the patient represents a real threat to staff at the surgery, or to other patients, should be strongly discouraged. The BMA General Practitioners Committee (GPC) defends vigorously the rights of both practices and patients to terminate a relationship that is not working. Practices must provide the patient with a reason for their removal and normally a warning should have been given by the practice in the last year. The GPC states that violence or threatening behaviour by the patient is a valid case for the removal of a patient as GPs have a right to protect themselves, their staff and any other individuals on their premises.¹⁴²

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

'GPs may feel unable to provide support to both sides equitably, especially to the perpetrator. Each situation should be considered independently. A GP needs to make an explicit decision about whether to continue to care for both parties. If it is difficult to continue to care for the perpetrator, this needs to be conveyed clearly and in a way that does not increase the danger to anyone, including the GP. However, a GP is ethically obliged to ensure that the perpetrator receives ongoing care and should refer on to another doctor.'¹⁴³

Meeting the healthcare needs of domestic abuse perpetrators

While the safety of a domestic abuse victim and their children is of primary importance in all cases of domestic abuse, healthcare professionals also have a duty to meet the healthcare needs of their patients who are perpetrators of abuse. Minimal research has been conducted on the service provision available to perpetrators of domestic abuse, and published research is of variable quality. A study completed in 2006, found that when perpetrators were prepared to find help they would most frequently access their GP. When consulting their GP however, few perpetrators were found to identify domestic abuse as 'the problem', instead it was more common to present a case for requiring psychological care.^{144, 145}

When discussing the subject of domestic abuse with a perpetrator, a GP needs to have some empathy with the perpetrator's situation and confidence that benefit can come from initiating discussion of the topic. It is the role of a healthcare professional to understand, but not excuse, the actions of the perpetrator, and to provide effective management of the situation.¹⁴⁵ There is a disappointing amount of guidance available for healthcare professionals on the management of domestic abuse perpetrators.

The DH has produced a comprehensive handbook titled *Responding to domestic abuse: a handbook for health professionals* (2005)¹⁴⁴ yet this contains no details on how a doctor should manage a patient who discloses that they are a perpetrator of domestic abuse.

Perpetrators of domestic abuse are most likely to present to a healthcare professional in times of crisis, for example when their partner may have threatened to leave or deny access to their children. Other situations which may alert doctors to the possibility of domestic abuse include drug and alcohol related problems or stress related illness.¹⁴⁵ It is the responsibility of a GP to direct patients who disclose that they are perpetrating domestic abuse, to appropriate specialist support services. The organisation Respect is available to assist healthcare professionals (as well as domestic abuse perpetrators, their (ex) partners, friends and family and all frontline workers) who come into contact with perpetrators in their work. Respect is the UK association for domestic abuse perpetrator programmes and associated support services. Through its phonenumber doctors can learn of what perpetrator programmes are available in their local area, receive advice about working with perpetrators, and receive information about how perpetrator programmes work, what is involved, what is best practice and how they are different from anger management courses.¹⁴⁶ This information can then be relayed to the patient, with the aim of encouraging them to seek further help themselves.

The Men's Advice Line & Enquiries (MALE) explains that perpetrator programmes are designed to help a perpetrator change their behaviour and develop respectful, non-abusive relationships. Most perpetrator programmes work with men, but occasionally also with women. They are usually small groups of eight to 15 men who have been violent or abusive in a current or previous relationship. Programmes will differ in length and content, some will take men who self-refer, whereas some will only take men who are mandated to attend by the courts. No programme can guarantee that the perpetrator will change. Research into the effectiveness of perpetrator programmes has found that most perpetrators who complete a programme do stop their violence for a period, although some replace their physical violence with heightened verbal or psychological violence.¹⁴⁵ Perpetrators who have voluntarily attended programmes are more likely to stop their physical violence than those referred by the courts.¹⁴⁷

Chapter 7 Management of domestic abuse within healthcare specialties

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

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

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

There are common elements across all medical specialties in the way victims of abuse should be dealt with, yet some key differences also exist. Healthcare professionals who encounter cases of domestic abuse comprise a number of the components of the multi-agency approach to tackling the crime. It is therefore crucial that in addition to meeting the specific medical needs of their patients they must take a consistent approach to the referral of patients to specialist domestic abuse services. Most regions have domestic abuse forumsⁱ (DAFs), which are collections of representatives from interested bodies. The aim of these forums is to coordinate agency responses to domestic abuse. These forums may be a starting point in helping to identify which voluntary body, for example Women's Aid, may be most appropriate. Certain professional organisations, such as the British Association for Emergency Medicine¹⁴⁸ (BAEM) have addressed the fact that each healthcare setting has specific aspects to their approach to domestic abuse and hence have produced guidelines for their members on how to identify and manage victims of domestic abuse.

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

The accident and emergency department

It is estimated that one in four women and one in five men have experienced domestic abuse by a partner since the age of 16.²⁹ These prevalence figures are extremely relevant to emergency medicine as a study in the UK has found that 1.2 per cent of A&E department visits are due to domestic abuse. To put this in context, an A&E department with 55,000 patients of all ages attending during one year would see over 500 adult patients suffering due to domestic abuse.³³ As stated by Boyle, Robinson and Atkinson (2004) it is, however, realistic to assume that the incidence rates derived from such interview based surveys are underestimates, as the interview-based nature of the surveys are invariably hampered by the reluctance of victims to disclose information.⁵⁰ An American study has identified that emergency department attendance is common in the two years before murder by a partner, thus further emphasising the importance of domestic abuse awareness in emergency medicine.¹⁴⁹

There are presently no guidelines in the UK to implement routine enquiry for domestic abuse in patients visiting A&E departments. The BAEM states that 'where there is a high index of suspicion, simple direct questions such as "We know that violence at home is a problem for many people, is there someone at home who is hurting you in some way?" are usually acceptable and effective'. A UK study in 2002 found that there is a high level of acceptability among patients for routine enquiry about domestic abuse, by either a doctor or nurse.¹⁵⁰ This gives an indication that the BAEM approach of questioning *only* when domestic abuse is suspected would also be acceptable to patients.

ⁱ More commonly referred to as domestic violence forums.

While routine enquiry for domestic abuse is not recommended in A&E departments, it is still important that emergency doctors know how to create the opportunity for a patient to disclose domestic abuse, so that self-reported victims can be offered help. Methods of providing an enabling environment include consultations taking place in a private room and patients being seen without the presence of a family member.^k A&E departments must also convey the message that domestic abuse is wrong and that help is available. This can be done by displaying posters and providing information leaflets in places where they can be discreetly picked up. It has been found that leaflets placed in the women's toilets disappear very quickly.⁵⁰

There are barriers to healthcare professionals identifying cases of domestic abuse in A&E departments. These include the following:

- the erroneous assumption that domestic abuse occurs exclusively to women which may lead to healthcare professionals not considering men as possible victims
- the attitudes of healthcare professionals who may feel apprehensive in asking patients about domestic abuse for fear of offending them or putting their patient at greater risk
- time constraints pose a large problem for providing each patient with the length of consultation they may require
- a common lack of private rooms for treating patients.⁵⁰

Training for healthcare professionals who work within emergency medicine needs to be implemented on a national scale. The BAEM states that training in identification and management of domestic abuse should be provided at least yearly as it increases the willingness of healthcare professionals to ask about domestic abuse and their comfort to manage a case.¹⁴⁸ Healthcare professionals need to be educated about the prevalence of domestic abuse, the risk factors associated with it, the signs and symptoms which can be commonly presented by the victims, how to enquire about domestic abuse and finally how to deal with a disclosure.

Management of domestic abuse within an A&E department is likely to be challenging for its staff as the working environment can be highly pressured. This could prevent a healthcare professional from being able to spend the necessary time with a patient to provide the calm, non-judgemental, and supportive treatment that they require. As stated above, there should be a multidisciplinary response to domestic abuse, and therefore it is the responsibility of all A&E healthcare professionals to know how to provide an immediate response, followed by methods of referring patients to the appropriate specialist services.

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

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

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

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

Dr Jo Nurse
Consultant in Public Health

Following a disclosure of domestic abuse in an A&E department, the BAEM advises that a healthcare professional should carry out specific enquiry into suicidal ideation, drug and alcohol use, and the presence of children in the home. When there are concerns about the welfare of children, this should lead to the prompt activation of local child protection services. Contact with the police and voluntary agencies should be offered from the A&E department as it may be safer for the victim to contact agencies for help from the hospital than from their home. Patients must be provided with written information about local voluntary agencies, which they can then opt to use in the future.¹⁴⁸

A healthcare professional's first priority with a patient who has suffered from domestic abuse would be to treat the physical injuries. It is crucial that these are meticulously recorded and photographs taken if appropriate. It must be explained to victims that domestic abuse is unacceptable and against the law. While police contact must be offered, the healthcare professional must not influence the patient to make any decisions about who they disclose the information to. A study into the relationship between domestic abuse disclosed in an A&E department and that disclosed to the police found that refusal of police contact is common. This study also estimated that less than one per cent of domestic abuse cases that present to A&E departments ultimately lead to a conviction.¹⁵¹

It is acknowledged that healthcare professionals within an A&E department may refer patients to another healthcare speciality for further treatment of their injuries. It is therefore important that healthcare professionals outside A&E, for example, orthopaedic surgeons, are knowledgeable about the various forms of domestic abuse and how it may present to them in their practices.

Obstetrics and gynaecology

The exact prevalence of domestic abuse victims who are pregnant remains unknown as this is highly dependent on the screening methods used and the population studied. The risks of domestic abuse are known to be particularly acute in pregnancy, as the health and safety of two potential victims are placed in jeopardy. The *National service framework for children, young people and maternity services* (2004) states that almost a third of domestic abuse begins during pregnancy and that for women suffering from existing abuse, it will often intensify during pregnancy.¹⁵²

Obstetricians are the key healthcare professionals in contact with women with, or at high risk of, complications during pregnancy, and therefore in an opportune position to identify victims of domestic abuse. Domestic abuse is associated with numerous negative health outcomes for both the mother and child. Research has found that physical violence during pregnancy is the second leading cause of trauma during pregnancy, after motor vehicle accidents.¹⁵³ Domestic abuse is associated with premature birth, low birth weight, fetal injury and fetal death, due to falls or blows to the abdominal region as a result of physical violence. There is also evidence to suggest a link between physical violence during pregnancy and kidney infections. Domestic abuse can also have an indirect effect on the developing fetus, whereby there is an increased likelihood of maternal smoking^l and alcohol consumption,^m in connection with the stress suffered by a victim of domestic abuse. The fetus may also be indirectly harmed by women being prevented from seeking or receiving proper antenatal or postpartum medical care by their abusive partners.

To encourage the disclosure of sensitive information, all pregnant women should have at least one consultation with the lead healthcare professional during the pregnancy which is not attended by the partner or any family member, and a set of confidential notes should be kept separate from those held by the patient. This recommendation is supported by the CEMACH report *Why mothers die 2000/02 – The sixth report of confidential enquiries into maternal deaths in the United Kingdom*.⁹⁰ This report also states that when treating an expectant mother a healthcare professional should ‘adopt a non-judgemental and supportive response to women who have experienced physical, psychological or sexual abuse and must be able to give basic information to women about where to get help. They should provide continuing support, whatever decision the woman makes concerning her future’.

