Dudley and Walsall NHS
Mental Health Partnership NHS Trust

Document Title
Domestic Abuse Policy

Document Description	
Document Type	Policy
Service Application	Trust Wide
Version	1.2
Policy Reference no.	POL 293

Lead Author(s)	
Name	Job Title
Lydia Pulford	Vulnerable Adults and Childrens practitioner
Liz Whitehouse	Vulnerable Adults and Childrens practitioner
Sharon Latham	Vulnerable Adults and Childrens lead

Change History – Version Control		
Version	Date	Comments
0.1	11/08/2014	Initial version circulated for consultation
1.0	07/01/2014	Version agreed by Policies and Procedures Focus Group and Formally Agreed by Trust Board
1.1	13/01/2016	Policy formally ratified by Policies and Procedures Focus Group 13/01/2016
1.2	04/09/2019	Policy updated and ratified at Policies and Procedures Group

Link with National Standards	
National Health Service Litigation Authority	
Care Quality Commission	
National Institute of Clinical Excellence (NICE) Guidance	
National Patient Safety Agency	
West Midlands Quality Review	
Essence of Care	
Aims Standards	
IG Toolkit	

Key Dates	Day	Month	Year
Ratification Date	06	08	2019
Review Date	06	08	2022

Executive Summary Sheet
Document Title: Domestic Abuse Policy

Please tick (☑) as appropriate	This is a new document within the Trust	
	This is a revised document within the Trust	☑

What is the purpose of this document?

The purpose of this policy is to identify roles and responsibilities when working with clients who present to Dudley and Walsall Mental health Trust and disclose domestic abuse. The aim of the policy is to ensure the safety and mental health well-being of service users by recognising that domestic abuse is a serious crime which has an adverse impact upon the mental health of individuals, families and communities.

What key issues does this document explore?

- Facilitate early identification of domestic abuse and to offer supportive and effective intervention to reduce the risk of harm by utilising identified care pathways.
- Inform staff of best practice when responding to domestic abuse
- Identify and address any safeguarding issues for children and vulnerable adults.
- Raise awareness of additional issues which can impact upon the safety of victims of domestic abuse from black and minority ethnic communities.
- Ensure that all departments are clear within their roles in tackling and responding to issues surrounding domestic abuse.
- Identify a framework for action within which all
- responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of Domestic Abuse ensuring effective response to any Domestic Abuse circumstances.

Who is this document aimed at?

All staff working within Dudley and Walsall Mental Health Partnership NHS Trust

What other policies, guidance and directives should this document be read in conjunction with?

- Safeguarding adults: multi-agency policy and procedures for the West Midlands, Mental Capacity Act 2005
- Mental Health Act (1983 and 2007 amendments)
- MCA, DOLS and MHA Codes of Practice
- National Assistance Act 1948
- Human Rights Act 1998
- Public Interest Disclosure Act 1998
- Care Standards Act 2000
- The Children Act (1989)
- Department of Health and UK Council of Caldicott Guardians (April 2012) 'Striking the Balance' Practical Guidance on the application of Caldicott Guardian Principles to Domestic Violence and MARACS (Multi Agency Risk Assessment Conferences)
- Observation and Engagement policy
- Management of aggression policy
- Medicines management policy
- Royal College of Psychiatrists (2004) Domestic violence: its effects on children, Factsheet for parents and teachers [online]. Available from www.rcpsych.ac.uk/mentalhealthinfo/mentalhealthandgrowingup/domesticviolence.aspx
- Department of Health (2017) FGM Safeguarding & Risk Assessment: A quick guide for health professionals
- Home Office (2016) Multi-agency Statutory guidance on Female Genital Mutilation
- Care Programme Approach policy
- Safeguarding Children Policy
- Data Protection Act
- Freedom of Information
- Risk management policy
- Think family, Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and abuse (2006)
- Safelives -Tool kit for MARAC (2019)

How and when will this document be reviewed?

This policy will be subject to review every 3 years by the policy author and in liaison with safeguarding procedures/policy or when any significant changes occur.

1. Introduction

1.1 This policy reflects local, national, strategic and operational guidance produced in response to the growing recognition of the detrimental effects that domestic abuse has on society as a whole. It demonstrates the principle that domestic abuse and violence is unacceptable behaviour and that everyone has a right to live free from fear and abuse. It recognises the need to share information and work in partnership with other agencies with greater experience of domestic abuse in order to reduce the risk of harm to victims.

1.2 The National Health Service has a particular contribution to make in the drive to address domestic abuse. Guidance produced by the Department of Health (2017) has established domestic abuse as a major concern for all health care professionals and identifies the NHS as the one service that almost all victims of domestic abuse come into contact with regularly within their lifetime (either as the first or only point of contact with professionals).

1.3 Abused women are more likely to be in touch with health services than any other agency (DOH, 2017).

Health practitioners are in a key position to identify domestic abuse and to initiate support and safety for victims. A study of 2,500 women accessing domestic abuse services, showed that prior to receiving specialist help, just under half had attended a GP an average of 5.3 times and one in five had attended A&E as a result of the abuse. (Safe Lives. *Insights into Domestic Abuse (1). A Place of Greater Safety* 2012)

1.4 In addition, between 4% and 19.5% of women attending healthcare settings in England and Wales may have experienced domestic violence in the past year. A high proportion of women attending accident and emergency, primary care, family planning, reproductive and sexual health settings are likely to have experienced domestic violence at some point (Alhabib et al. 2010; Feder et al. 2009).

1.5 Between 30% to 60% of female psychiatric inpatients also report experiencing domestic violence in their lifetime (Howard et al. 2010). For women age 19-44, domestic abuse is the leading cause of morbidity – greater than, cancer, war and motor vehicle accidents - and is the leading cause of injury and illness for girls and women aged 15-44.In the UK Domestic abuse claims the lives of two women per week.

1.6 Violence and abuse can lead to increased risk of poor mental health, injuries, chronic physical conditions, unwanted and complicated pregnancy, sexually transmitted infections and substance misuse, and the effects can last a lifetime and into subsequent generations. Early intervention can reduce the impact of the many health consequences.

1.7 Domestic abuse is a key public health issue and treating related physical injuries and addressing mental health needs, costs the National Health Service in the region of £1.7 billion per annum (Walby, 2009).

