



**Parsons Green Walk in Centre**

**Central London Community Health**

**Domestic violence routine enquiry protocol**

**Registered Office:**

Room 44D  
The Polish Centre  
238-246 King Street  
London W6 0RF

**Telephone:**

020 8748 5717

**Fax:**

020 8748 5921

**E-mail:**

[admin@standingtogether.org.uk](mailto:admin@standingtogether.org.uk)

**Website:**

[www.standingtogether.org.uk](http://www.standingtogether.org.uk)

**Charity number:** 1088844

## Domestic Violence routine enquiry Protocol

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## Introduction

This protocol applies to Parsons Green Walk in Centre.

Routine enquiry is the questioning of all patients over the age of 16, regardless of their presenting symptoms, if they have experienced or are currently experiencing domestic violence.

Parsons Green WIC believe that all people are entitled to the right to live free from violence or threat of violence from current or former partners. As healthcare professionals may be the first professionals to whom an abused person turns to for help, medical staff have an opportunity and responsibility to provide appropriate, sensitive and safe interventions. Parsons Green WIC and Standing Together against Domestic Violence are both committed to developing and implementing policies and procedures for identifying, treating and referring victims of domestic violence.

Staff are required to follow the main principles behind routine enquiry. In order to promote and work towards the goal of routine enquiry, staff will be required to document why enquiry about domestic violence may not have been made, the patient's response and any subsequent action taken.

Screening should be conducted in the clinical room. This is a safe and confidential area where patients can be asked about DV.

### Reason for screening patients

- To effectively treat all injuries and illnesses.
- To provide and communicate a safe environment for the patient.
- To identify domestic violence through routine enquiry and through recognition of possible indicators of abuse.
- To offer specialist advice, support, and safety planning through ADVANCE.
- To document correctly and thoroughly.
- To provide referral information during the healthcare contact.

### Definitions of domestic violence

The agreed definition of domestic violence (England and Wales) is the Home Office definition which has been adopted by the Department of Health, the Local Safeguarding Children Board and the London Safeguarding Children Board:

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

An adult is any person aged 18 years and over, and family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family. The definition is supported by an explanatory text that makes it clear that domestic violence includes female genital mutilation, forced marriage and so-called honour based violence.

### Background

Domestic violence is experienced by 1 in 4 women, and in H&F accounted for 10% of all reported crime in 2008/9. On average, 2 women a week are killed by a violent partner or ex-partner.

Current research and the experiences of a wide range of agencies indicate that overwhelmingly it is women who experience abuse and almost always, it is the male partners or ex-partners who are the perpetrators. Other forms of abuse include LGBT domestic violence, domestic violence towards older people, inter-familial domestic violence, female to male domestic violence and domestic violence between young people. Further information on these topics can be found in appendix 4.

The term "victim" is often perceived as negative and so this protocol refers to those who experience domestic violence as "survivors" as they are often surviving the abuse on a daily basis. It is important to note that the definition of domestic violence clearly describes more than physical violence, and for this reason the words violence and abuse are generally used interchangeably in this protocol. In the questions the word abuse is specifically used to open up the discussion. It is common to feel scared and concerned

about the behaviour of someone without identifying it as domestic violence. The word abuse opens up the discussion and allows people to disclose more easily.

People may experience domestic violence regardless of ethnicity, religion, class, age, sexuality, disability or lifestyle. It is estimated to cost the NHS £1.7bn a year and can affect mental health, physical health, substance misuse and the wellbeing of children involved. Simply put; by knowing which of your patients are experiencing domestic violence, you can treat them more effectively, more cost-effectively and more safely.