Domestic abuse includes sexual assault by an intimate partner or family member. Such acts increase a woman’s risk of contracting STIs, and raise the possibility that conception may occur as a result of rape. Victims of domestic abuse are significantly more likely to describe their pregnancy as unplanned and unwanted than women without such experience.¹⁵⁴ STIs such as chlamydia can have serious implications for both men and women, but the consequences are notably more serious for reproduction in females. Paavanen and Eggert-Kruse (1999)¹⁵⁵ reported that chlamydia is the most important preventable cause of infertility and adverse pregnancy outcome. The adverse pregnancy outcomes which may result from the transmission of chlamydia include ectopic pregnancy, premature rupture of membranes, preterm birth, low birth weight and stillborn.¹⁵⁵ Gynaecologists are likely to encounter women suffering from STIs, and therefore due to the association between STIs and domestic abuse gynaecologists are in an important position to identify cases of domestic abuse.

^l See BMA report *Breaking the cycle of children’s exposure to tobacco smoke* (2007), available at: www.bma.org.uk.

^m See BMA report *Fetal alcohol spectrum disorders* (2007), available at: www.bma.org.uk.

Gynaecologists and obstetricians must be well-informed in order to raise their awareness of domestic abuse. It is critical that these healthcare professionals understand the possible implications of domestic abuse on women, whether pregnant or not, as this should help to increase the chance of identification. The CEMACH (2004) report recommends that enquiries about domestic abuse should be routinely included when taking a social history during the antenatal period, but that a programme of routine enquiry must not begin until all appropriate staff have received training. Obstetricians and gynaecologists must be aware of the role of social services and child protection matters and work in liaison with all necessary support services.⁹⁰ The RCOG published guidance in 1997 stating that teaching about domestic abuse should be an integral part of training for obstetricians and gynaecologists, and their ability to address this delicate subject should be evaluated in examinations. It also recommended that obstetricians should routinely ask patients about domestic abuse by introducing questions about abuse during the course of all obstetric and gynaecological consultations.¹⁵⁶

No evidence exists on whether or not RCOG guidelines are being followed and hence whether routine enquiry has been implemented in obstetrics and gynaecological healthcare settings. Similarly little is known about the effectiveness of routine enquiry in identifying cases of domestic abuse during pregnancy. Evidence from primary healthcare indicates that direct questioning increases the likelihood of disclosure and so on this basis, screening of pregnant women during obstetrics and gynaecological consultations should have a positive impact. This is an area of research which must be developed.

Midwifery

Conclusive evidence has demonstrated that pregnancy may trigger or exacerbate domestic abuse;^{157, 158} hence midwives should play a pivotal role in its detection and management. It is estimated that 30 per cent of domestic abuse commences during pregnancy.⁹⁰ Domestic abuse can have extremely damaging effects on both the health of a mother and her baby and it is therefore something of that all midwives should be acutely aware. Domestic abuse during pregnancy increases the rate of miscarriage, low birth weight, premature birth, fetal injury and fetal death.¹⁵⁸

In response to the evidence provided by the University of the West of England and North Bristol NHS Trust project, the government recommended in 2005 that all trusts should be working towards routine enquiry in maternity services.¹⁴ The training project aimed to equip a group of community midwives with knowledge and confidence to enquire effectively about domestic abuse during the antenatal period. The research confirmed that midwives see routine enquiry as important and acknowledge their key role to play within it. The training was positively received by participants and resulted in an increase in the level of disclosure facilitated by midwives. The most significant barriers to enquiry were perceived to be the presence of a family member followed by lack of time and resources.¹⁵⁹

The RCM strongly supports the significance of midwives in tackling domestic abuse. The RCM states that every midwife has a responsibility to provide each woman in their care with support, information and referral appropriate to her needs. The RCM supports routine enquiry into domestic abuse throughout pregnancy and the postnatal period, which is accompanied by measures including a systematic and structured framework for referral and support for women who disclose domestic abuse. The RCM states that same-sex independent interpreters and advocates must be used for non-English speaking women, rather than family members and that education and training programmes on domestic abuse are essential for all midwives. The RCM proposes that domestic abuse is best challenged by a multidisciplinary approach, in which professionals work in partnership with local service providers, police, voluntary sector and the woman herself. The RCM addresses its responsibility in the protection of midwives by recommending that 'employers of midwives should have procedures and facilities in place to support midwives who may themselves be in abusive relationships'.¹⁶⁰ Further, the RCM has produced a comprehensive guidance paper on domestic abuse⁹³ which

provides midwives with information about the scale of the problem as well as working practice guidelines. It highlights that the midwife is ideally placed to recognise and detect ongoing domestic abuse and to offer care, support and information to the woman. In summary, the RCM states that a midwife's role and responsibility following routine enquiry and a disclosure of domestic abuse is 'to provide the appropriate response, believing the woman, showing her that someone cares, not judging her, respecting her reasons and decisions to stay or leave the relationship, offering her support, providing her with helpful information, referring her to appropriate agencies, or any other action that may be required'.⁹³

Psychiatry

Domestic abuse can have long-term consequences on the mental health of its victims. Over a third of female victims of domestic abuse and a tenth of male victims are likely to suffer (self-defined) emotional problems as a result.³⁰ Psychiatric disorders in victims of domestic abuse are generally the consequence of the trauma; however, it is also possible that individuals currently suffering from depression, anxiety or phobia may be drawn to, or attract, dominant or aggressive partners.¹²⁶



See chapter 3 for further information about psychological abuse.

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

The RCPsych states that psychiatrists must:

- be aware of the nature and prevalence of domestic abuse
- understand the dynamics of domestic abuse and how it affects the safety and autonomy of abused patients
- be able to ask sensitively about domestic abuse
- be able to provide information about a range of interventions
- be able to carry out a risk assessment and be aware of the factors associated with risk of increased violence, homicide and suicide
- be aware of and prepared to collaborate with community organisations and other professionals working in the area of domestic abuse, including child protection services
- have some understanding of civil and criminal law related to domestic abuse, and of police, social services and community help available to victims of domestic abuse.¹²⁶

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

There is no single way of managing cases of domestic abuse. Instead the psychiatrist must support the victim through a process of empowerment so that they feel capable of seeking further help and putting an end to the cycle of abuse. There are few guidelines to offer help to psychiatrists for increasing the identification and management of domestic abuse cases. While the DH states that 'although there are some common basic training and education requirements in respect of domestic violence across all healthcare specialties, there are also distinctive needs in respect of the particular skills and knowledge required in different healthcare settings'¹²⁵ there is currently no specific training on domestic abuse at pre- or post-membership levels within the RCPsych.¹²⁶ The RCPsych curriculum does, however, make reference to assessing children and families where abuse is suspected and identifying and accurately recording signs and symptoms of actual or potential abuse.^{161, 162}

Women's Aid has suggested numerous guidelines for mental health services which include the need to develop specific domestic abuse policies, together with appropriate protocols and guidelines for responding to domestic abuse victims.¹⁶³ Raising awareness of domestic abuse, including for example its prevalence, manifestation and available support services for victims, is paramount in improving the service provided by mental healthcare professionals, and education and training are essential in achieving this aim.

Nursing and health visiting

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

In the book *Family violence in primary care* (2003)¹⁶⁴ the role of the community nurse in the prevention, detection and management of elder abuse is highlighted. The principles can, however, be applied to all types of domestic abuse. Community nurses, including district nurses, health visitors and community psychiatric nurses, are ideally placed to deal with cases of domestic abuse mainly due to their ongoing relationship with their patient. The nurse is usually welcomed into the home and so has the opportunity to see the interactions between other family members as appropriate.

Practice nurses working within GP surgeries are largely involved with well-women care and are therefore in a commonly able position to see a female patient without the presence of a family member or partner. The resulting private consultation may enable the patient to feel at ease discussing domestic abuse with the nurse. School nurses must be aware of the impact domestic abuse can have on children. Aside from the possible physical injuries, there may be a psychological impact. School nurses should be vigilant for changes in the behaviour of a child as witnessing domestic abuse can cause children to display both aggressive and antisocial behaviour or become fearful and inhibited.

Despite the clear role for the nursing profession in the detection, treatment and prevention of domestic abuse there is a lack of existing protocols and guidelines. A survey published in *Nursing Times* (2002) found that not all nursing and midwifery tutors included domestic abuse in their curricula. The report concluded that 'the inclusion of domestic violence in the nursing and midwifery curricula should become an institutional priority and should not be left to the motivation of the individual tutor'.¹⁶⁵ The Royal College of Nursing (RCN)¹⁶⁶ advocates that due to the seriousness of domestic abuse it must be acknowledged through education and local policies that endorse protection of victims of domestic abuse. The RCN recommends that every nurse adopt an empowering and supportive approach to patients using a structured framework. The RCN guidance (2000) emphasises the importance of nurses operating a collaborative approach to dealing with domestic abuse, ie working with a local DAF.

Domestic abuse training

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

Health visitor

Chapter 8 Adopting a multi-agency approach

The need for a multi-agency approach

In 2004 the biggest overhaul of legislation on domestic abuse for 30 years took place in England and Wales with the Royal Assent of the Domestic Violence, Crime & Victims Act 2004.¹¹ The Home Office has catalysed a substantial development in the approach to dealing with domestic abuse by working closely with other central government departments and regional government and local partnerships. They have developed an effective, multi-agency response to domestic abuse in the context of the government's strategic framework, as set out in the consultation paper *Safety and justice* (2003).⁹ The Domestic Violence, Crime & Victims Act 2004 was introduced to increase the protection, support and rights of victims and witnesses. It also gives the police and other agencies the tools to get to the heart of domestic abuse crimes.

Laying the foundations of the multi-agency approach to tackling domestic abuse is an 'Inter-Ministerial Group on Domestic Violence'. This group is leading the implementation of the government's strategy, focused on education and awareness raising, early identification and intervention, the response from the authorities, safe accommodation choices for victims and relationships between the civil, criminal and family law courts. This group includes representation from Northern Ireland and Wales and Ministers from key departments, including Constitutional Affairs, the Solicitor General, Health, Education, Department of Trade and Industry, Office of the Deputy Prime Minister, and Work and Pensions. The work of the group is evidenced by the Home Office's National Delivery Plan for domestic abuse¹⁶⁷ which laid out its plan of action for 2005/06 as well as outlining the progress made to date.

In Scotland there is a comparable arrangement with a national group of stakeholders, chaired by the Deputy Minister of Social Justice, which oversees the implementation of the Scottish Executive's action plan on domestic abuse. This action plan was included within *A national strategy to address domestic abuse in Scotland* (2000).¹⁶⁸ The Scottish Executive allocated a budget of £4.5m for the implementation of the action plan from 2001-04 which stated that support services should be informed, efficient, pro-active and multi-agency.¹²⁷ The Northern Ireland Office's report *Tackling violence at home* (2005) details the 'strategy for addressing domestic violence and abuse in Northern Ireland'.¹⁶⁹

The VVAPP was announced by the government in 2004 and was established in response to the high prevalence of domestic abuse and evidence of mental and physical health implications associated with this. The VVAPP is a two-year programme running within England until late 2007 with the purpose of ensuring that services and professionals in all sectors and settings are equipped to identify and respond to the needs of domestic abuse victims whose mental and/or physical health has been affected. To achieve this, the VVAPP will develop evidenced-based guidelines to inform policy, improve practice and promote access to services. To date, achievements of this programme include the production of a training manual for healthcare professionals,¹⁷⁰ and in relation to policing and criminal justice guidance has been published on investigating domestic abuse.¹⁷¹

The government's emphasis on implementing a multi-agency approach to dealing with domestic abuse is best demonstrated by the development of over 200 DAFs in England and Wales since their initial establishment in the 1980s. Essentially DAFs, which are in existence nationwide,^{127, 169} bring together both statutory and voluntary sector agencies to share information, and to coordinate activities in response to domestic abuse. Participating agencies include local authority departments, the police, probation, health services, refuges, women's support and outreach projects, community projects and the voluntary sector. It is known that while the police and refuges are frequently the most heavily involved, the health service is at the opposite end of the spectrum.¹⁷² The DH explains that the reasons why healthcare professionals have been relatively absent from DAFs remain unclear. They do, however, speculate that it is due to the additional burden of work they generate and the implications for confidentiality of becoming involved in discussions with other agencies.¹²⁵ There is no standard model

for how DAFs should operate as by their nature they must respond to local needs and conditions. The Home Office¹⁷³ describes five main areas of work for a DAF:

1. coordinating and facilitating the development of local agency responses and services
2. improving the practice of agencies and their service delivery, for example, through training
3. supporting projects to assist domestic abuse survivors, and setting up new ones
4. awareness-raising among the general public
5. preventative measures such as perpetrators' programmes and work in schools.