1.8 Domestic abuse is a criminal act and a fundamental breach of trust and human rights, and contravenes an individual's right to feel safe, both within their home and within a personal relationship.

1.9 Dudley and Walsall Mental Health Partnership Trust is committed to ensuring that victims of domestic abuse receive a high standard of care irrespective of age, race, culture, sexuality, religion or ability, and equality underpins all its service provision. It also recognises that perpetrators of domestic abuse may be service users.

1.10 Dudley and Walsall Mental Health Partnership Trust recognises the serious adverse impacts that domestic abuse has on children who live in a violent abusive household, and the short and long term damage to their physical and mental health. Within this context DWMH recognises its responsibilities to safeguard and protect children.

1.11 Domestic abuse is not only an issue for service users, and there is a need to address domestic abuse issues for staff, male or female when they themselves may be current or past victims of domestic abuse, or are perpetrators of domestic abuse.

The Ending Violence against Women & Girls vision strategy 2016-2020 (VAWG) aims to tackle violence against women and girls in all its forms over the next four years. It aims to drive a transformation in the delivery of VAWG services, make prevention and early intervention the foundation of our approach, and embed VAWG as 'everyone's business' across agencies, services and the wider public.

The accompanying action plan to the VAWG strategy can be found at https://www.gov.uk/government/publications/strategy-to-end-violence-against-women-and-girls-2016-to-2020

2. Purpose

2.1 The purpose of this document is to:

- Improve safety and improve health by recognising domestic abuse is a serious crime which has an adverse impact upon the health and mental health of individuals, families and communities.
- To provide and communicate a safe environment for the service user.
- Facilitate early identification of domestic abuse and to offer, supportive and effective intervention to reduce the risk of harm by utilising identified care pathways
- Inform staff of best practice when responding to domestic abuse
- Identify and address any safeguarding issues for children and vulnerable adults in line with the changes in the care act April 2015 which puts adult safeguarding on a legal footing and ensures practitioners work with the adult all the way through the concerns in a person centred way.
- Raise awareness of additional issues which can impact upon the safety of victims of domestic abuse from black and minority ethnic communities.
- Ensure that all staff are clear within their roles in tackling and responding to issues surrounding domestic abuse.
- Ensure that processes are in place to support actions plans developed following a domestic homicide review, serious case review or internal management review.
- To facilitate adherence to the safeguarding Board, Child Protection and Safeguarding Policies.
- To provide support and guidance to the work of early detection and reduction of domestic violence.

3. Definition

3.1 Domestic abuse is a generic term to describe a pattern of coercive behaviours used by one person for the purpose of maintaining power and control over another adult or child. Domestic abuse is a serious social and criminal problem resulting in devastating consequences for those affected, including any children who live in the household. It is a hidden crime and is one that is largely under reported.

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

- Psychological
- Physical
- Sexual
- Financial
- Emotional
- Coercion and Control
- Honour Based Violence (HBV)
- Female Genital Mutilation (FGM)
- Forced Marriage

4. Who might experience domestic abuse?

4.1 A conservative estimate suggests that one in four women and one in six men will be a victim of domestic abuse in their lifetime (Home Office, 2003) and that 1 in 9 women presenting to health services at any one time will be currently living with abuse.

- Women and girls are more likely to experience repeated physical violence, a greater severity of violence, increased sexual violence, higher levels of coercive control and greater fear of their partners (Responding to domestic abuse a resource for health professionals Department of Health (2017))

4.2 Although the majority of domestic abuse incidents relate to male perpetrators and female victims, this is not always the case. Domestic abuse also affects the lesbian, gay, bi-sexual and transgender community as well as male victims.

4.3 The terms ‘abuser’ and ‘perpetrator’ are used interchangeably and refer to males and females, however statistically, most perpetrators are male.

4.4 Domestic abuse occurs among people of all income levels, ages and among people from all black, white and minority ethnic backgrounds. In terms of domestic abuse and ethnicity, British Crime Survey findings show little variation in the experience of inter-personal violence by ethnicity (Walby, 2004).

4.5 Domestic abuse is rarely a one-off incident, and should be seen as a pattern of abuse and controlling behaviour through which the abuser seeks power over their victim.

4.6 Factors associated with being a victim of domestic violence include:

- Being female
- Long-term illness or disability (women and men with a long-term illness or disability are almost twice as likely to experience domestic violence as others)
- Use of any recreational drug in the last year
- Marital status (married people had the lowest risk, while those who had previously been married had the highest risk)
- Age (women in younger age groups, in particular, in those aged 16–24 years are at greatest risk)

(All of the above are from: Home Office 2011)

- Alcohol or drug consumption (partner assaults are four to eight times higher among people seeking treatment for substance-dependence) (Murphy and Ting 2010)
- Pregnancy (the greatest risk is for teenage mothers and during the period just after a woman has given birth (Harrykissoon et al. 2002)
- Being lesbian, gay, bisexual or transgender (Barter et al. 2009; Browne and Lim 2008; Home Office 2010b).

5. Children and young people

5.1 The issue of children living with domestic abuse is now recognised as a matter of concern in its own right by both government and key children's services agencies. The link between child abuse and domestic abuse is high with estimates ranging from 30 % - 66% depending upon the study. Therefore, whilst domestic abuse and child abuse do not always co-exist, it can be an important indicator of a child at risk of harm from either actual physical, sexual and/or emotional abuse or by exposure to abusive relationships.

5.2 Children living in households where domestic violence is happening are identified as "at risk" under the Adoption and Children Act 2002. From 31 January 2005, Section 120 of this act extended the legal definition of harming children to include harm suffered by seeing or hearing ill treatment of others. This would include witnessing domestic abuse.

5.3 Domestic Abuse/Violence can start at any point but often starts or escalates during pregnancy putting the unborn baby at risk. Babies under one who live with domestic violence have been shown to display poor health, poor sleeping and excessive crying. Children and young people can be harmed in the violence or in trying to protect the victim but all children living with domestic abuse suffer emotional harm.

Figures based on findings from 11-17 year olds. 17.5% said they had been exposed to domestic abuse between adults in their home (Child abuse and neglect in the UK today. Radford, L. et al 2011).