## Safeguarding and Confidentiality

### **Child Protection and Vulnerable Adults**

In all circumstances, the safety of children is your priority. If you have any concerns about the safety of a child, please refer to your child protection policies. **This protocol is not intended to replace your safeguarding policies but to be used in addition. You must always follow your Child Protection and Vulnerable Adults procedures.**

“Seeing or hearing the ill-treatment of another” is considered significant harm under the Adoption and Children Act 2002 and in 40 – 70% of families where a woman are being abused, the child/ren are also being directly abused. The link between domestic violence and child abuse and neglect should be known by everyone working in health. The Care Quality Commission (CQC) expects that Child Protection policies include a process for ensuring all adults are asked about dependants such as children or about any caring responsibilities. If you receive a disclosure from a woman who is pregnant or has a child under 12 months old you should automatically refer them to the Contact and Assessment (CAS) team. For women with children older than this, referrals depend on professional judgement and making an assessment of risk. If in doubt, always err on the side of caution.

Similarly, if you have concerns or suspicions regarding the safety of someone who is a vulnerable adult, you must immediately refer to your safeguarding procedures and make a safeguarding alert within 24 hours. It is the responsibility of all professionals to report abuse of vulnerable adults. The response from Adult Social Care will be sensitive and proportionate to the seriousness and risk.

If you do need to make a referral to CAS you should always seek the consent of the non-abusing parent, unless this would put the child at further risk. Remember that the blame for the abuse lies with the abuser, not with their victims.

### **Criminal Justice System**

Physical violence and threats are a criminal offence and a person experiencing domestic violence may choose to seek relief through the criminal justice system as well as civil remedies such as injunctions and non-molestation orders. You should only ever report past adult abuse to the police with the abused person's knowledge and consent unless that person is classified as a vulnerable adult.

The abused person is generally better placed to assess the risk posed to themselves, but if you have concerns about risk posed to children or vulnerable adults you must act on those concerns.

### **Confidentiality**

It is extremely important that interviews regarding domestic violence are conducted in private. Domestic violence should not be discussed if there is someone else in the room, even if that is a friend, a family member or a child (unless they are an infant).

There are legal restrictions in place around the sharing of information, but the law does not prevent you from sharing information with other practitioners if the public interest in a child or vulnerable adult's welfare overrides the need to keep information confidential.

You cannot promise confidentiality as an absolute because the safety children and vulnerable adults must be your priority. Information can only be passed on if you're making a referral to Children's Services, Adults Social Care, MARAC, or if you have the express permission of the patient.

## Questioning Procedure

Staff are encouraged to remember that success is asking the patient about domestic violence in a safe way no matter what the response or what help is accepted by the patient. This sends a strong message to the patient that domestic violence is a serious issue. Just asking the question may change the patient's thinking about what is happening to them. It also sends the message that there is help available. The patient may not accept help on the day but may ask for help in the future.

### **Conduct initial screening for domestic violence in the clinical room**

#### **Who to ask about domestic violence?**

- The question on domestic violence is a mandatory question on the Adastra system. Female + male patients above the age of 16 should be screened regardless of their presenting medical complaint.
- Staff will be asked to record why the patient has not been asked about domestic violence. This is to help promote the practice of routine domestic violence enquiry.
- Staff should follow a "common sense" approach regarding how often to ask "frequent visitors". The nurse does not have to ask a patient seen and screened the day before but is encouraged to ask a patient if they have come in with a new problem.

#### **Assurance of Privacy and Confidentiality**

The nurse should speak to the patient in the clinical room in private. The nurse will:

- Ensure that any visitors (including visitors of the same sex) are asked to leave and told that this is a routine policy.
- If unable to speak to the patient alone, the nurse should make additional attempts to assess privately. This may be to interview the patient in another private area.

**Do not** ask a patient about domestic violence if:

- The patient is accompanied by another adult (even if they are the same sex)
- The patient is accompanied by children (unless the child is an infant)

***If staff are unable to ask about domestic violence the reason why must be recorded in the Patients notes***

#### **How to ask about domestic violence**

Overleaf are some examples of questions staff should use to ask about domestic violence.