For healthcare professionals, working with or supporting the work of a DAF can be extremely beneficial to the service they are able to provide to patients. A DAF may, for example, address referral systems between A&E departments and refuges, produce material to improve local liaison, such as the development of local resource directories. They may also develop and implement good practice guidelines, provide training in domestic abuse awareness, produce written materials on domestic abuse to raise public awareness and run educational and preventative programmes within schools.¹²⁵ Organisations such as the RCN, RCM and RCOG endorse the importance of healthcare professionals adopting a team-orientated approach to domestic abuse by utilising the work of DAFs.^{93, 166, 174}

Due to the multi-agency approach to tackling domestic abuse, the numerous services available to support a victim may be overwhelming and often difficult to navigate. The Home Office promotes the importance of domestic abuse advocates who should be independent and act on behalf of the victim.¹⁷⁵ Domestic abuse advocates provide domestic abuse survivors with support, information and advice. They also liaise between survivors and various agencies and organisations. Advocacy recognises that individuals coming from positions of fear and isolation will often require the skills of an advocate to negotiate housing, legal support and benefit entitlements.¹⁷⁶ Research has shown that victims receiving the services of domestic abuse advocates experience less physical abuse over time and additionally report an increased quality of life, higher social support, less depressive symptoms, and increased effectiveness in obtaining resources.¹⁷⁷ The BMA acknowledges the importance of domestic abuse advocates, and considers that they are well placed to work within hospitals.



Please refer to appendix 5 for an illustration of a possible preventative framework for violence and abuse.

Chapter 9 Other services involved in domestic abuse

Healthcare professionals can play a large part in tackling domestic abuse but they are by no means alone in so doing. Due to the physical and mental health implications of domestic abuse, the health service is in the ideal position to identify victims of domestic abuse. Healthcare professionals are responsible for knowing the signs which can indicate the occurrence of domestic abuse, how to sensitively ask questions to aid disclosure and the availability of the specialist services existing in their local area. Healthcare professionals have a responsibility to refer patients disclosing domestic abuse to an expert domestic abuse agency which can offer specialised help and support. It is also feasible that professionals working outside of the health service may identify new cases of domestic abuse and may either assist these individuals directly, or they may recommend another more appropriate support facility. This chapter explains the key services which exist outside of the health service to help individuals affected by domestic abuse.



For a comprehensive list of support services please see chapter 11.

Voluntary and community services

The voluntary and community sector is a major provider of specialist services to victims and perpetrators of domestic abuse. Such organisations vary in size and the range of services they are able to offer. Women's Aid is an example of an organisation which operates on a national scale and provides a variety of different services to women and children suffering from domestic abuse including a 24-hour helpline, refuge accommodation, outreach services and support groups. Smaller organisations specialise their expertise, such as the National Centre for Domestic Violence which specialises in helping victims of domestic abuse obtain non-molestation and other orders (injunctions) from court to protect them from further abuse. Seeking the services or advice of organisations such as Women's Aid will enable a healthcare provider to learn about other less well known services which are available for victims in their local area, for example in London and Yorkshire the charity Dogs Trust has launched the Freedom Project which serves to foster dogs for women fleeing a violent household.¹⁷⁸ Women's Aid produces *The UK gold book* (2006), which is a valuable reference tool for professionals and agencies working with victims of domestic abuse as it is a directory of refuge and domestic abuse services across the country. This can be purchased from Women's Aid. The Men's Health Forum (MHF)¹⁷⁹ is an independent body which provides an authoritative voice for male health and aims to tackle the issues affecting the health and wellbeing of boys and men in England and Wales. The MHF are publishing a manual for men on domestic abuse in summer 2007.

Emergency accommodation for victims of domestic abuse can mean the difference between life and death. If a victim feels they have nowhere to run they may be increasingly likely to remain living with the perpetrator for longer periods of time. Staying in a refuge can provide victims fleeing domestic abuse with a degree of safety and support that would otherwise not be available to them. A refuge is a safe house where individuals who are experiencing domestic abuse can stay free from abuse. Refuge addresses (and sometimes telephone numbers) are confidential and there are over 500 refuge and support services in England, Scotland, Wales and Northern Ireland.¹⁸⁰ Refuges are consistently rated more positively by domestic abuse victims than any other agencies in terms of the services they provide. Refuges were found to be helpful in terms of the actual assistance provided and the attitudes of the staff, and additionally victims of domestic abuse value the opportunity to share their experiences and feelings with other victims.¹⁸¹ A survey by Women's Aid found that in 2004/05 there were 284 refuge organisations in England operating an estimated 729 residential properties for women and children affected by domestic abuse. It has been calculated that these properties provided 19,836 women and 24,347 children with temporary accommodation across England in this period.³³ The number of refuges for men remains unknown but the helplines for male domestic abuse victims such as that provided by MALE is able to provide advice on housing options for men. MALE states that despite the helplines for men, there is a vast lack of a wide network of specialist services that exist specifically for men and are staffed by trained workers.¹⁸²

William's story ...

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

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

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

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

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

There are refuges operating around the country which are in existence to meet the needs of domestic abuse victims from specific ethnic minorities, for example the Jewish Women's Aid¹⁸³ which runs the only secure refuge where Kashrut, Shabbat and festivals are fully observed and Ashiana,¹⁸⁴ an Asian women's refuge, located in South Yorkshire.

The organisation Broken Rainbow, the first LGBT organisation dedicated to confronting and eliminating domestic abuse within and against LGBT individuals, has reported a shortage of refuge services for LGBT people but aims to set up such a provision. Although lesbian, bisexual and transgender women can stay in women's refuges; these are traditionally focused on the needs of heterosexual women. For gay, bisexual and transgender men there are almost no emergency refuge services.¹⁸⁵

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

Voluntary and community organisations can also provide advocacy and outreach responses to domestic abuse. Outreach services support victims of domestic abuse in their homes and communities and, provide accessible and flexible points where information about service provision, and follow-up contact, are available. Advocates provide individuals suffering from domestic abuse with support, information and advice. A study of advocacy and outreach services by the Home Office (2000) concluded that they can prevent repeat victimisation through a more effective use of the legal system and the support of victims during resettlement and separation. Additionally, outreach services enable earlier intervention which may prevent the risk of domestic abuse escalation.¹⁷⁶ An example of such services include the Southall Black Sisters which is a not-for-profit organisation providing specialist advice, information, casework, advocacy, counselling and self-help support services in several community languages for Asian and African-Caribbean women.¹⁸⁶

Local authorities

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

An individual may be considered homeless by local authorities if they live in accommodation where it is probable that living there will lead to abuse from someone else who lives there or used to live there. A local authority's housing department is obliged to provide advice about finding somewhere else to live, and depending on the individual situation the domestic abuse victim may be entitled to emergency accommodation. Under the Homelessness Act 2002, in England and Wales individuals who 'are vulnerable because they have fled their home because of violence' are in the priority need category which places stronger duties on a housing authority to secure accommodation for them and their household.¹⁸⁷ The Homeless etc (Scotland) Act 2003 places people deemed vulnerable as a result of domestic abuse in the 'priority need' group for local authority accommodation.¹⁸⁸ The government report *Sustainable communities: settled homes; changing lives* (2005) states that between 1997 and 2004 more than 146,000 homeless households were rehoused by local authorities because of domestic abuse. The government pledges to increase the number of refuge places, and improve their quality, and will support new approaches to domestic abuse and homelessness, including 'Sanctuary'ⁿ schemes that provide extra security to help the victims of domestic abuse to stay in their own homes, where it is safe for them and they choose to do so.¹⁸⁹

By definition, social care services look after the health and welfare of the population.¹⁹⁰ Social workers often work with people whose behaviour presents risks to either themselves or others and in such situations social workers may have to take action in order to safeguard the welfare of a vulnerable person. Social workers may be presented with cases of domestic abuse either via direct contact from an affected individual, or the case may be referred to them from another professional, such as a GP or police officer. Following disclosure of domestic abuse, a GP may refer the case to social services with the consent of the patient. Social services primarily become involved in cases of domestic abuse when children are at risk. It is good practice, and beneficial to the doctor-patient relationship that if a healthcare professional is obliged to refer the case to social services when consent has not been given, that the patient is informed beforehand. Healthcare professionals must be mindful of the fear embedded in many individuals that social services will automatically remove children from homes where there is domestic abuse.¹⁹¹ This is not the sole intention of social services, and the report

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

Supporting parents, safeguarding children (2006) outlines the approach of social services to reduce the number of children taken into care due to domestic abuse. The report states that 'the challenge for health and social services lies in ensuring that children whose parents are finding it difficult to care for them (i) get enough help and support to assure their safety and wellbeing, and (ii) receive help early enough to minimise the risk of children becoming looked after'.¹⁹²

As part of a local authority's domestic abuse prevention strategy they may provide programmes for perpetrators of domestic abuse. Such programmes are designed to help change the behaviour of the perpetrator and enable them to develop respectful, non-abusive relationships. All programmes should be compatible with the *Statements of principles and minimum standards of practice* (2004), issued by Respect, the UK-wide membership association for domestic abuse perpetrator programmes and associated support services. Most perpetrator programmes work with men and according to Women's Aid 'there are currently no perpetrator programmes and associated services being run in the UK for same-sex domestic violence or for female perpetrators'.¹⁹³ Some programmes take men who self-refer, others take men who are mandated to attend by the courts as part of a probation order, or as a recommendation from the family courts. A perpetrator of domestic abuse can call the Respect phoneline for further information about the perpetrator programmes available in their local area which take self-referrals.¹⁹⁴



For further information on perpetrator programmes see chapter 6.

For detailed information on the government's achievements and future plans in tackling domestic abuse please see the *National domestic violence delivery plan – Progress report 2005-06*.¹⁶⁷

Legal agencies

Healthcare professionals have an important relationship with the legal profession, since prosecutors striving to gain protection for domestic abuse victims may rely heavily on a doctor's medical records. Morris (2003) explains that doctors may be asked by solicitors for medical reports and these must be written promptly and must contain all the facts. Doctors must record what they saw, observed and heard. Doctors may worry about making definite statements because they fear they are being asked to make a judgement. They, however, need only record the facts as it is the responsibility of the court to pass judgement.¹⁹⁵



For information about the police and legal profession's involvement with domestic abuse please refer to appendix 6.

Chapter 10 Recommendations

As the major professional organisation representing doctors in the UK, the BMA through this report, aims to lead the way in encouraging all healthcare professionals in all disciplines to raise awareness of the problem of domestic abuse. Developing strategies to identify and reduce the substantial impact upon the health and wellbeing of adults and children is equally important.