5.4 Living with domestic abuse can adversely affect all of the five outcomes for children identified in Every Child Matters (2004). In addressing the needs of children living with domestic abuse, it is important to be aware that children develop their own coping strategies; however, it is known that adverse experiences in childhood can detrimentally affect cognitive, psychological, physical, social and educational development. This may warrant long term involvement of health services.

5.5 Domestic abuse often means that children live in an environment where there are high levels of physical punishment, misuse of power and authority and the generation of feelings of fear, anxiety and helplessness despite the best efforts of the non-abusive partner. Living with domestic abuse can cause distortion in children's perceptions of relationships, blame, cause and effect.

5.6 1 in 5 teenagers have been physically abused by their boyfriend or girlfriend Barter et al (2009) Partner exploitation and violence in teenage intimate relationships

5.7 Parents can also be the victims of abuse perpetrated by a child or adolescent, although the proportion affected in England is unknown (Kennair and Mellor 2007).

5.8 Domestic Abuse often begins or increases when a woman is pregnant. This presents an immediate need to safeguard the victim and the unborn child.

5.9 In OFSTED's biennial analysis of Serious Case Reviews (2009) the significance of the combined effect of domestic abuse, mental ill health and substance misuse (the 'toxic trio'/ 'trilogy of risk'/ 'trio of vulnerabilities') as major contributory factors to children's deaths has been highlighted. These findings are reflected at a local level.

5.10 The welfare of a child is paramount. In all cases where children & young people are known to be in a household where Domestic Abuse takes place a referral should be made to Children Social Care.

5.11 All staff should follow child protection procedures; seek advice if you are concerned. All contact numbers can be found on the Trust intranet or in the appendix at the back of the policy.

6. Vulnerable adults

6.1 It is recognised that some victims of domestic abuse and forced marriage may face additional vulnerability factors and that these should be taken into consideration when offering help and support.

6.2 In England, 1.6% of older people (aged 66 years and over) reported experiencing abuse (psychological, physical, sexual and financial) in the past year from a family member, close friend or care worker (DH 2007). Forty per cent of the abuse was perpetrated by a partner and 43% by another family member.

6.3 Women and men with a long-term illness or disability are almost twice as likely to experience domestic violence as others.

6.4 All health professionals must follow Dudley and Walsall's Safeguarding Adult Protection Policies.

7. Responding to the patient/client following disclosure or recognition of signs of domestic abuse

7.1 Responding effectively in a health setting requires non-judgemental, supportive attitudes, a knowledge of physical and emotional abuse, an understanding of appropriate and inappropriate responses, and having a good understanding of local domestic abuse care pathways and services. Forced Marriage shares significant similarities to domestic abuse (and often domestic abuse occurs in relationships where there has been forced marriage), it is also different to domestic abuse in that there are often multiple perpetrators who can be members of the same family or members of a community. Therefore there are additional factors to bear in mind when responding to forced marriage situation.

7.2 If a service user has disclosed domestic abuse or forced marriage, it is essential to allow them time to tell you their story. HM Government (2014)

7.3 Risk assessment for domestic abuse

7.3.1 In line with the Trusts clinical documentation expectations a risk assessment must always be completed and an assessment of safety should be undertaken. If you need to seek advice in

relation to this assessment speak directly with manager, senior clinical lead or Safeguarding Vulnerable Adults and Child Specialist Practitioner (VACSP)

Once identified as suffering domestic abuse, the Safelives Risk Identification Checklist (RIC) should be used to establish if the victim is at high risk of harm (See appendix 1, or access via http://www.safelives.org.uk/node/516)

7.3.2 If the score on the Safelives RIC has a score of 14 or above then this would meet the threshold for referral in to MARAC

7.3.3 This can be facilitated by contacting the DWMH VACSP to assist you with the referral process.

7.3.4 In all cases that involve young people less than 18 years of age you should seek advice, follow child protection procedures and refer to Children's social care. Where there has been an actual assault of the young person consideration should be taken with the young person around reporting the incident to the Police.

7.3.5 Ensure young people are supported until a risk assessment has been completed and signpost to relevant support services.

7.4 Following a disclosure of domestic abuse

7.4.1 The staff member who receives or observes any concerns/allegations of domestic abuse will complete a DWMH safeguarding alert to highlight the concerns, and consult with their line manager, clinical lead, or senior nurse who will make a decision about whether or not the safeguarding adult's procedures should be evoked.

7.4.2 If the staff member is unable to consult with their manager they can discuss the case with the VACSP Dudley and Walsall MHPT who will offer advice on making this decision.

7.4.3 If there are immediate risks identified the appropriate action to be taken i.e. telephone the police and a referral to children's services if applicable

7.4.4 Safelives risk assessment to be completed as mentioned above to ascertain level of risk.

7.4.5 The staff member will be required to input a domestic abuse warning flag on the oasis system highlighting concerns and follow the procedures in line with the domestic abuse flow chart. (Appendix 3).

7.4.6 Risk assessments and care plans must be updated to reflect concerns raised and actions to be taken.

7.5 Asking appropriate questions

7.5.1 Women who have been abused say they were glad when a health practitioner asked them about their relationships.

7.5.2 You need to ask the service user for more information to help you to assess the situation and gather as much information as possible. Evidence suggests that people who are being subjected to violence want to be asked, and that people who have not experienced abuse do not mind being asked (Friedman et al., 1992). It is important to ask direct questions in a gentle, non-threatening manner (Schei, 1989). A suggested opening for selective enquiries might be:

"I am sorry if someone has already asked you about this , and I don't wish to cause you any offence, but we know that throughout the country 1 in 4 women and 1 in 6 men experience domestic abuse at home and sometime in their life. I noticed that you have a number of bruises/cuts/burns (whatever) - it is routine for health care staff to ask about domestic abuse in these situations."

Please see appendix 5 for further suggested questions.

7.5.3 The service user's answers to these questions will help you to assess the possible risks to their safety and that of their children.