- Enquiry should begin by framing the question so that the patient understands that this is a routine question asked of every patient and that their confidentiality is assured. The staff member should make it clear that they would need to pass any safeguarding concerns on to the appropriate agency.
- A direct question should follow. Studies show that people will disclose more often if asked directly. Remember if medical staff are not able to speak directly about this issue, then neither will the patient.
- If the patient requires an interpreter, call Language Line. NEVER use the patient's children or friends to interpret information about abuse. Be aware when using an interpreter that the definition of abuse may change according to the language. Try to be as clear as possible with the interpreter about what you mean. STADV has produced best practice around the use of interpreters which can be found in appendix 11.
- Use gender-neutral terms such as "partner" instead of "girlfriend" or "boyfriend," "husband" or "wife."

### **Examples of framing the question:**

- You may have seen our posters and leaflets outside. We are asking all patients about violence in the home.
- In addition to your health concerns, we are also asking patients about the possibility of abuse within the home.
- As domestic violence in the home is so common we now ask patients about it routinely.

### **Then state:**

Please be assured that whatever you say will be kept confidential, unless there is a concern about a child or vulnerable adult. If I have a concern I need to talk to another professional and this might result in a referral to children's services or adult social care.

### **Examples of asking a direct question:**

- Do you ever feel frightened of your partner or a family member? Do you feel that you are in danger?
- Have you been physically hurt by your partner or a family member? Has a partner or a family member ever threatened to hurt you or someone you care about?
- Does your partner or a family member ever say or do anything that makes you feel afraid?
- Do you feel controlled and isolated by your partner? Does your partner or a family member make you insult you or make you feel small?
- For a more direct question: "Your injuries may have been caused by abuse within the home. Is this something you are experiencing? Help is available."

### **What to do if domestic violence is disclosed**

- Mark "Domestic Violence" as mechanism of injury on the medical notes.
- Ask, "Are you safe now?" Find out if the abuser is with the patient. If the abusive partner is in the clinic, observe for risk and ensure that the patient does not leave before being seen. Offer a private place to wait if possible.
- If you receive a disclosure from a woman who is pregnant or has a child under 12 months old you should automatically refer them to the Contact and Assessment (CAS) team. For women with children older than this, referrals depend on professional judgement and making an assessment of risk. If in doubt, always err on the side of caution. If any children are with the abuser, the patient may be concerned about their welfare and leave before being treated. Refer to child protection policy if concerns are raised.
- Offer a referral to ADVANCE (see appendix 1 for further information)
- Do not ask the patient to return to the waiting area (even if the injury is minor) as they may leave before she is seen and/or the perpetrator may attend and place them in danger.
- Ensure you record that the patient has been asked about DV and subsequent action in the patient notes
- Take special care at your hand-over during the shift change to introduce the new Contact Nurse to the patient and to fully brief the Contact Nurse on safety concerns and plan of action.
-

## **Respond to the patient**

- Let the patient know that they will have the opportunity to speak with someone in private and that they will not be asked to do anything that they do not want to do but that specialist domestic violence support is available for them.
- Let them know that abuse is something that you are concerned about and it can impact on their health. Explain that this is why you would like to offer some help and/or some information.

## **If the patient does not identify as being abused**

Think through the possible indicators of abuse and ask again if you feel there may be cause for concern. If the patient denies abuse but suspicion still exists:

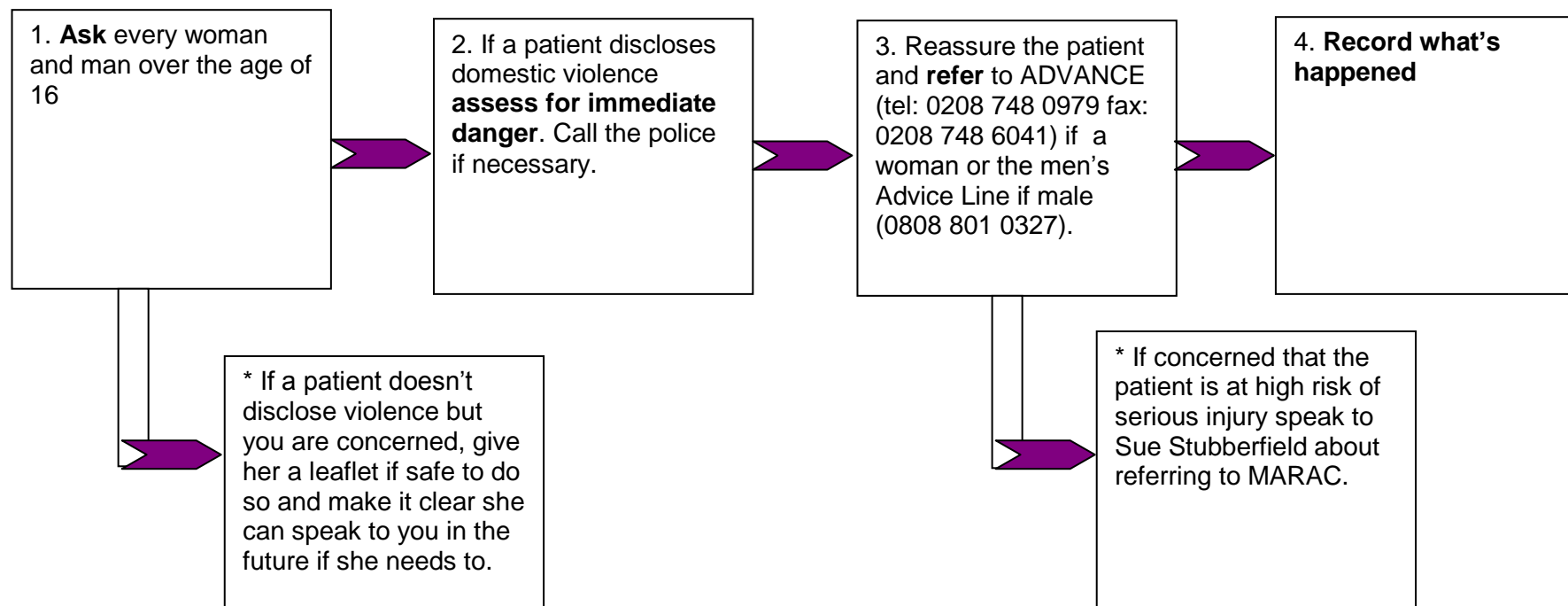
- Offer a resource “palm” card or leaflet
- Record that the patient has been asked about domestic violence in the patients notes
- If abuse is identified, refer to the process as set out in this protocol.

## **Nurses’ role in documenting DV related injuries**

If the patient consents to having any injuries documented as domestic violence related:

- Explain that you will fill in the Domestic Partner Violence Assessment Proforma and that it will be stored confidentially in their medical file/notes.
- Explain that this may be useful in the future e.g. for future use in court or when applying for emergency housing.
- Fill in the domestic violence Assessment Proforma with as much detail as much as possible and leave for the Doctor to finish and sign.
- Ensure that the patient file is kept in an area where the abuser does not have access to it.

## Clinical Questioning Flowchart



You must always adhere to your child protection policies and if you receive a disclosure from an adult with a child under the age of 12 months (including unborn children) you have a statutory obligation to refer to Children's services. If you receive a referral from an adult who has a child older than this you **must** consult with your safeguarding team with regards to referrals.

CONTACT AND ASSESSMENT – 020 8753 5392 or 0208 748 9787 (emergency out of hours)  
Duty social work team tel: no 020 8753 5392 / 5536

An adapted referral form for instances where domestic violence is the referral reasons can be found at the end of this protocol.

## **Detailed Recording information:**

Medical evidence can be instrumental in getting a conviction by the police. H&F police are members of the Domestic Violence Partnership and should be able to provide a helpful and supportive service to a survivor. Do not report an injury to the police without the survivor's permission. Only they are able to assess how safe it is to report their situation to the police.

If an adult has an injury that you know to be, or suspect to be, as a result of domestic violence, there are several things you can do to help support any future investigation around the injury. Police are happy to accept evidence from any medically trained staff member (doctor, nurse, health visitor etc).

### **In the patient's medical notes record the following:**

#### **Lacerations**

The measured size of the laceration as well as the depth if possible.