Recommendations

Healthcare professionals

- Addressing domestic abuse in the healthcare setting is a priority. In order to achieve this, all healthcare professionals should:
 - receive training on domestic abuse. This needs to be implemented on a national scale within emergency medicine
 - take a consistent approach to the referral of patients to specialist domestic abuse services
 - give the clear message that domestic abuse is unacceptable and not the victim's fault, and that there are specialist support services which can provide essential information, advice and support
 - ensure that they ask patients appropriate questions in a sensitive and non-threatening manner in order to encourage disclosure of abusive experiences
 - recognise that men can also be victims of domestic abuse and should therefore be questioned if domestic abuse is suspected.

The UK governments

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

Research

- There already exists a good research base on domestic abuse, in particular with regard to female victims. The list of research below emphasises where there is relative weakness and further research is needed:
 - the prevalence of elder abuse
 - domestic abuse within ethnic minority groups
 - the experience of disabled people who are victims of domestic abuse
 - pregnant victims of domestic abuse
 - the implementation and effect of the Royal College of Obstetricians and Gynaecologists guidelines on the routine enquiry of female patients within this healthcare setting
 - the number of refuges which exist for male victims
 - the effectiveness of interventions after disclosure of abuse to healthcare professionals
 - system changes in healthcare settings that improve the response of healthcare professionals to survivors of domestic abuse
 - prevalence and experiences of gay male victims of domestic abuse
 - prevalence and experience of transgender victims of domestic abuse
 - effective treatment and interventions for perpetrators of domestic abuse.

Chapter 11 Useful contacts

National Domestic Abuse Helpline: 0808 2000 247 (for women and children)
Men's Advice Line: 0808 801 0327

For women

Women's Aid

www.womensaid.org.uk

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

Scottish Women's Aid

www.scottishwomensaid.co.uk

Helpline: 0800 027 1234

Welsh Women's Aid

www.welshwomensaid.org

Helpline: 0808 8010 800

Women's Aid Federation Northern Ireland

www.niwaf.org

Helpline: 0800 917 1414

Refuge

www.refuge.org.uk

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

For men

Men's Advice Line (MALE)

www.mensadvice.org.uk

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

Men's Aid

www.mensaid.com

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

Survivors UK

www.survivorsuk.org

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

Men's Health Forum

www.menshealthforum.org.uk

Provide an independent and authoritative voice for male health. The men's health forum is due to publish a manual for men on domestic abuse (both as victims and perpetrators) in summer 2007.

For specific groups

Action on elder abuse

www.elderabuse.org.uk

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

Ashiana

www.ashianahelp.org.uk

Ashiana is an Asian women's refuge, located in South Yorkshire.

Broken rainbow

www.broken-rainbow.org.uk

Support for LGBT people experiencing domestic abuse. LGBT people staff a helpline on 08452 604460 (Mondays to Fridays 9am to 1pm and 2pm to 5pm).

Chinese Information and Advice Centre

www.ciac.co.uk

UK charity offering free legal advice and support to disadvantaged Chinese people living in the UK.

Women's Support Project is dedicated to helping Chinese women and families who are struggling or in distress.

Dogs Trust, Freedom Project

www.dogstrust.org.uk/wayswehelp/freedom_project

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

Jewish Women's Aid

www.jwa.org.uk

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

Powerhouse

www.thepowerhouse.org.uk

Set up the Beverley Lewis House which is a safe house for women with learning difficulties.

Refugee Council

www.refugeecouncil.org.uk

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

Relate

www.relate.org.uk

Relate is the UK's largest provider of relationship counselling and sex therapy. Relate offers a wide range of services for couples, families and individuals, supporting them through all stages of their relationships. Services available in England, Wales and Northern Ireland.

Couple Counselling Scotland

www.couplecounselling.org

Couple Counselling Scotland offers similar services to Relate.

Southall Black Sisters

www.southallblacksisters.org.uk

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

UK Disability Forum

www.edfwomen.org.uk/abuse.htm

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

For children

The Hideout

www.thehideout.org.uk

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

ChildLine

www.childline.org.uk

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

Legal advice

National Centre for Domestic Violence

www.ncdv.moonfruit.com

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

Northern Ireland Legal Services Commission

www.nilsc.org.uk

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

Other organisations

Respect

www.respect.uk.net

Respect is the UK membership association for domestic abuse perpetrator programmes and associated support services. The Respect Phonenumber 0845 122 8609 offers information and advice to domestic abuse perpetrators, their (ex)partners, friends and family and to frontline workers who come into contact with perpetrators in their work.

Samaritans

www.samaritans.org.uk

Samaritans is available 24 hours a day (telephone 08457 909090) to provide confidential emotional support for people who are experiencing feelings of distress or despair.

Victim Support

www.victimsupport.org

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

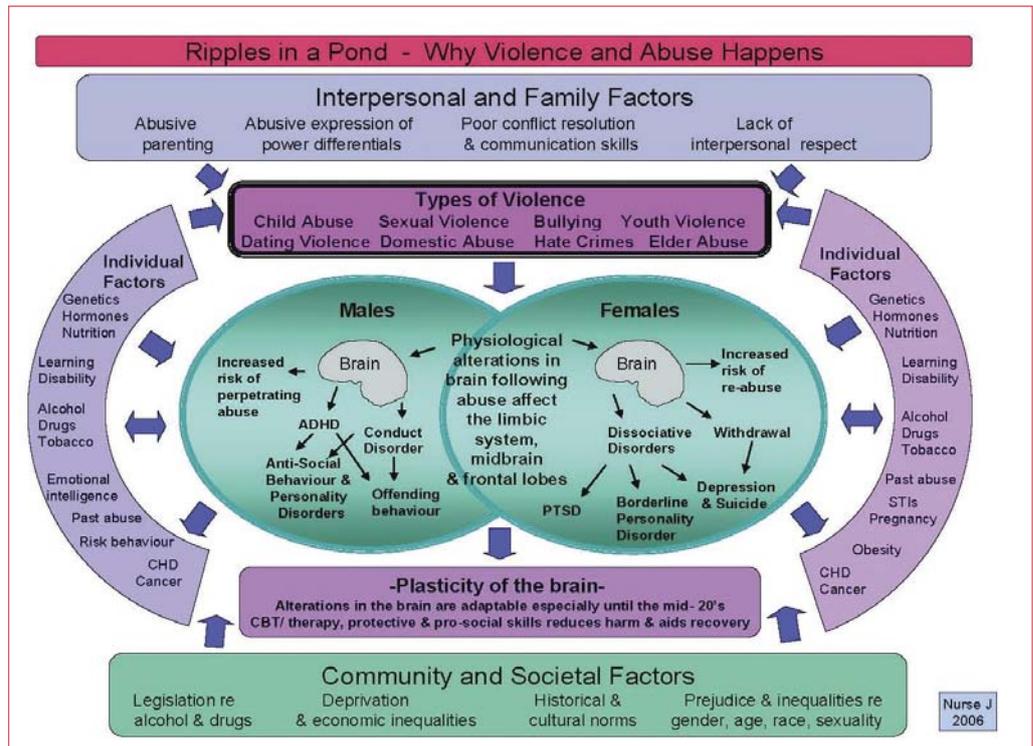
CAADA (Coordinated action against domestic abuse)

www.caada.org.uk

CAADA is a charity established to encourage the use of independent advocacy as a way to increase the safety of domestic abuse survivors, particularly those at high risk.

Appendix 1

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



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

Diagram provided by South East Regional Public Health Group, Information Series 1, Preventing Violence and Abuse: Creating Safe and Respectful Lives (2006)

Appendix 2

Patient and healthcare professional opinion on routine enquiry for domestic abuse

Numerous studies on the routine enquiry about domestic abuse in women have been analysed.¹⁹⁶ Although the majority of analysis is centred on studies from the USA, the findings gave a clear indication of the perceived views of both women and doctors on this topic. The analysis found that half to three-quarters of female patients in primary care responding to surveys think that routine enquiry about domestic abuse in a healthcare setting is appropriate, and there was no significant difference between victim and non-victim respondents. A study of A&E department patients in South Lancashire found a high level of acceptability for routine enquiry about violence (all forms, not just domestic), by either doctors or nurses. They also found that older patients in particular supported a more active role for healthcare professionals. They discovered that the majority of respondents agreed that healthcare staff should encourage victims of abuse or violence to inform the police, and a slightly lower percentage of respondents felt that healthcare staff should routinely inform the police.¹⁵⁰ A study in Ireland has found that doctors may be able to identify women who experience domestic abuse by asking them if they are afraid of their partner. Seventy-seven per cent of the women attending GP practices said that it would be 'all right' for their doctor to ask about abuse in relationships.⁴² A survey in the UK found that one in five women objected to the idea of routine enquiry about domestic abuse in primary care.¹⁰⁸

A Home Office report has stated that 'most women, including victims and non-victims do not mind being asked about their experiences of violence'. It explains how research suggests that identifying victims of domestic abuse can best be done by 'universal screening' rather than by 'selective screening' based on risk. The report also points out that 'screening' could do harm as well as good, as healthcare professionals could inadvertently increase the risks of victims to further more intense abuse.¹⁰⁹ Further research is required on the exact advantages and disadvantages of routine enquiry before any thought can be given to making the procedure compulsory for doctors.

Doctors and nurses have been found to be far less enthusiastic about routine enquiry for domestic abuse in all patients, in comparison with the patients themselves. A study in the UK found that a minority of healthcare professionals wish to routinely enquire for a history of domestic abuse in women. Thirty-two per cent of healthcare professionals questioned thought that health visitors should routinely ask about domestic abuse, 15 per cent thought it should be practice nurses and 14 per cent GPs.¹⁹⁷ The rationale behind why healthcare professionals are predominantly against routine enquiry is described in more detail in chapter 5 of this report, and includes lack of education in or experience of routine enquiry, time constraints, fear of offending or endangering patients, and lack of effective interventions.¹¹¹ A healthcare professional may also worry that as a result of their intervention a violent perpetrator may act in a threatening or violent manner towards members of the healthcare team.

Appendix 3

Detecting domestic abuse during consultations with healthcare professionals

Evidence suggests that victims of domestic abuse want to be asked by their doctor about their experiences.¹¹⁹ It is crucial that a doctor or other healthcare professional ask appropriate questions and in a gentle and non-threatening manner in order to encourage the disclosure of a patient's abusive experiences. The safety of the victim is of the utmost importance and thus it is vital that before any form of enquiry begins a healthcare professional must assess whether their intervention will leave the victim in either greater safety or danger. Additionally, before asking any questions a healthcare professional must consider the following aspects of good practice.

1. Treat people with respect and dignity at all times

If the patient is being abused they are likely to feel ashamed, humiliated and frightened, and hence even the slightest hint that a healthcare professional is sceptical about their story could stop them disclosing the information.

2. Respect, confidentiality and privacy

It is important to acknowledge the possible dangers associated with breaching these. The consultation must take place in a private room where confidentiality can be guaranteed and the patient must be assured that unless there are exceptional circumstances, the information they provide will be fully confidential.

3. See the victim alone

The presence of a partner or relative may prevent the patient from being honest about the domestic abuse they are suffering. The only exception to this is when you have a professional interpreter present.