7.5.4 Before you begin to ask any questions, be aware of the following:

- Any interview should be undertaken in a suitable environment which does not include the perpetrator or any inappropriate person and respects the client's entitlement to privacy and dignity.
- Staff should never ask about possible abuse in the presence of the partner, children or other family members.
- Where the victim does not speak English it is essential that an interpreter is used to obtain a direct history from the victim. In no circumstances should a family member be asked to interpret.
- It is important when asking the client direct questions about their experience to do this sensitively and in a manner that is empathetic and supportive.
- Ask direct questions rather than letting an improbable explanation pass without saying anything. Use professional curiosity.
- Listen carefully. The person may talk around the subject before disclosing to you. Requests for help are often veiled and may 'hide' behind other things. Think about ways in which you could draw out further information.
- Respect confidentiality and privacy – also understand the need to share information if immediate protection is required for either the adult or the children (follow safeguarding procedure and pathways as out lined by DWMH)
- Respect and validate what they tell you and remember that you may be the first person who has listened to them and taken them seriously. Reassure them that you will their reports seriously.
- Emphasise the unacceptability of violence and that they are not responsible for this.
- Ensure the immediate safety of the abused and any dependent children/vulnerable adults
- Seek to empower- do not try to make decisions on their behalf
- Know how to ask the right questions to let the service user know they can talk about domestic abuse.

7.6 **Working with domestic abuse when both partners are service users**

7.6.1 The needs of both service users should be addressed independently:

- When abuse is suspected or confirmed, both parties should be seen without the other being present.
- Affirm to the abused person that their health and safety are important and that confidentiality will be protected, unless disclosure is required by law.
- There should be no discussion about the suspected or confirmed abuse with the alleged abuser unless the victim consents to it.
- It is not a conflict of interest to ask a patient about the possibility of abuse or to have an active management plan when it is suspected or confirmed if the alleged abuser is also a patient.

- Consider signposting perpetrators of abuse to specialist perpetrator programmes.

8. Monitoring/audit

8.1 Monitoring arrangements for safeguarding processes are via the Trust's incident reporting system (Safeguard). Processes and procedures are further scrutinised by the safeguarding strategic group. The Governance and Quality committee also received a monthly exception report of all safeguarding activity across the service lines:

8.2 The processes for referring and recording adult at risk concerns can be found in the adult safeguarding procedures. The process and standards for safeguarding procedures remain in line with multi-agency requirements as outlined in the Trust Adult safeguarding policy.

8.3 To monitor compliance with the Trust's training expectations; the Learning and Development team maintain all records of mandatory Safeguarding Training attendance

8.4 As outlined within the Trust's Annual Audit Programme, compliance with the Safeguarding Adult and children's Policy is monitored through the Trust's Safeguarding Adult audit which is co-ordinated by the Clinical Governance Department and forms part of the Trust's annual audit cycle.

9. Domestic homicide review

9.1 Section 9 of the Domestic Violence, Crime and Victims Act 2004 introduced a statutory basis for local bodies to establish homicide reviews for victims of domestic violence. This provision creates an expectation that local areas should undertake a multi-agency review following a domestic violence homicide. DWMH will comply with this duty and will adhere to the guidance when participating in a review (see Safeguarding Vulnerable Adults Policy).

10. Training

10.1 Good practice would dictate that all members of staff receive training on recognising and responding to domestic abuse.

10.2 Bespoke training will be provided to all specialist members of staff who work in the organisation in accordance with their role and responsibilities.

10.3 High quality supervision, support and training for staff is crucial in promoting effective practice. It is a requirement that all staff responsible for working within DWMHT will attend Safeguarding Adults and children's mandatory training provided through the Trust and other training in line with their Roles and Responsibilities to meet their required competencies as stipulated in the competency framework.

10.4 The Trust provides appropriate levels of training to all relevant staff in order to implement this policy. Training to underpin this policy will be provided as identified in the Trust's Training Needs Analysis. Such training will be undertaken in line with standards agreed with Dudley and Walsall Safeguarding Boards.

11. Equality and diversity

11.1 This policy aims to safeguard all individuals who may be at risk of abuse, irrespective of disability including mental capacity, race, to include: colour, language, birth, nationality, ethnic or national origin, religion and belief, gender, age sexual orientation, gender identity, marriage and civil partnerships, pregnancy or maternity,

11.2 All Trust staff and providers must respect the alleged victim's (and their families) culture, religious beliefs, gender, sexuality, race, and gender identity, however this must not prevent action to safeguard someone who is at risk or experiencing abuse. Support in clarifying or understanding diversity issues can be sought from the Equality and Diversity Lead.

11.3 Approaches to adult protection must be person centred. All staff and providers must take into account the individual's culture, religious beliefs, gender and sexuality when assessing risks and formulating individual protection plans.

11.4 All reasonable endeavours must be used to establish the person's preferred method of communication and to communicate in a way people can understand. This will include ensuring access to the Trust translation and interpreters service where people use languages (including signing) other than English. Every effort must be made to respect the person's preferences regarding gender and background of the interpreter.

12. Confidentiality and information guidance

12.1 Information will only be shared on a "need-to-know basis" when it is in the best interest of the patient/service user.

12.2 Confidentiality must never be confused with secrecy (i.e. the need to protect the management interests of an organisation should not over-ride the need to protect a vulnerable adult).

12.3 It is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in situations when other people may be at risk.

12.4 Individuals normally have a right to decide how they wished to be helped and, if they have capacity, should be a contributing to the process as a whole. They should be supported in their decisions as to how they wish to proceed should they find themselves in a situation where they are abused.

12.5 There will be circumstances when the wider public interest will outweigh the responsibility to any one individual. In this situation the vulnerable adult should be informed of the duty to pass on the information, to who the information is to be passes and the reason for doing so.

12.6 It should not be assumed that consent to the sharing information regarding one particular set of circumstances gives consent to share information about another different set of circumstances.

12.7 While acknowledging difficulties around maintaining confidentiality of the vulnerable adult, this should not lead to failure to take action to protect that adult from abuse.

12.8 Where language or communication difficulties exist it is important to use independent advocates and independent interpreters to liaise with the adult to gain consent for sharing information. A family member should not be used for interpretation purposes, or someone from a local cultural or religious organisation of which the victim or suspected abuser is a member.

13. Support for employees experiencing domestic abuse

13.1 Domestic abuse is not only a service delivery issue. It affects all sections of society and DWMH recognises the need to have clear and effective responses to help minimise the impact of domestic abuse upon employees. Domestic abuse can affect work performance and the health and safety of employees.

13.2 Please refer to staff domestic abuse policy

13.3 Staff offering support to work with colleagues should follow the same basic principles and practices outlined in this policy and recommend referral to a staff support service and/or domestic abuse specialist service.