#### **Bruises**

The measured size, the colour and shape of bruises

#### **Treatment**

Note the treatment needed for the injury

## **Photographs**

The police prefer that photographs of injuries are taken either by a police doctor or by the survivor to help maintain consistency of evidence. If a survivor wants to photograph advise them to take two clear images of the injury, one close up and one showing the whole body. If the survivor is giving the police a printed image they need to sign and date the image. An original copy of the photograph should be kept by the survivor.

## **Other information**

Domestic violence resource information folders to assist staff have also been provided. One folder is located in each of the Clinical rooms. These folders contain domestic violence information, good practice information and protocol resource materials. A flow chart has been devised to assist staff in following the screening protocol. The flow chart is included in DV resource information folders.

## Appendix 1

### **ADVANCE Advocacy Service**

Inform the patient that an advocate from ADVANCE can be reached (provide them with an information leaflet) and explain that the advocate is someone who can inform them of their rights and options and the advocate will not force them to do anything that they do not want to do. ***It is important that the help available is clearly explained to the patient – use the leaflet to help you with this if you are unsure.***

#### **Referral Guidelines**

The ADVANCE number and on call rota are located in the yellow domestic violence file  
The leaflets on domestic violence are located in each clinical room

#### **If the patient agrees to speak with an ADVANCE advocate, staff can offer the following:**

- The nurse can allow the patient to speak with the Advocate over the phone for an initial contact. This is available 24 hours a day, 7 days a week. Phones are not answered between 13:00 and 14:00 but please leave message and ADVANCE will respond after lunch. **Do not use the on-call number during office hours and do not give the patient the on-call number.**
- The nurse can pass along basic details to ADVANCE so that they can call the patient later on. The details needed would be the patient's name, contact numbers, and when it is safe to call the patient.
- The nurse can give the ADVANCE office number to the patient along with a leaflet (if it is safe for her to take it) and leave it up to the patient to call ADVANCE at a time most convenient for her. Do not give a patient the on-call number of any of the advocates.
- Make clear to the patient that the Advocate will not see his/her medical file or notes
- If you receive an answering phone message at ADVANCE during office hours, please leave them a detailed message.

#### **Staff advice and support available from ADVANCE**

- The nurse can also contact ADVANCE for confidential advice if so required

#### **If the patient has indicated abuse but does not want to speak with an ADVANCE advocate**

- The nurse should express concern for the patient's safety and indicate that there is help available if they would ever need it.
- Offer written materials to the patient. Offer a specific leaflet on domestic violence if it is safe for them to take it.
- Do not offer advice/information leaflets if the abuser is present.
- Remember it may not be safe for her to take away written information.
- The nurse can also contact ADVANCE for advice if so required.

Appendix 2

CONFIDENTIAL – KEEP WITH MEDICAL NOTES

**DOMESTIC PARTNER VIOLENCE ASSESSMENT PROFORMA.**

Nurse to complete this side of proforma.

*This form should be completed to document domestic violence related injuries. The completed form is to be attached to the clinical record. Patient consent must be obtained before completing the form. This form can be used by the patient (now or in the future) to assist them obtain a civil injunction, occupation order, access emergency Local Authority accommodation or to pursue a criminal case. It is also used to assist the completion of a medical statement.*

**PATIENT INFORMATION**

Date of examination	
Name of patient	
DOB	
Patient number	
Is the patient pregnant? If yes note how many weeks.	

How did the injuries occur? If patient was assaulted what is the patient's description of what happened? e.g. struck with fists, object used, kicked, slapped. Use the patient's own words where possible:

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Any other relevant information:

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Signature of nurse completing Proforma: \_\_\_\_\_

Name and grade of nurse completing proforma (please print)