4. Consider the need for an interpreter

This service may be necessary to provide an interpreter for a different language or an advocate for an individual with a learning disability. The interpreter must be a professional and independent of both the doctor and the patient.^{14, 125}

It would be a mistake for a healthcare professional to focus only on the treatment of a patient's injuries or distress, without asking about their causes, as this would provide only limited help to a victim of domestic abuse. Enquiring about domestic abuse is a challenging task as the victim will often be feeling extremely daunted by the situation. The DH and the RCGP have therefore produced guidance on how healthcare professionals and GPs, respectively, should deal with domestic abuse in a healthcare setting.^{14, 125, 198} The DH advises that to help put a victim at ease, asking some indirect 'lead-in' questions would be beneficial. These include such questions as:

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

Healthcare professionals should not be afraid to ask direct questions as these are more likely to result in a disclosure of the abuse being suffered by a patient. Many of the direct questions focus on evidence of physical assault and injury, but many victims of domestic abuse will not display such symptoms at the time of the consultation.¹²⁵ This therefore means that certain questions may not always be necessary or appropriate, and as such the healthcare professional must assess each individual patient separately. The following questions have been suggested by the RCGP as examples of what a GP could ask their patient:

- I noticed you had a number of bruises. Could you tell me how they happened? Did someone hit you?
- you seem frightened by your partner. Have they ever hurt you?
- you mention your partner loses their temper with the children. Do they ever lose their temper with you? What happens if they do?
- have you ever been in a relationship where you have ever been hit, punched, kicked or hurt in any way? Are you in such a relationship now?
- does your partner sometimes try to put you down or control your actions?
- sometimes, when others are over-protective and as jealous as you describe, they react strongly and use physical force. Is this happening in your situation?
- your partner seems very concerned and anxious. That can mean they feel guilty. Were they responsible for your injuries?¹⁹⁸

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

Each and every time a healthcare professional enquires about domestic abuse with a patient they must emphasise that the discussion will be confidential. Fear is often one of the reasons why a victim may remain in an abusive relationship and not feel able to tell anyone about their suffering. Such reassurance could make the difference as to whether or not a patient chooses to disclose information. As reported by the RCGP, 'the concept of confidentiality may be unfamiliar to many first generation immigrants and the protection it offers will need to be carefully explained and emphasised'.¹⁹⁸ There are, however, limits to confidentiality which must be explained to the patient, such as if there is reason to suspect children are at risk, safeguarding and protection should always take precedence over confidentiality.¹⁴

Appendix 4

Actions required following a disclosure

If a patient reveals that they are being abused by a person close to them then it is important that the healthcare professional feels confident in responding to this. The patient must feel that they can trust the healthcare professional to help them stop the abuse. As explained by the DH, the role of a healthcare professional is to provide support and information to help the patient make a decision about what to do next, encourage them to have a safety plan and to help assess the risk to both the patient and if applicable, their children. One key message to convey to all healthcare professionals is that in cases when a patient is being abused by their partner, they must not advise them to leave. This can put the victim at an increased risk of injury or murder, and hence leaving immediately may not be the best option.¹⁴

Combining the suggestions by Heath in 1992,¹⁹⁹ the DH in 2000¹²⁵ and 2005¹⁴ and the BMA's original report on domestic abuse in 1998,¹ the following six-staged approach is recommended for healthcare professionals, following the disclosure of domestic abuse. The stages are respect and validation, assessment and treatment, record keeping, information giving, information sharing, follow-up and support.

1. Respect and validation

A healthcare professional's response to a victim of domestic abuse is of great importance as it may be significant in determining whether a victim chooses to disclose further information and seek further help, or whether they feel that they cannot trust the healthcare professional and hence choose to face the situation alone. The victim may have been suffering domestic abuse for a long period of time before gaining the courage to confide in a healthcare professional, and therefore they must be treated with a sympathetic, supportive and non-judgemental response. It is imperative that the healthcare professional reassures the victim that they believe them, that the abuse is not their fault, and that they have a right to safety. Confidentiality must also be further emphasised at this stage.^{14, 125}

2. Assessment and treatment

Patients who disclose domestic abuse during an appointment with a healthcare professional may present with physical injuries which require an immediate response. It is not the job of a healthcare professional to give advice to the domestic abuse victim about what action should be taken. The professional is, however, expected to refer a patient to specialist services for further treatment. Domestic abuse is rarely a one-off incident and so it is important that the safety of the victim is assessed and a safety plan prepared. The safety plan does not need to be written, but it must be talked through with the patient so that they are aware of what it entails. There are specialist organisations and charities listed at the end of this report, that can help a victim devise a safety plan. The victim of domestic abuse is the only person who can reliably predict the risks they are susceptible to, and thus it is the job of the healthcare professional to prompt the victim to think about the following points:

- history of abuse to both the victim and children
- has the domestic abuse increased in severity?
- what does the abuse entail? Including both the physical and emotional aspects
- victims' current fear of the situation and thoughts about the immediate danger
- self-harm or suicide threats/attempts by the victim
- attempts to get help over the last year
- availability of support from family and friends, and whether any alternative accommodation is available if necessary.

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

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

If there are children in the household who are thought to be in danger, then local safeguarding guidelines must be followed. This may include contacting social services, ideally with the victim's consent. The DH document *Responding to domestic abuse: a handbook for healthcare professionals* (2005)¹⁴ gives clear advice on what to do in such situations.

A healthcare professional must also consider their own safety and that of their colleagues. If there is an immediate risk, for example if the perpetrator is behaving aggressively in the reception area, then the police should be called. A healthcare professional should never take on the responsibility for dealing with a high-risk situation.^{14, 125}

3. Record keeping

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

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

1. date of birth
2. ethnicity
3. response to screening questions
4. relationship to perpetrator
5. if female, whether they are pregnant
6. whether there are any children in the household
7. nature of abuse, and if physical – the type of injuries
8. brief description of all forms of domestic abuse experienced
9. whether this is the first episode, and if not, what frequency over what period

10. safety assessment
11. indication of information provided on local sources of help
12. indication of any action taken, eg referral to specialist service.

Each primary care organisation should have its own guidelines on recording domestic abuse information. It is advised by the DH that a healthcare professional should use the patient's own words rather than their own, document injuries in as much detail as possible and record whether the victim's explanation for it are consistent. Taking photographs of physical injuries will convey the severity of them more effectively than a verbal description. Drawings or body maps to show the injuries are a further method of record keeping. The location of where a healthcare professional should record information about domestic abuse is very important as keeping this confidential is of the utmost importance. Notes on domestic abuse should be kept separately from the main patient record and they should never be written in hand-held notes, such as maternity notes. Keeping domestic abuse notes separately can have adverse effects as it may mean that the abuse is not put in context with a patient's overall wellbeing. With the introduction of computerised records, it may be easier to attach the domestic abuse notes to a patient's main notes, however, care must be taken that none of this information is visible on the opening screen.^{14, 125, 198}

4. Information giving

As stated earlier, it is not the job of a healthcare professional to give advice to a victim of domestic abuse about what action they should take. Ill-informed advice could have serious consequences for all those involved.¹²⁵

A healthcare professional must provide the victim with information about where they can go for help and how to contact local services. The DH¹⁴ states that 'patients who experience domestic abuse don't have a set list of options'. This is because these will depend on matters such as their personal circumstances, the immediate risk they face, whether children are involved, and the available services in their area and what capacity these have at that time. Victims should be provided with information about seeking advice from helplines, getting support from domestic abuse agencies, contacting the police, getting legal advice about obtaining a restraining order, taking additional safety measures, and seeking emergency refuge accommodation. It is acceptable for a doctor to offer help to the victim in making contact with other agencies.¹⁹⁸

5. Information sharing

The legalities of confidentiality and information sharing for a healthcare professional are complex. The DH,^{14, 125} GMC,²⁰⁰ and Home Office⁹ have all published guidance for healthcare professionals about sharing information, and these are further explained in chapter 6 of this report. Each trust or health authority should have information sharing policies to help inform healthcare professionals, and these should be followed. Overall, as stated by the Home Office in its paper *Safety and justice (2003)*⁹ 'information which attracts a duty of confidence may only be shared if the individual consents, if there is a legal obligation to share the information, or if the public interest in sharing the information overrides the need to keep it confidential'.

6. Follow up and support

Due to the nature of primary care, and especially with the work of GPs, a patient is likely to have repeat consultations with the same healthcare professional over time. It is the role of a healthcare professional to provide continuing support every time they see a patient who has once disclosed that they are suffering from domestic abuse. This will allow a healthcare professional to monitor the patient for signs of further, or increased, domestic abuse. Following the original disclosure a safety plan should be in place, and hence during follow-up appointments a healthcare professional should revisit this to check whether it needs updating, and also to support the victim in following the plan and utilising the available specialist services.¹²⁵

A further element of support, as described by the DH,¹²⁵ is meeting the needs of healthcare professionals working with domestic abuse cases. In England the local health authority and PCT should address the best way to support staff dealing with this area of healthcare. Additionally, the working environment should be accommodating so that staff would feel comfortable disclosing their own experiences of domestic abuse.

Appendix 5

An illustration of a preventative framework for violence and abuse

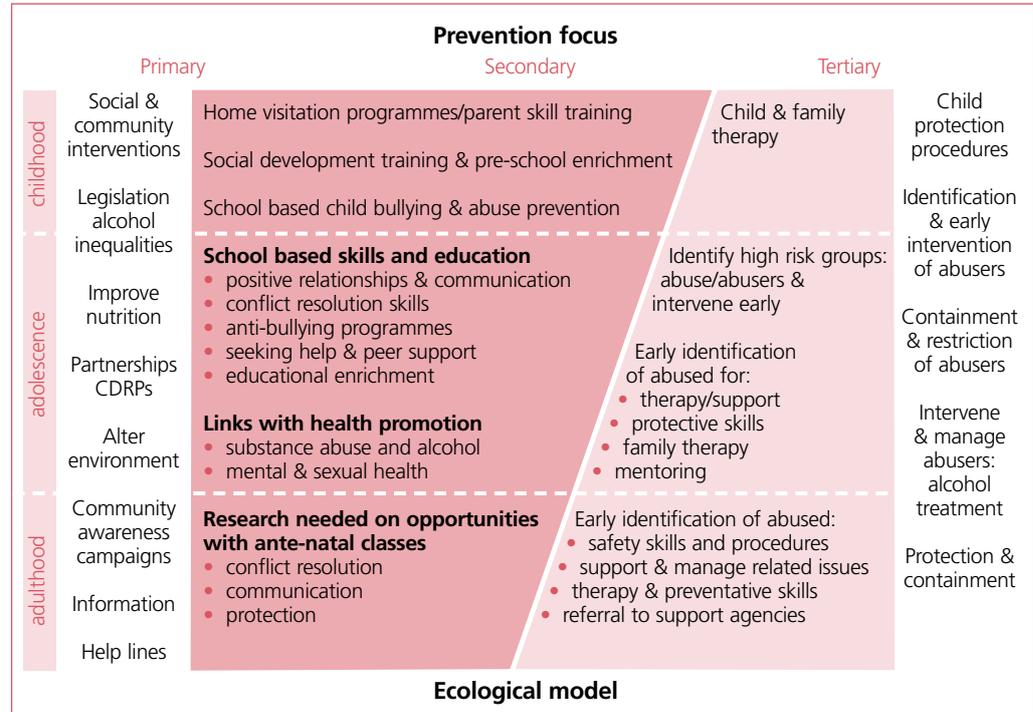


Diagram provided by South East Regional Public Health Group, Information Series 1, Preventing Violence and Abuse: Creating Safe and Respectful Lives (2006)

Appendix 6

The police and legal profession's involvement with domestic abuse

The police

The role of the police service in domestic abuse cases is considered to be the protection of the victim and any children and the enforcement of the law through positive action towards offenders. Through action to positively target and prosecute known or current offenders, police can increase the safety of the victim and send strong messages to offenders that their actions will not be tolerated.²⁰¹ Most police officers have received training in handling cases of abuse and most local forces have domestic abuse liaison officers specifically to deal with such cases.¹²⁷

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

- all call handlers within control rooms and call centres should receive training to ensure they increase the level of detail recorded to ensure the best possible investigation
- police forces should consider deploying a dedicated domestic abuse response vehicle with domestic abuse officers
- police officers should undertake enquiries to ensure that outstanding offenders not present at crime scenes are arrested at the earliest opportunity and cases are subject to dynamic and robust, accountable management by frontline services.²⁰¹

The Association of Chief Police Officers provides robust guidance for police officers in *Investigating domestic violence* (2004).²⁰² These guidelines aim to provide the police service with clear information about the policing of domestic abuse by providing operational, tactical and strategic advice. The police service acknowledges the importance of multi-agency working and the guidance highlights that a police officer is responsible for informing victims of the local availability of refuges, victim support, outreach services and places of safety.