14. References

Adoption and Children Act (2002)

Alhabib S, Nur U, Jones R (2010) Domestic violence against women: systematic review of prevalence studies. Journal of Family Violence 25: 369–82

Barter et al (2009) Partner exploitation and violence in teenage intimate relationships

Bates, Elisabeth, A; Graham – Kevan, Dr Nicola; Archer, John. 2013. Testing Predictions From the Male Control Theory of Men's Partner Violence. Aggressive Behaviour. Vol. 9999. Pp. 1 – 14.
Black Country Womens Aid 2019

British Crime Survey 2008/09 Table 3.07 (page 76)

Browne & Lim (2008) Count Me In Too. LGBT Lives in Brighton & Hove.
Department for Children, Schools and Families (2004) Every Child Matters: Change For Children

Department of Education (2018) Working together to Safeguard Children

Department of Health (2007) UK study of abuse and neglect of older people. Prevalence survey report.

Department of Health (2009) Learning Lessons from Serious Case Reviews 2009-2010

Domestic Violence, Crime and Victims Act (2004)

Feder G, Ramsay J, Dunne D et al. (2009) How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. Health Technology Assessment 13 (16)
Friedman, L.S., Samet, J.H., Roberts, M.S., Hudlin, M. and Hans, P. (1992) Inquiry about victimization experiences, a survey of patient preferences and doctor practices, Archives of Internal Medicine 152, 1186-1190.

Home Office (,2003,2004 +2011) British Crime Survey

Home Office (2011) Multi- Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

Home Office (2014) Multi agency Practice guidelines: Handling cases of Forced Marriage

Howard LM, Trevillion K, Khalifeh H et al. (2010) Domestic violence and severe psychiatric disorders: prevalence and interventions. Psychological Medicine 40: 881–93

http://www.mensadviceline.org.uk/mens_advice.php.html

http://www.safelives.org.uk/sites/default/files/resources/Dash%20with%20guidance%20FINAL.pdf

https://www.gov.uk/government/publications/strategy-to-end-violence-against-women-and-girls-2016-to-2020

Kissoon (2002) Prevalence and Patterns of Intimate Partner Violence Among Adolescent Mothers During the Postpartum Period

Kissoon et al (2002) Prevalence and Patterns of Intimate Partner Violence Among Adolescent Mothers During the Postpartum Period

Mark Brooks (2018) ManKind Initiative

Murphy, C.M., & Ting, L.A. (2010).Interventions for perpetrators of intimate partner violence: A review of efficacy research and recent trends. Partner Abuse, 1, 26-44.

Nicky Stanley, Pam Miller, Helen Richardson Foster and Gill Thomson NSPCC (2009)

Nicola Kennair and David Mellor (2007) Parent abuse: a review.

ONS BCS Focus on Violent Crime and Sexual Offences 2014/15 http://bit.ly/1p8CGl0 Table 4.28 on Appendix Table: http://bit.ly/1M1diC5

Radford, L. et al (2011) (Child abuse and neglect in the UK today.)

Responding to domestic abuse a resource or health professionals Department of Health (2017)

Schei B (1989) Interviewing women about sexual abuse - experience from a controlled study of women in abusive relationships. In Von Hall E and Everaerd W (eds) The Free Woman. Women's Health in the 1990s. Carnforth, Lancashire: Parthenon Publishing Group. pp. 726-33.

Walby S (2009) The cost of domestic violence: up-dates 2009 [online]. Available from www.lancs.ac.uk/fass/sociology/profiles/34/

Appendix 1 new dash 2019

Ending domestic abuse

SafeLives Dash risk checklist

Aim of the form

- To help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'- based violence.
- To decide which cases should be referred to Marac and what other support might be required. A completed form becomes an active record that can be referred to in future for case management.
- To offer a common tool to agencies that are part of the Marac[1] process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence.
- To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

How to use the form

Before completing the form for the first time we recommend that you read the full practice guidance and FAQs. These can be downloaded from the 'Resources for identifying the risk victims face' section on the SafeLives website. Risk is dynamic and can change very quickly. It is good practice to review the checklist after a new incident.

Recommended referral criteria to Marac

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

2. **'Visible High Risk':** the number of 'ticks' on this checklist. If you have ticked 14 or more 'yes' boxes the case would normally meet the Marac referral criteria.

3. **Potential Escalation:** the number of police callouts to the victim as a result of domestic violence in the past 12 months. This criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at Marac. It is common practice to start with 3 or more police callouts in a 12 month period but **this will need to be reviewed** depending on your local volume and your level of police reporting.

Please pay attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a Marac or in another way. **The responsibility for identifying your local referral threshold rests with your local Marac.**

What this form is not

This form will provide valuable information about the risks that children are living with, but it is not a full risk assessment for children. The presence of children increases the wider risks of domestic violence and step children are particularly at risk. If risk towards children is highlighted, you should consider what referral you need to make to obtain a full assessment of the children's situation.

[1] For further information about Marac please refer to the 10 principles of an effective Marac: http://www.safelives.org.uk/node/361

SafeLives Dash risk checklist for use by Idvas and other non-police agencies[2] for identification of risks when domestic abuse, 'honour'-based violence and/or stalking are disclosed

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

[2] Note: This checklist is consistent with the ACPO endorsed risk assessment model DASH 2009 for the police service.

Tick the box if the factor is present. Please use the comment box at the end of the form to expand on any answer.	YES	NO	DON'T KNOW	State source of info
15. Has [name of abuser(s)] ever attempted to strangle / choke / suffocate / drown you?	☐	☐	☐	
16. Does [name of abuser(s)] do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? If someone else, specify who.	☐	☐	☐	
17. Is there any other person who has threatened you or who you are afraid of? If yes, please specify whom and why. Consider extended family if HBV.	☐	☐	☐	
18. Do you know if [name of abuser(s)] has hurt anyone else? Consider HBV. Please specify whom, including the children, siblings or elderly relatives: Children ☐ Another family member ☐ Someone from a previous relationship ☐ Other (please specify) ☐	☐	☐	☐	
19. Has [name of abuser(s)] ever mistreated an animal or the family pet?	☐	☐	☐	
20. Are there any financial issues? For example, are you dependent on [name of abuser(s)] for money/have they recently lost their job/other financial issues?	☐	☐	☐	
21. Has [name of abuser(s)] had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? If yes, please specify which and give relevant details if known. Drugs ☐ Alcohol ☐ Mental health ☐				
22. Has [name of abuser(s)] ever threatened or attempted suicide?				
23. Has [name of abuser(s)] ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? You may wish to consider this in relation to an ex-partner of the perpetrator if relevant. Bail conditions ☐ Non Molestation/Occupation Order ☐ Child contact arrangements ☐ Forced Marriage Protection Order ☐ Other ☐				
24. Do you know if [name of abuser(s)] has ever been in trouble with the police or has a criminal history? If yes, please specify: Domestic abuse ☐ Sexual violence ☐ Other violence ☐ Other ☐	☐	☐	☐	
Total 'yes' responses				