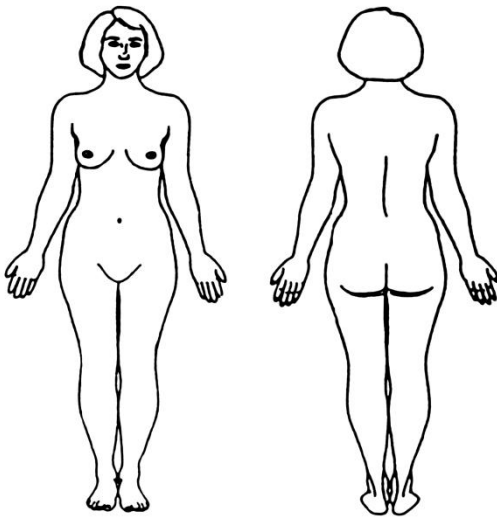
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**Please turn over**

**DOCTORS TO FILL IN THIS SECTION**

Indicate where injury was observed:

Examination Notes:



Injury	Location on the body	Other notes/observations
Bruising		
Swelling		
Redness		
Bleeding		
Soft tissue tenderness		
Bone tenderness		
Wounds		
Other marks : bites, scratches, burns (specify)		

Continue on a separate sheet if needed.

Treatment given:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Doctor completing proforma: \_\_\_\_\_

Name of Doctor completing proforma (please print) \_\_\_\_\_

*Provide patient with a copy of the form if requested for their own records.*

## Appendix 3

### **Possible indicators of domestic violence**

#### **Possible presenting complaints**

- Complains of abuse directly
- "Falls"
- "Stranger" assault
- Chronic pain syndrome, headaches
- Overdose/ suicide attempts or ideation
- Anxiety, depression, multiple somatic complaints
- Miscarriage/vague gynaecological complaints (e.g. pelvic pain)
- Psychosomatic complaints

#### **Possible indicators of abuse from patient's history**

- Mechanisms described by patient do not fit injury
- Delay in seeking care
- "Accident prone" patient
- History of children being abused
- High stress in family (financial worries, pregnancy, relocation, change or loss of job, bereavement)
- Frequent Walk-in Centre visits
- Drug/alcoholism

#### **Possible behavioral indicators of abuse**

- Patient evasive/guarded
- Patient embarrassed with poor eye contact
- Patient depressed with injuries
- Patient denies abuse too strongly
- Patient has charged/fearful behaviour with partner
- Patient defers to partner
- Patient minimises injury or demonstrates inappropriate responses

#### **High risk injuries**

- Mid-arm injuries (defensive)
- Strangulation marks
- Injuries to areas not prone to injury by falls
- Weapon injuries or marks
- Symmetrical injuries
- Old, as well as new injuries
- Bites and burns (scald and cigarette)
- Injuries to multiple sites
- Poor nutrition

#### **Common injuries**

- Black eyes
- Dental injuries
- Mid face injuries
- Breast/ abdominal injuries
- Injuries hidden by clothing
- Internal injuries

## Appendix 4

### Information about domestic partner violence

#### Domestic violence is:

- A pattern of violent and coercive tactics
- A pattern of controlling behaviour
- A learned pattern of behaviour
- Destructive to all those around the adult and child survivor.

#### Domestic violence perpetrators:

- Seek complete control of the thoughts, beliefs and conduct of their partner
- Punish their partner for resisting their control.

#### What causes domestic violence?

- Domestic violence is caused by a need to have power and control over an intimate partner or family member
- It is embedded in our social customs and institutions
- Domestic violence is learned through observation, experience and reinforcement, culture, family, and the community.

#### Domestic violence is NOT caused by:

- Illness\*
- Alcohol or other drugs\*
- Anger
- Stress
- The survivor's behaviour

- 
- There are examples of illness and use of drugs such as steroids, speed, cocaine or cocaine derivatives that produce general violent behaviours. However, these circumstances create a situation where one is generally violent and not usually concentrating violent acts towards one person.

### Additional Forms of Abuse

#### LGBT domestic violence

LGBT (lesbian, gay, bisexual and transgendered) people experience the same types of domestic abuse (emotional, physical, financial and sexual) as non LGBT people. LGBT people can experience abuse from a partner, ex partner or family member, and the abuse can be within a same sex relationship or in a heterosexual relationship.