Police in the Devon and Cornwall Constabulary have conducted a pilot to test the use of head cameras at violent and other crime incidents, such as domestic abuse incidents. Early results have shown this as an innovative way to help reduce violent crime and it has been found that since using the cameras there has been an increase of 20 per cent in converting a violent incident into a crime and an increase of 85 per cent in violent incidents resulting in arrest.²⁰³

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

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

All officers whether on the telephone or at the scene of the crime must be equipped to handle initial contact with victims of domestic abuse in a professional and sympathetic manner.¹²⁷

Legal profession

A solicitor can help a victim of domestic abuse understand their legal options for gaining protection against the perpetrator of the abuse. Victims of domestic abuse should be advised to approach solicitors specialised in this subject, and organisations such as Women's Aid and MALE can help recommend relevant solicitors. Victims of domestic abuse may not pursue their legal rights to protection due to the high costs often involved. Individuals on income support or family credit should be eligible for Legal Aid which covers the costs of taking the matter to court. Healthcare professionals must be aware of the service which solicitors can provide and advise patients accordingly. Once a victim has made the initial contact with the legal profession, they will have all the options explained to them about how they can put a stop to the crime they are falling victim to.¹²⁷

References

- 1 BMA (1998) *Domestic violence: a health care issue?* London: BMA.
- 2 BMA (1999) *Growing up in Britain: ensuring a healthy future for our children; a study of 1-5 year olds.* London: BMJ Books.
- 3 BMA (2006) *Child and adolescent mental health: a guide for healthcare professionals.* London: BMA.
- 4 BMA (2004) *Medical Ethics Today. The BMA's handbook of ethics and law (2e).* London: BMJ Books.
- 5 BMA (2001) *The medical profession & human rights handbook for a changing agenda.* London: Zed Books Ltd.
- 6 Walker A, Kershaw C & Nicholas S (2006) *British Crime Survey 2005/2006.* Available at: www.homeoffice.gov.uk/rds/pdfs06/hosb1206.pdf (accessed May 2007).
- 7 Scottish Executive (2006) *Domestic abuse recorded by the police in Scotland, 2005-06.* Edinburgh: Scottish Executive.
- 8 Freel R & Robinson E (2005) *Experience of domestic violence in Northern Ireland: findings from the 2003/04 Northern Ireland crime survey.* Belfast: Northern Ireland Office.
- 9 Home Office (2003) *Safety and justice: the government's proposals on domestic violence.* Norwich: The Stationery Office.
- 10 Criminal Justice System (2002) *Justice for all.* Norwich: The Stationery Office.
- 11 www.opsi.gov.uk/ACTS/acts2004/20040028.htm (accessed May 2007).
- 12 www.crimereduction.gov.uk/domesticviolence/domesticviolence51.pdf (accessed May 2007).
- 13 www.crimereduction.gov.uk/domesticviolence/domesticviolence61.pdf (accessed May 2007).
- 14 Department of Health (2005) *Responding to domestic abuse: a handbook for health professionals.* London: Department of Health.
- 15 Department of Health (2006) *Tackling the health and mental health effects of domestic and sexual violence and abuse.* London: Department of Health.
- 16 Department of Health (2005) *Interventions to reduce violence and promote the physical and psychosocial well-being of women who experience partner violence: a systematic review of controlled evaluations.* London: Department of Health.
- 17 World Medical Association (1996, editorially revised in 2006) *World Medical Association statement on family violence.* South Africa: World Medical Association.
- 18 Original reference: Berkowitz L (1993) *Aggression: its causes, consequences and control.* New York: McGraw-Hill. As quoted in: Browne K & Herbert M (1997) *Preventing family violence.* West Sussex: John Wiley & Sons Ltd.
- 19 www.womensaid.org.uk
- 20 Respect (2004) *Statement of principles and minimum standards of practice for domestic violence perpetrator programmes and associated women's services.* London: Respect.
- 21 Johnson MP (2006) Conflict and control: gender symmetry and asymmetry in domestic violence. *Violence Against Women* **12**: 1003-18.
- 22 Frye V, Manganello J, Campbell JC et al (2006) The distribution of and factors associated with intimate terrorism and situational couple violence among a population-based sample of urban women in the United States. *Journal of Interpersonal Violence* **21**: 1286-313.
- 23 www.crimereduction.gov.uk/dv/dv01.htm (accessed May 2007).
- 24 www.cps.gov.uk/legal/section3/chapter_c.html#_Toc44571262 (accessed May 2007).
- 25 www.cps.gov.uk
- 26 www.dewar4research.org/DOCS/dvg-v3.pdf (accessed May 2007).
- 27 Coleman K, Jansson K, Kaisa P et al (2007) *Homicides, firearm offences and intimate violence 2005/2006.* Home Office Statistical Bulletin, January.
- 28 Scottish Executive (2006) *Homicide in Scotland, 2005/06 – statistics published.* Edinburgh: Scottish Executive.
- 29 *Domestic violence, sexual assault and stalking: findings from the 2004/05 British Crime Survey.* Home Office Online Report 12/06.
- 30 Walby S & Allen J (2004) *Domestic violence, sexual assault and stalking: findings from the British Crime Survey. Home Office Research Study No. 276.* London: Home Office.

- 31 Sethi D, Watts S, Zwi A et al (2004) Experience of domestic violence by women attending an inner city
accident and emergency department. *Emerg Med J* **21**: 180-4.
- 32 Estimate by: www.helptheaged.org.uk/en-gb/Campaigns/ElderAbuse/ (accessed May 2007). Original Ref:
Ogg J, Bennett G, (1992) Elder abuse in Britain. *BMJ* **305**: 998-9.
- 33 Williamson E (2006) *Women's Aid Federation of England 2005 survey of domestic violence services
findings*. England: Women's Aid.
- 34 Doyle JP, Frank E, Saltzman LE et al (1999) Domestic violence and sexual abuse in women physicians:
associated medical, psychiatric, and professional difficulties. *Journal of Women's Health and Gender
Based Medicine* **8**: 955-65.
- 35 www.bbc.co.uk/relationships/domestic_violence/whathh_index11.shtml (accessed May 2007).
- 36 Boyle A & Todd C (2003) Incidence and prevalence of domestic violence in a UK emergency department.
Emerg Med J **20**: 438-42.
- 37 Brown K (1998) Dispatches: 'Battered men' survey. Available at: [www.dewar4research.org/
docs/bms1.pdf](http://www.dewar4research.org/docs/bms1.pdf) (accessed May 2007).
- 38 Zink T, Regan S, Goldenhar L et al (2004) Intimate partner violence: what are physicians' perceptions?
JABFP **17**: 332-40.
- 39 World Health Organisation (2004) *The economic dimensions of interpersonal violence*. Switzerland:
World Health Organisation.
- 40 Walby S (2004) *The cost of domestic violence*. England: Women and Equality Unit.
- 41 Bergman B & Brismar B (1991) A 5-year follow up study of 117 battered women. *Am J Public Health*
81:1486-9.
- 42 Bradley F, Smith, Long J et al (2002) Reported frequency of domestic violence: cross sectional survey of
women attending general practice. *BMJ* **324**: 271-74.
- 43 Coker AL, Smith PH, Bethea L et al (2000) Physical health consequences of physical and psychological
intimate partner violence. *Arch Fam Med* **9**: 451-57.
- 44 World Health Organisation (2004) *Violence against women and HIV/AIDS: critical intersections*.
Switzerland: World Health Organisation.
- 45 Avdibegovic E & Sinanovic O (2006) Consequences of domestic violence on women's mental health in
Bosnia and Herzegovina. *Croat Med J* **47**: 730-41.
- 46 Original reference: World Health Organisation (2000) *Factsheet No 239*. As quoted in: Women's Aid
(2005) *Domestic violence: frequently asked questions factsheet 2004/05*. England: Woman's Aid.
- 47 Original reference: Stets JE & Straus MA (1990) Gender difference in reporting marital violence and its
medical and psychological consequences. In: *Physical violence in American families: risk factors and
adaptations to violence in 8,145 families* (eds MA Straus & RJ Gelles). London: Transaction Publishers.
Quoted in: Royal College of Psychiatrists (2002) *Domestic violence council report CR102*. London: Royal
College of Psychiatrists.
- 48 Golding JM (1999) Intimate partner violence as a risk factor for mental disorders: a meta-analysis. *Journal
of Family Violence* **14**: 99-132.
- 49 Shepherd J (1990) Victims of personal violence: the relevance of Symond's model of psychological
response and loss theory. *Br J Soc Work* **20**: 309-32.
- 50 Boyle A, Robinson S & Atkinson P (2004) Domestic violence in emergency medicine patients.
Emerg Med J **21**: 9-13.
- 51 Quoted in: www.seniorsummit.ca.gov/materials/betty_malks.pdf (accessed May 2007).
- 52 www.citizenship.gov.on.ca/seniors/english/weaad/all/Fact4_WEAAD.pdf (accessed May 2007).
- 53 Tueth MJ (2000) Exposing financial exploitation of impaired elderly persons. *Am J Geriatr Psychiatry*
8: 104-11.
- 54 Reed K (2005) When elders lose their cents: financial abuse of the elderly. *Clinics in Geriatric medicine*
21: 365-82.
- 55 Mitchell & Gilchrist E. (2004) *Can knowledge of panic attack help to explain some domestic violence
offending*. Paper presented at the British Psychological Society Division of Forensic Psychology, Leicester.