For consideration by professional

Is there any other relevant information (from victim or professional) which may increase risk levels? Consider victim's situation in relation to disability, substance misuse, mental health issues, cultural / language barriers, 'honour'- based systems, geographic isolation and minimisation. Are they willing to engage with your service? Describe.	
Consider abuser's occupation / interests. Could this give them unique access to weapons? Describe.	
What are the victim's greatest priorities to address their safety?	

Do you believe that there are reasonable grounds for referring this case to Marac?		Yes ☐ No ☐	
If yes, have you made a referral?		Yes ☐ No ☐	
Signed		**Date**	
Do you believe that there are risks facing the children in the family?		Yes ☐ No ☐	
If yes, please confirm if you have made a referral to safeguard the children?	Yes ☐ No ☐	**Date referral made**	
Signed		**Date**	
Name			

Practitioner's notes

Appendix 2

MULTI AGENCY RISK ASSESSMENT CONFERENCE (MARAC)

A Multi Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety. In a single meeting, MARAC combines up to date risk information with a timely assessment of a victim's needs and links those directly to the provision of appropriate services for all those involved in a domestic abuse case: victim, children and perpetrator

Meetings are held every other week and bring together representatives from both statutory and voluntary agencies with the aim of sharing information and developing a safety plan for victims and their families with a view to reducing the risks and the likelihood of repeat victimisation.

The victim does not attend the meetings but is represented by an Independent Domestic Violence Advisor (IDVA) who speaks on their behalf. Ideally the victims consent to be referred/discussed at MARAC should be obtained but they can be discussed without their consent if the professionals involved have sufficient concern.

MARAC meetings are chaired by West Midlands Police. Attendees include specialist domestic violence police officers, IDVA, mental health, Probation Trust, Children and Young Adults Department, Adult Care department, /Dudley Community Health Services, Housing Officers, voluntary domestic abuse support services and other professionals presenting cases that fit the criteria.

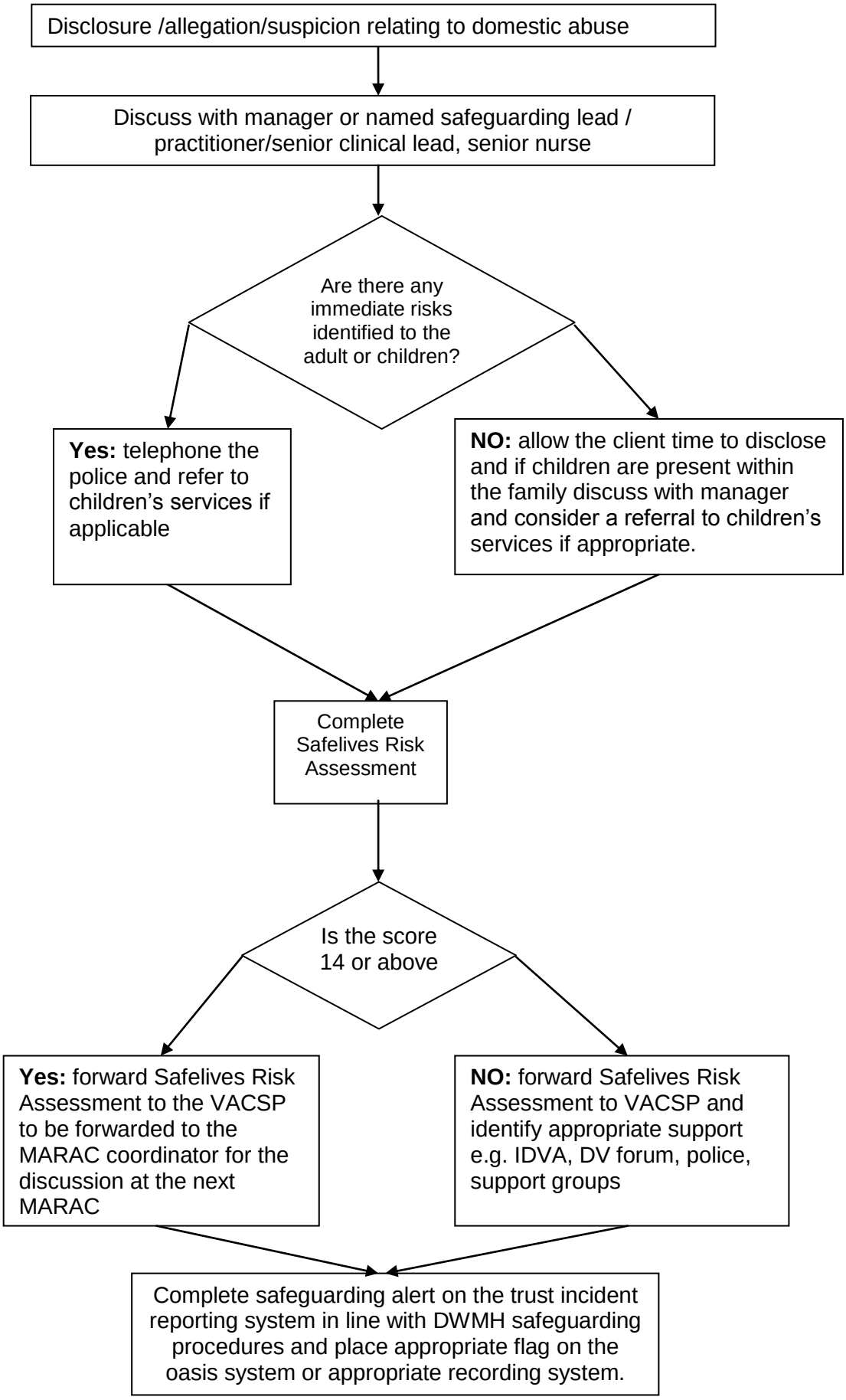
A multi-agency response is essential in ensuring that victims and their families are as safe as possible. Each agency working with a client holds a piece of the jigsaw and only by communicating with one another and working together can the best outcome for the victim be achieved.