LGBT people may experience different risks due to their sexuality and/or gender identity and as a result of people's response to their identity (i.e. homophobia, or transphobia). It is important to be aware that a person's sexual or gender identity could be a factor in other forms of violence (e.g. forced marriage or so-called honour based violence).

#### Female to male domestic violence

It is more common for female to male domestic violence to be joint or retaliatory but this is not always the case. It has also been found that female to male violence tends to have less serious incidents and have fewer long term consequences. However, violence within any relationship should be dealt with appropriately and men experiencing domestic violence should be referred to ADVANCE who will signpost them to appropriate services.

#### Young People

The protocol advocates asking adults about domestic violence but there might be an increase in disclosures from people under the age of 18 because of the posters in the waiting room. In this circumstance, you must immediately refer to child protection guidelines and refer to children's services if you are concerned.

Research has shown that young people feel that their experiences of domestic violence tends to be treated less seriously and with less respect than the experience of older adults. Issues particular to this age group might include difficulties with avoiding a partner/ex-partner that they may still go to college with, lack of means to move away from a violent family member or a lack of peer condemnation about the abuse.

The definition of domestic violence does not cover young people under the age of 18, but MARAC will accept high risk cases for survivors of 16 years and above. ADVANCE will also accept referrals for survivors of 16 and above.

#### Culturally specific issues

As well as being key safeguarding issues, these issues are relevant for family violence. Female Genital Mutilation (FGM), so-called honour based violence and forced marriage are all covered by the definition of domestic violence used by the Department of Health. These issues can be further complicated by English as a second language so it is important to be aware of best practice around the use of interpreters. Standing Together has produced information on best practice around the use of interpreters<sup>1</sup>. Culturally specific issues tend to be linked to wider community attitudes and cultural norms so can incur strong disapproval when spoken out against.

#### FGM

Female genital mutilation (FGM) is defined by the World Health Organisation (WHO) as "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs

<sup>1</sup> [www.standingtogether.org.uk](http://www.standingtogether.org.uk)

for non-medical reasons". FGM is generally performed before a woman reaches the age of 15, so is generally a Child Protection issue. However, it is possible that FGM would be discovered by a health practitioner once the woman reaches adulthood. It has significant health impacts and can lead to infections, difficulties urinating and problems with childbirth. All forms of FGM are illegal to perform and illegal to arrange (either in the UK or abroad). If a woman over the age of 18 discloses their own FGM, you should be alert to any possible risk to younger female children. A female child is considered at risk of FGM if their mother or sister has been subjected to it. If a child under the age of 18 discloses that they have been subjected to or might be subjected to FGM, you must follow Child Protection procedures and refer to children's services.

### **So-called honour based violence**

Similarly, so-called honour based violence can affect children and adults. This form of abuse is bound up in cultural traditions relating to notions of family shame. Violence can be meted out to survivors for what can seem to outsiders to be relatively minor infringements of social norms. The London Met has reported a huge rise in recorded incidents of honour based violence in 2009, with a particular increase for men (though they are still a minority, at 15% of recorded cases)

### **Forced Marriage**

There is a huge difference between an arranged marriage and a forced marriage. As with all elements of domestic violence, the key issue is one of choice for the person/people involved. Victims can be coerced into marriage through violence, threats, manipulation or trickery. Forced marriage can also be linked to so-called honour based violence.

### **Disabilities**

Physically disabled women are approximately twice as likely to experience domestic violence as non-disabled women. In situations where the person's family member, partner or ex-partner is their carer they can be particularly vulnerable to domestic violence. Examples of abuse within relationships where one person is disabled can include denial of medication, the carer taking control of benefit or wages, or the denial of equipment (e.g. wheelchair, hearing aid, mobile phone) necessary for communication. If a survivor has a history of mental health issues, an abuser might use this to manipulate healthcare staff into disbelieving a survivor.

### **Inter-familial Violence**

There is an increased awareness of the issue of inter-familial violence, which can include abuse of parents from their children. It is difficult to get a detailed picture of the prevalence of inter-familial violence and there is a lack of service provision for people experiencing it. ADVANCE are able to take referrals for women experiencing it and MARAC can also look at inter-familial domestic violence. It can be mistaken for "normal" family conflict.