- 56 Original reference: Browne KD (1993) Violence in the family and its links to child abuse. *Bailliere's Clinical Paediatrics* **1**: 149-64. As quoted in: Browne K & Herbert M (1997) *Preventing family violence*. West Sussex: John Wiley & Sons Ltd.
- 57 www.mentalhelp.net
- 58 As quoted in: Soloman PL, Cavanaugh MM, Gelles RJ et al (2005) Family violence among adults with severe mental illness. *Trauma, Violence & Abuse*. **6**: 40-54.
- 59 As quoted in: www.psychpage.com/gay/library/gay_lesbian_violence/index.html (accessed May 2007). Original reference: Merrill G (1996) Ruling the exceptions: same-sex battering and domestic violence theory. In Renzetti CM & Charles Harvey Miley (eds) *Violence in Gay and Lesbian Domestic Partnerships* (page 9-22). Binghamton, NY: Haworth.
- 60 www.psychpage.com/gay/library/gay_lesbian_violence/causes_of_dv.html (accessed May 2007).
- 61 Walker L (1979) *The battered woman*. New York: Harper and Row.
- 62 www.psychpage.com/gay/library/gay_lesbian_violence/cycle_of_violence.html (accessed May 2007).
- 63 www.edvp.org/AboutDV/cycle.htm (accessed May 2007).
- 64 www.actabuse.com/cycleviolence.html (accessed May 2007).
- 65 www.fvlc.org/gethelp_whywomenstay.html (accessed May 2007).
- 66 www.rcpsych.ac.uk/files/pdfversion/cr102.pdf (accessed May 2007).
- 67 Griffing S, Ragan DF, Morrison S et al (2005) Reasons for returning to abusive relationships: effects of prior victimisation. *Journal of Family Violence* **20**: 314-48.
- 68 Classen C, Field NP, Koopman C et al (2001) Interpersonal problems and their relationships to sexual revictimization among women sexually abused in childhood. *Journal of Interpersonal Violence* **16**: 495-509.
- 69 Blizard RA & Bluhm ES (1994) Attachment to the abuser: integrating object-relations and trauma theories in treatment of abuse survivors. *Psychotherapy* **31**: 383-90.
- 70 Henderson AJZ, Bartholomew K, Trinke SJ et al (2005) When loving means hurting: an exploration of attachment and intimate abuse in a community sample. *Journal of Family Violence* **20**: 219-30.
- 71 Mirrlees-Black C (1999) *Domestic violence: findings from a new British Crime Survey self-completion questionnaire*. Home Office Research Study 191. London: Home Office.
- 72 World Health Organisation (2006) *Intimate partner violence and alcohol*. Switzerland: WHO.
- 73 Brecklin LR (2002) The role of perpetrator alcohol use in injury outcomes of intimate assaults. *Journal of Family Violence* **17**: 185-97.
- 74 World Health Organisation (2002) *World Report on violence and health*. Switzerland: WHO.
- 75 Royal College of Psychiatrists (2004) *Domestic violence: its effects on children. Factsheet for parents and teachers*. London: Royal College of Pschiatrists.
- 76 Department of Health (2002) *Women's mental health: into the mainstream*. London: Department of Health.
- 77 National Statistics (2002) *Children and young people on child protection registers: by age and category, at 31 March 2002: Regional Trends 38*. UK: National Statistics.
- 78 ChildLine (2004) *A ChildLine information sheet. Domestic violence*. UK: ChildLine.
- 79 Edleson JL (1999) *Problems associated with children's witnessing of domestic violence*. Harrisburg: VAWnet.
- 80 Mullender A (2004) *Tackling domestic violence: providing support for children who have witnessed domestic violence*. London: Home Office.
- 81 Silvern L, Karyl J, Waeld L et al (1995) Retrospective reports of parental partner abuse: relationships to depression, trauma symptoms and self-esteem among college students. *Journal of Family Violence* **10**: 177-202.
- 82 Women's Aid Federation Northern Ireland (2005) *Delivering domestic violence preventive education programmes in schools and external settings: good practice guidelines*. Belfast: Women's Aid Federation Northern Ireland.

- 83 Hester M & Westmarland N (2005) *Tackling domestic violence: effective interventions and approaches*. London: Home Office.
- 84 As quoted in: Hester M & Westmarland N (2005) *Tackling domestic violence: effective interventions and approaches*. London: Home Office. Original reference: Hague G (2001) Multi-agency initiatives In: Taylor-Browne J (ed) *What works in reducing domestic violence: a comprehensive guide for professionals*. London: Whiting and Birch.
- 85 Channel Four Dispatches. *When did you last beat your wife?* Broadcast: Monday 19 March 2007 08:00 PM.
- 86 Confidential enquiry into maternal and child health for England and Wales (2001) *Why mothers die? 1997-1999*. London: RCOG Press.
- 87 www.who.int/gender/violence/who_multicountry_study/summary_report/summary_report_English2.pdf (accessed May 2007).
- 88 Original reference: Gazmararian JA et al (2000) Violence and reproductive health; current knowledge and future research directions. *Maternal and Child Health Journal* **4**: 79-84. As quoted in: Family Violence Prevention Fund. *The facts on reproductive health and violence against women*. Available at: www.endabuse.org
- 89 Steele B (1999) Why mothers die: confidential enquiry into maternal deaths. *RCM Midwives Journal* **2**: 80-1.
- 90 Confidential enquiry into maternal and child health for England and Wales (2004) *Why mothers die? 2000-2002 – the sixth report of confidential enquiries into maternal deaths in the United Kingdom*. London: RCOG Press.
- 91 As quoted in: Royal College of Obstetricians and Gynaecologists (1997) *Violence against women*. London: RCOG. Original Ref: Hillard PJA (1985) Physical abuse in pregnancy. *Obstet Gynae* **66**: 185-90.
- 92 Royal College of Midwives (1999) *Position paper No 19a Domestic abuse in pregnancy*. London: RCM.
- 93 Royal College of Midwives (2006) *Domestic abuse: pregnancy, birth and the puerperium. Guidance paper number 5*. London: RCM.
- 94 www.stonewall.org.uk/information_bank/health/lesbian_gay_bisexual_health_care_needs/1347.asp (accessed May 2007).
- 95 Broken Rainbow (2005) *Annual Report 2004-2005*. Available at: www.brokenrainbow.org.uk/press/annual%20reports/2004-05.pdf (accessed May 2007).
- 96 Henderson L (2003) *Prevalence of domestic violence among lesbians and gay men*. London: Sigma Research.
- 97 www.broken-rainbow.org.uk/content/definition.htm (accessed May 2007).
- 98 Parmar A, Sampson A & Diamond A (2005) *Tackling domestic violence: providing advocacy and support from black and other minority ethnic communities*. London: Home Office.
- 99 www.bbc.co.uk/asiannetwork/features/hh/awadv_01.shtml (accessed May 2007).
- 100 Action on elder abuse website at: www.elderabuse.org.uk
- 101 www.elderabusecenter.org
- 102 National Centre on Elder Abuse (1997) *Trends in elder abuse in domestic settings*. Washington: National Centre on Elder Abuse.
- 103 World Health Organisation (2002) *Abuse of the elderly – facts*. Switzerland: WHO.
- 104 House of Commons Health Committee (2004) *Elder Abuse – second report of session 2003-04. volume 1*. London: The Stationery Office Limited.
- 105 Ogg J & Bennett G (1992) Elder Abuse in Britain. *BMJ* **305**: 998-9.
- 106 O'Brien ME (1994) Elder abuse: how to spot it – how to help. *N C Med J* **55**: 409-11.
- 107 www.helptheaged.org.uk
- 108 Richardson J, Coid J, Petrukevitch A et al (2002) Identifying domestic violence: cross sectional study in primary care. *BMJ* **324**: 274-77.
- 109 Davidson L, King V, Garcia J et al (2000) *Reducing domestic violence... what works? Health Services*. London: Policing & Reducing Crime Unit.

- 110 Taft A, Broom DH & Legge D (2004) General practitioner management of intimate partner abuse and the whole family: qualitative study. *BMJ* **328**: 618-21.
- 111 Waalen J, Goodwin MM, Spitz AM et al (2000) Screening for intimate partner violence by healthcare providers: barriers and interventions. *Am J Prev Med* **19**: 230-7.
- 112 Glowa PT, Frasier PY, Wang L et al (2003) What happens after we identify intimate partner violence? The family physician's perspective. *Family Medicine* November – December 730-36.
- 113 Taket A (2004) *Tackling domestic violence: the role of health professionals*. London: Home Office.
- 114 Kahan E, Rabin S, Tzur-Zilberman H et al (2000) Knowledge and attitudes of primary care physicians regarding battered women. Comparison between specialist in family medicine and GPs. *Family Practice* **17**: 5-9.
- 115 Elliott L, Nerney M, Jones T et al (2002) Barriers to screening for domestic violence. *J Gen Intern Med* **17**: 112-16.
- 116 Rodriguez MA, Quiroga SS, Bauer HM (1996) Breaking the silence. Battered women's perspectives on medical care. *Arch Fam Med* **5**: 153-58.
- 117 Gerbert B, Caspers N, Bronstone A et al (1999) A qualitative analysis of how physicians with expertise in domestic violence approach identification of victims. *Ann Intern Med* **131**: 578-84.
- 118 Petersen R, Moracco KE, Goldstein KM et al (2003) Women's perspectives on intimate partner violence services: The hope in Pandora's box. *Journal of the American Medical Women's Association* **58**: 189-90.
- 119 Burge SK, Schneider DF, Ivy L et al (2005) Patients' advice to physicians about intervening in family conflict. *Annals of Family Medicine* **3**: 248-54.
- 120 As quoted in: Feder GS, Hutson M, Ramsay J et al (2006) Women exposed to intimate partner violence. *Arch Intern Med* **166**: 22-37. Original ref: Hamberger LK, Ambuel B, Marbella A et al (1998) Physician interaction with battered women: the women's perspective. *Arch Fam Med* **7**: 575-82.
- 121 American Medical Association Policy H-515.965 (2000) *Family and Intimate Partner Violence*. USA: AMA. www.acog.org/departments/dept_notice.cfm?recno=17&bulletin=585 (accessed May 2007).
- 122 Department of Health (1998) *Why mothers die: report on the confidential enquiries into maternal deaths in the United Kingdom 1994-1996*. London: Department of Health.
- 123 As quoted in: Department of Health (2000) *Domestic violence: a resource manual for health care professionals*. London: Department of Health. Original Reference: Bewley S, Friend J & Mezzy G (eds) (1997), Op Cit, Chapter 10. *Recommendations arising from the study group on violence against women*.
- 124 Department of Health (2000) *Domestic violence: a resource manual for health care professionals*. London: Department of Health.
- 125 Royal College of Psychiatrists (2002) *Domestic Violence Council Report CR102*. London: Royal College of Psychiatrists.
- 126 Scottish Executive (2003) *Responding to domestic abuse. Guidelines for health care workers in NHS Scotland*. Edinburgh: TSO.
- 127 General Medical Council (2003) *Tomorrow's doctors*. London: GMC.
- 128 The Foundation Programme Committee of the Academy of Medical Royal Colleges, Modernising Medical Careers and Department of Health. *Curriculum for the foundation years in postgraduate education and training*. Available at: www.mmc.nhs.uk
- 129 Royal College of General Practitioners (2007) *Royal College of General Practitioners Curriculum Statement 10.1. Women's Health*. London: Royal College of General Practitioners.
- 130 Hamberger LK, Guse C, Boerger J et al (2004) Evaluation of a health care provider training program to identify and help partner violence victims. *Journal of Family Violence* **19**: 1-11.
- 131 As quoted in: Varjavand N, Cohen DG, Novack DH (2002) An assessment of residents' abilities to detect and manage domestic violence. *J Gen Intern Med* **17**: 465-68. Original reference: Alpert EJ, Tonkin AE, Seeherman AM et al (1998) Family violence curricula in U.S. medical schools. *Am J Prev Med* **14**: 273-82.
- 132 Park ER, Wolfe TJ, Gokhale M et al (2005) Perceived preparedness to provide preventative counselling. *J Gen Intern Med* **20**: 386-91.