Action plans resulting from the MARAC are shared with the relevant services for their information and action including GPs.

MARAC Referral Process

- Identify – Agencies should have processes in place to identify victims of domestic abuse.
- Risk Assess – Once identified as suffering domestic abuse, the Safelives Risk Identification Checklist (RIC) should be used to establish if the victim is at high risk of harm (Appendix 1).
- Carry out immediate safety measures for victim, children and perpetrator.
- Referral – If high risk (score of 14+ on safelives) then consult with your DWMH VACSP
- Research – All agencies receive MARAC meeting agenda from MARAC Co-ordinator and research all cases on the agenda.
- Meeting & Information Sharing – A MARAC representative will present information at the meeting on their agency's referrals as well as information relating to other cases in which their agency has been involved.

- Identify risks for the victim, children, perpetrator and agency staff.
- Action Planning – Necessary actions are identified & allocated to the appropriate agency
- Follow Up – Inform colleagues of actions and complete in time agreed.
- Keep MARAC coordinator informed of relevant information.
- IDVA service keeps victim informed of plan where safe to do so.
- MARAC coordinator liaises with agencies to coordinate & monitor the action plan.


Disclosure /allegation/suspicion relating to domestic abuse
Discuss with manager or named safeguarding lead / practitioner/senior clinical lead, senior nurse
Are there any immediate risks identified to the adult or children?
Yes: telephone the police and refer to children's services if applicable
NO: allow the client time to disclose and if children are present within the family discuss with manager and consider a referral to children's services if appropriate.
Complete Safelives Risk Assessment
Is the score 14 or above
Yes: forward Safelives Risk Assessment to the VACSP to be forwarded to the MARAC coordinator for the discussion at the next MARAC
NO: forward Safelives Risk Assessment to VACSP and identify appropriate support e.g. IDVA, DV forum, police, support groups
Complete safeguarding alert on the trust incident reporting system in line with DWMH safeguarding procedures and place appropriate flag on the oasis system or appropriate recording system.

Appendix 4


PHYSICAL
VIOLENCE
SEXUAL
USING COERCION AND THREATS
Making and/or carrying out threats to do something to hurt her • threatening to leave her, to commit suicide, to report her to welfare • making her drop charges • making her do illegal things.
USING INTIMIDATION
Making her afraid by using looks, actions, gestures • smashing things • destroying her property • abusing pets • displaying weapons.
USING ECONOMIC ABUSE
Preventing her from getting or keeping a job • making her ask for money • giving her an allowance • taking her money • not letting her know about or have access to family income.
USING EMOTIONAL ABUSE
Putting her down • making her feel bad about herself • calling her names • making her think she's crazy • playing mind games • humiliating her • making her feel guilty.
POWER AND CONTROL
USING MALE PRIVILEGE
Treating her like a servant • making all the big decisions • acting like the "master of the castle" • being the one to define men's and women's roles
USING ISOLATION
Controlling what she does, who she sees and talks to, what she reads, where she goes • limiting her outside involvement • using jealousy to justify actions.
USING CHILDREN
Making her feel guilty about the children • using the children to relay messages • using visitation to harass her • threatening to take the children away.
MINIMIZING, DENYING AND BLAMING
Making light of the abuse and not taking her concerns about it seriously • saying the abuse didn't happen • shifting responsibility for abusive behavior • saying she caused it.
PHYSICAL
VIOLENCE
SEXUAL

Appendix 5

Definition and Further Information and Advice

Domestic abuse means an incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse by a partner, ex-partner or family member. It is based on one person having power or control over another, and it often gets worse over time. (Black Country Women's Aid 2019)

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

- Psychological
- Physical
- Sexual
- Financial
- Emotional

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

Domestic abuse is appalling in its toll on the people and families affected. More than 2 million people over 16 years old in England and Wales suffer domestic abuse in some form every year. That is 1 in 4 women and 1 in 6 men. (Responding to domestic abuse a resource for health professionals Department of Health (2017))

15% of men and 26% of women and aged 16 to 59 had experienced some form of domestic abuse since the age of 16, equivalent to an estimated 2.4 million male victims and 4.3 million female. For every three victims of domestic abuse, two will be female, one will be male. One in four women and one in six to seven men suffer from domestic abuse in their lifetime. (Mark Brooks, ManKind Initiative March 2018)

Health practitioners are in a key position to identify domestic abuse and to initiate support and safety for victims. A study of 2,500 women accessing domestic abuse services, showed that prior to receiving specialist help, just under half had attended a GP an average of 5.3 times and one in five had

attended A&E as a result of the abuse. (Safe Lives. Insights into Domestic Abuse (1). A Place of Greater Safety 2012)

A conservative estimate suggests that one in four women and one in six men will be a victim of domestic abuse in their lifetime (Home Office, 2003) and that 1 in 9 women presenting to health services at any one time will be currently living with abuse.

A study based on reports to police (taking account of context and consequences, and reflecting the view that domestic violence is a pattern of behaviour over time) found that only 5% of cases involved female perpetrators in heterosexual relationships.6

- Women and girls are more likely to experience repeated physical violence, a greater severity of violence, increased sexual violence, higher levels of coercive control and greater fear of their partners (Responding to domestic abuse a resource for health professionals Department of Health (2017))

Possible indicators of domestic abuse in adults

There are a whole range of indicators to warn health professionals that a patient may be experiencing domestic abuse. Some of these are quite subtle and it is important that professionals remain alert to the potential signs and respond appropriately often the indicators of Domestic Abuse will mirror the symptoms of mental illhealth such as low mood, anxiety, poor self care. Some victims also drop hints in their interactions with health and care staff and their behaviours may also be telling. They rely on staff to listen, persist and enquire about signs and cues. They need staff to follow up conversations in private, record details of behaviours, feelings and injuries seen and reported, and support them to take action suitable for their organisation's systems and local pathways. Where the patient is an adult with mental capacity issues action is taken in line with their preferences and consent.

All health practitioners, whether working in emergency, acute, primary care or community health, have a professional responsibility, if you identify signs of domestic abuse or if things are not adding up, to ask patients alone and in private, whether old or young about their experience of domestic or other abuse, sensitively. Routine enquiry into domestic violence and abuse is Department of Health policy in maternity and adult mental health services (Responding to domestic abuse a resource or health professionals Department of Health 2017).

The following are potential indicators of domestic abuse which may trigger the need for selective enquiry:

- Frequent appointments for vague symptoms
- Frequent missed appointments
- Injuries inconsistent with explanation of cause
- Patient tries to hide injuries or minimise their extent
- Partner is aggressive or dominant, talks for the patient or refuses to leave the room when asked

- Partner always accompanies patient for no apparent reason
- Patient is submissive and/or reluctant to speak in front of partner; they appear frightened, overly anxious or depressed
- Patient presents with unexplained bruises, whiplash injuries consistent with shaking, areas of erythema consistent with slap injuries, lacerations, burns or multiple injuries at different stages of healing
- Injuries to the breast or abdomen
- Injuries to face, head or neck- common injuries include perforated eardrums, detached retinas
- Recurring sexually transmitted infections or urinary tract infections
- Evidence of sexual abuse
- Hair loss- consistent with hair pulling
- Presentation with alcohol and/or substance abuse, depression, anxiety, self-harm, eating disorders or psychosomatic symptoms
- Obsessive compulsive disorder
- History of behaviour problems or unexplained injuries or abuse affecting children
- Suicide attempts
- History of repeat miscarriages, terminations, still births or pre-term labour
- Poor contraceptive use
- Poor or non-attendance at antenatal clinics
- Non-compliance with treatment
- Early self-discharge from hospital
- Substantial delay between time of injury and presentation for treatment
- Review of medical record reveals that patient has presented with repeated ‘accidental’ injuries

Recognition of domestic abuse in children

Whilst a child will respond differently to the abuse they have witnessed or experienced depending on their age, their personal resilience and support mechanisms, there is evidence that children suffer long term damage through living in a household where domestic abuse is taking place even though they themselves may not be directly harmed. Their emotional, physical and psychological development may be impaired.

Living in a home where there’s domestic abuse is harmful. It can have a serious impact on a child's behavior and wellbeing. Parents or carers may underestimate the effects of the abuse on their children because they don’t see what’s happening. Children witnessing domestic abuse is recognised as 'significant harm' in law. Domestic abuse can also be a sign that children are suffering another type of abuse or neglect (Stanley, 2011). The effects can last into adulthood. But, once they're in a safer and more stable environment, most children are able to move on from the effects of witnessing domestic abuse.

Male victims of domestic abuse

1 in 6 men will experience domestic abuse at some stage in their lives. Abuse experienced by men is in many cases the same as that experienced by women.

To many, the idea of a grown man being frightened or vulnerable is a taboo, the idea of a man – usually physically the stronger – of being battered, ludicrous. Hence many male victims of abuse may feel "less of a man" for suffering abuse, feel as though they are in some way not manly enough and ought to have the ability to prevent the abuse.

Men don't leave abusive relationships for various reasons – the top reasons being: concern about the children (89%), marriage for life (81%), love (71%), the fear of never seeing their children again (68%), a belief she will change (56%), not enough money (53%), nowhere to go (52%), embarrassment (52%), not wanting to take kids away from their mother (46%), threats that she will kill herself (28%) and fears she will kill him (24%). (Bates, Elisabeth, A; Graham – Kevan, Dr Nicola; Archer, John. 2013. Testing Predictions From the Male Control Theory of Men's Partner Violence. Aggressive Behaviour. Vol. 9999. Pp. 1 – 14).

Male victims (39%) are over three times as likely as women (12%) not to tell anyone about the partner abuse they are suffering from (ONS BCS Focus on Violent Crime and Sexual Offences 2014/15 http://bit.ly/1p8CGl0 Table 4.28 on Appendix Table: http://bit.ly/1M1diC5)

The percentage of gay or bi-sexual men (6.2%) who suffered partner abuse in 2008/09 is nearly double the number for heterosexual men (3.3%) (British Crime Survey 2008/09 Table 3.07 page 76).

Should a man disclose that he has been a victim of abuse from his partner or a family member it is important to acknowledge that disclosure and offer assistance in finding help and support for him.

His pain is real and it will have taken a great deal of courage to disclose this information. Be aware that domestic abuse knows no boundaries and the male disclosing will need help and advice from specially trained workers who can deal with issues of male domestic abuse. He will be fearful of the repercussions of his disclosure and may not take up the offer of help immediately.

Assessment and Asking Appropriate Questions

You need to ask the service user for more information to help you to assess the situation and gather as much information as possible. Evidence suggests that people who are being subjected to violence want to be asked, and that people who have not experienced abuse do not mind being asked (Friedman

et al., 1992). It is important to ask direct questions in a gentle, non-threatening manner (Schei, 1989). A suggested opening for selective enquiries might be:

“I am sorry if someone has already asked you about this , and I don’t wish to cause you any offence, but we know that throughout the country 1 in 4 women and 1 in 6 men experience domestic abuse at home and sometime in their life. I noticed that you have a number of bruises/cuts/burns (whatever) - it is routine for health care staff to ask about domestic abuse in these situations.”

further suggested questions.

- You seem very anxious and nervous. Is everything alright at home?
- Does your partner get jealous of you seeing friends, talking to other people or of you going out? If so, what happens?
- You seem frightened of your partner. Has he/she ever hurt you?
- When I see injuries like this I wonder if someone could have hurt you.
- Has your partner or anyone else at home, threatened or hurt you?
- You mention your partner loses his/her temper with the children. What happens when they lose their temper? Does he/she ever lose their temper with you?
- Have you ever been in a relationship where you have been hit, punched, kicked or hurt in any way? Are you in such a relationship now?
- You mentioned your partner uses drugs/alcohol. How does he/she act when drinking or on drugs?
- 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 he/she feels guilty. Was he/she responsible for your injuries?
- Would you like support?
- Are you ever worried about your children’s safety?

Please see flow chart and DASH Risk Assessment for further information (appendices 1 & 3)