- 134 Janssen PA, Landolt MA & Grunfield AF (2003) Assessing for domestic violence exposure in primary care settings. *Journal of Interpersonal Violence* **18**: 623-33.
- 135 Royal College of General Practitioners (2007) *The primary health care team RCGP information sheet no21*. London: RCGP.
- 136 Lo Fo Wong S, Wester F, Mol S et al (2007) Utilisation of health care by women who have suffered abuse: a descriptive study on medical records in family practice. *British Journal of General Practice* **57**: 396-400.
- 137 General Medical Council (2004) *Confidentiality: protecting and providing information*. Paragraph 11. London: GMC.
- 138 General Medical Council (2004) *Confidentiality: protecting and providing information*. Paragraph 27. London: GMC.
- 139 Nursing and Midwifery Council (2004) *The NMC code of professional conduct: standards for conduct, performance and ethics*. London: NMC.
- 140 HM Government (2006) *Working together to safeguard children*. London: TSO.
- 141 BMA (2004) *Doctors' responsibilities in child protection cases. Guidance from the Ethics Department*. Available at: www.bma.org.uk
- 142 British Medical Association General Practitioners Committee (2005). *Removal of patients from GP lists*. London: BMA. Available at: www.bma.org.uk
- 143 Shakespeare J & Davidson L (2003) *Domestic Violence in families with children. Guidance for primary health care professionals*. London: Royal College of General Practitioners. Available at: www.rcgp.org.uk/default.aspx?page=2260 (accessed May 2007).
- 144 Hester M & Westmarland N (2006) *Service provision for perpetrators of domestic violence*. Bristol: University of Bristol.
- 145 Romans SE, Poore MR & Martin JL (2000) The perpetrators of domestic violence. *MJA* **173**: 484-88.
- 146 www.respect.uk.net
- 147 As quoted in: Romans SE, Poore MR & Martin JL (2000) The perpetrators of domestic violence. *MJA* **173**: 484-88. Original reference: Shepard M (1992) Predicting batterer recidivism five years after community intervention. *J Family Violence* **7**: 167-78.
- 148 British Association for Emergency Medicine (2005) *Guidelines for the management of domestic violence*. London: British Association for Emergency Medicine.
- 149 Wadman MC & Muelleman RL (1999) Domestic violence homicides: ED use before victimization. *Am J Emerg Med* **17**: 689-91.
- 150 Howe A, Crilly M & Fairhurst R (2002) Acceptability of asking patients about violence in accident and emergency. *Emerg Med J* **19**: 138-40.
- 151 Boyle A, Kirkbride J & Jones P (2005) Record linkage of domestic assault victims between an emergency department and the police. *J Epidemiol Community Health* **59**: 909-10.
- 152 Department of Health & Department for Education and Skills (2004) *National service framework for children, young people and maternity services*. London: Department of Health.
- 153 As quoted in: Cokkinides VE, Coker AL, Sanderson M et al (1999) Physical violence during pregnancy: maternal complications and birth outcomes. *Obstet Gynecol* **93**: 661-6. Original reference: Connolly AM, Katz VL, Bash KL et al (1997) Trauma and pregnancy. *Am J Perinatol* **14**: 331-6.
- 154 Gazmararian JA, Adams M, Saltzman LE et al for PRAMS working group (1995) The relationship between pregnancy intendedness and physical violence in mothers of newborns. *Obstet Gynecol* **85**: 1031-8.
- 155 Paavananen J & Eggert-Kruse W (1999) Chlamydia trachomatis: impact on human reproduction. *Human reproduction update* **5**: 433-47.
- 156 Bewley S, Friend J & Mezey G (1997) *Violence against women*. London: RCOG Press.
- 157 Cokkinides VE, Coker AL, Sanderson M et al (1999) Physical violence during pregnancy: maternal complications and birth outcomes. *Obstet Gynecol* **93**: 661-6.

- 158 Yost NP, Bloom SL, McIntire DD et al (2005) A prospective observational study of domestic violence during pregnancy. *Obstet Gynaecol* **106**: 61-5.
- 159 Salmon D, Baird K, Price S et al (2004) *An evaluation of the Bristol Pregnancy and Domestic Violence Programme to promote the introduction of routine enquiry for domestic violence at North Bristol NHS Trust*. Bristol: University West of England.
- 160 Royal College of Midwives (2006) *Domestic abuse: pregnancy, birth and the puerperium. Position statement No.19a*. London: Royal College of Midwives.
- 161 Royal College of Psychiatrists (2006) *A competency based curriculum for specialist training in psychiatry. Specialist module in child and adolescent psychiatry*. London: Royal College of Psychiatrists.
- 162 Royal College of Psychiatrists (2006) *A competency based curriculum for specialist training in psychiatry. Specialist module in the psychiatry of learning disability*. London: Royal College of Psychiatrists.
- 163 Women's Aid (2005) *Health and domestic violence – Good practice guidelines – Guidance for mental health professionals*. Available at: www.womensaid.org.uk/landing_page.asp?section=0001000100100004000200020001 (accessed May 2007).
- 164 Phair L & Goodman W (2003) The role of the community nurse. In: Amiel S & Heath I (eds) *Family violence in primary care*. Oxford: Oxford University Press.
- 165 Keling J & Birch L (2002) Domestic violence in nursing curricula. *Nursing Times* **98**: 36-7.
- 166 Royal College of Nursing (2000) *Domestic violence – Guidance for nurses*. London: Royal College of Nursing.
- 167 Home Office (2006) *National Domestic Violence Delivery Plan 2005/06*. London: Home Office.
- 168 Scottish Partnership on Domestic Abuse (2000) *A national strategy to address domestic abuse in Scotland*. Edinburgh: Scottish Executive.
- 169 Northern Ireland Office (2005) *Tackling violence at home – action plan number 1 October 2005 to March 2007*. Stormont: Department of Health, Social Services & Public Safety, Northern Ireland Office.
- 170 Home Office & Department of Health (2006) *Domestic abuse training manual for health practitioners. National domestic violence health practice forum*. Available at: www.crimereduction.gov.uk/domesticviolence/domesticviolence58.pdf (accessed May 2007).
- 171 Association of Chief Police Officers (2005) *Identifying, assessing and managing risk in the context of policing domestic violence*. London: ACPO.
- 172 Hague G (2000) *Reducing domestic violence... what works? Multi-agency fora*. London: Policing and Reducing Crime Unit, Home Office.
- 173 Home Office (2000) *Domestic violence: break the chain. Multi-agency guidance for addressing domestic violence*. London: Home Office.
- 174 Maternity Care Working Party (2006) *Modernising maternity care – a commissioning toolkit for England*. UK: The National Childbirth Trust, The Royal College of Midwives, The Royal College of Obstetricians and Gynaecologists.
- 175 Parmar A, Sampson A & Diamond A (2005) *Tackling domestic violence: providing advocacy and support to survivors of domestic violence*. London: Home Office.
- 176 Kelly L & Humphreys C (2000) *Reducing domestic violence... what works? Outreach and advocacy approaches*. London: Policing and Reducing Crime Unit, Home Office.
- 177 Sullivan CM & Bybee DI (1999) Reducing violence using community-based advocacy for women with abusive partners. *Journal of Consulting and Clinical Psychology* **67**: 43-53.
- 178 Dogs Trust, Freedom Project. Information available at: www.dogstrust.org.uk/wayswehelp/freedom_project/ (accessed May 2007).
- 179 www.menshealthforum.org.uk
- 180 Women's Aid (2005) *The survivor's handbook*. Bristol: Women's Aid Federation of England.
- 181 Mullender A & Hague H (2000) *Reducing domestic violence... what works? Women survivors' views*. London: Policing and Reducing Crime Unit, Home Office.
- 182 www.mensadviceline.org.uk
- 183 www.jwa.org.uk

- 184 www.ashianahelp.org.uk
- 185 Broken Rainbow LGBT Domestic Violence Service (UK) Press Release January 2005. Available at: www.broken-rainbow.org.uk/press/press_releases/PressReleaseJan05.htm (accessed May 2007).
- 186 www.southhallblacksisters.org.uk
- 187 Department for Communities and Local Government (2006) *Homelessness code of guidance for local authorities*. West Yorkshire: DCLG Publications.
- 188 Scottish Executive (2005) *Code of guidance on homelessness*. Edinburgh: Scottish Executive.
- 189 Office of the Deputy Prime Minister (2005) *Sustainable communities: settled homes; changing lives*. London: Office of the Deputy Prime Minister.
- 190 www.nhs.uk/England/SocialCare/Default.cmsx (accessed May 2007).
- 191 Penhale B (2003) Onward referral to social services. In: Amiel S & Heath I (eds) *Family violence in primary care*. Oxford: Oxford University Press.
- 192 Commission for Social Care Inspection (2006) *Supporting parents, safeguarding children*. Newcastle: Commission for Social Care Inspection.
- 193 Women's Aid. *Policy and Practice – Working with perpetrators*. Available at: womensaid.nemisis1.uk.com/page.asp?section=00010001000900070001 (accessed May 2007).
- 194 Respect website – *Domestic violence perpetrator programmes*. Available at: www.respect.uk.net
- 195 Morris T (2003) Solicitors and law centres. In: Amiel S & Heath I (eds) *Family violence in primary care*. Oxford: Oxford University Press.
- 196 Ramsay J, Richardson J, Carter YH et al (2002) Should health professionals screen women for domestic violence? Systematic review. *BMJ* **325**: 314-18.
- 197 Richardson J, Feder G, Eldridge S et al (2001) Women who experience domestic violence and women survivors of childhood sexual abuse: a survey of health professionals' attitudes and clinical practice. *British Journal of General Practice* **51**: 468-70.
- 198 Heath I (2002) *Domestic violence: the GPs role*. The Royal College of General Practitioners. Available at: www.rcgp.org.uk/default.aspx?page=2259 (accessed May 2007).
- 199 As quoted in: BMA (1998) *Domestic violence: a health care issue?* London: BMA. Original reference: Heath I (1992) *Domestic violence: the general practitioner's role*. Royal College of General Practitioners *Members Reference Book*. London: Sabrecrown.
- 200 General Medical Council (2004) *Confidentiality: protecting and providing information*. London: GMC.
- 201 Police and Crime Standards Directorate (2006) *Lesson learned from the domestic violence enforcement campaigns 2006*. Produced by COI on behalf of the Home Office.
- 202 Association of Chief Police Officers (2004) *Guidance on investigating domestic violence*. London: ACPO.
- 203 Devon and Cornwall Constabulary (2007) *Police news release – police head camera pilot interim evaluation report released*. Exeter: Devon and Cornwall Constabulary.

Board of Science publications

2007

- Fetal alcohol spectrum disorders: a guide for healthcare professionals
- Evidence-based prescribing
- Breaking the cycle of children's exposure to tobacco smoke
- Gambling addiction and its treatment within the NHS: a guide for healthcare professionals

2006

- Child and adolescent mental health: a guide for healthcare professionals
- Reporting adverse drug reactions: a guide for healthcare professionals
- Tackling sexually transmitted infections – examples of good practice
- Sexually transmitted infections update 2006
- Healthcare associated infections: a guide for healthcare professionals

2005

- Population and genetic screening
- Vaccine development – web resource
- Mobile phones and health – an update
- Healthcare in a rural setting
- Binge drinking
- Hepatitis B vaccination in childhood
- Over the counter medication
- Preventing childhood obesity

2004

- Biotechnology, weapons and humanity II
- Refuse management and health
- The impact of flying on passenger health – a guide for healthcare professionals
- Genetically modified foods and health – second interim statement
- Diabetes mellitus: an update for healthcare professionals
- Smoking and reproductive life: the impact on smoking, reproductive and child health

Copies of these and other reports can be obtained from:

Science and Education Department

British Medical Association

BMA House

Tavistock Square

London

WC1H 9JP

Tel: +44 (0) 20 7383 6164

Fax: +44 (0) 20 7383 6383

Email: info.science@bma.org.uk

www.bma.org.uk



Science and Education Department
British Medical Association, BMA House, Tavistock Square, London, WC1H 9JP
www.bma.org.uk

© British Medical Association, 2007