### **Older People**

It is often assumed that domestic violence is not experienced by older women, and as it can be classified as Elder Abuse, it can be difficult to get accurate figures on the prevalence. It might feel more difficult to ask older patients, particularly if you have treated them for a long time or also treat their family/partner/husband/wife but it is important to be consistent. No one deserves to be abused, no matter how long the abuse has been occurring. Older people can be particularly vulnerable as they may be dependant on a family member or partner as a carer. Additionally, there might be fewer peers to gain support and guidance from.

## Appendix 6

### **Domestic Partner Violence and Health**

- Domestic Violence does have health-related consequences that extend beyond the immediate injuries from physical assault.
- Survivors of domestic violence are more likely to be in contact with health professionals than any other service (Pahl 1995).
- 35% of women attending A&E have experienced domestic violence and a 1997 study found that only 6% of women were assessed for violence (Jeziarski, 1994, Warshaws, 1989).
- 1 in 9 women experience domestic violence where medical attention is needed (Stanko, 1998).
- 1 woman is murdered every 3 days in the UK as a result of domestic violence (Home Office).
- Women will experience 35 episodes of violence before seeking help (Jaffe, 1982).
- Twice as many women approach GP's and Health Visitors as approach the Police (Dominy and Radford).
- Domestic Violence is five times more prevalent than what is indicated in medical case notes (Mezey and Bervely, 1999).

#### ***Guidelines for Domestic Violence already exist for the following medical groups and organisations:***

*Department of Health, Royal college of General Practitioners, Royal College of Midwives, and the British Association of A&E Medicine. The Royal College of Nursing has produced a position paper and the Community Practitioners and Health Visitors Association, the British Medical Association, and the Royal College of Obstetricians and Gynaecologist have all produced publications highlighting domestic violence.*

## Appendix 7

### **Barriers to Leaving an Abusive Relationship**

#### **Fear**

- More abuse or severe abuse
- Destroy belongings or the home
- Harm to their job or reputation
- Have them arrested or charged with a crime
- Harm to their children, pets, family or friends
- Take the children
- Of losing custody of their children
- Of being charged with kidnapping if she/he takes their children away
- Of retaliation on them, family, friends, and/or those who help them
- Of court involvement
- Of loneliness
- That their partner is not able to survive without them

#### **Resources**

- Lack of social support
- Lack of support from institutions
- Lack of a housing alternative
- Lack of money
- Does not want to leave their home, belongings, or community

#### **Beliefs**

- That the violence is temporary or caused by unusual circumstances
- That the children need to be raised in a two parent home
- That the abuse stems from alcoholism, stress, or lack of spirituality
- That a perpetrator intervention programme (violence prevention programmes) as ones in probation or DVIP) can 'fix' him
- That all men are violent and that violence should be expected in a relationship
- That they can stop the violence
- That divorce or separation is wrong

#### **Pressures**

- Cultural and religious constraints to remain in marriage
- Guilt about the failure of her relationship
- Unaware that domestic violence is a crime
- Love for the perpetrator
- Feelings of person incompetence

## Appendix 8

### Concerns about seeking help

1. **Concern about how to communicate with the worker**

The survivor may be so overwhelmed by all of what is going on in their life that in anticipating talking with you; she may worry about what to say. They may be worried that you will use what they tell you to hurt them or their children.

2. **Fear of being judged or viewed as less than human**

The survivor may be concerned that you will judge her harshly because they need help and is embarrassed about what has happened to them. This is probably the response they have received from other and has internalized those views. She they view themselves in a negative way because they need help.

3. **Concerned about confidentiality**

The survivor may be concerned with confidentiality for many reasons. They may be concerned that other agencies will be aware of their personal information or that information will get out and in particular, back to the perpetrator.

4. **Concern about being pressured**

They may fear that you will pressure or make them do something that they do not want to do. They may fear that we will be pressured to make a decision that they are not sure they can comply with.

5. **Concerned about the negative consequences of seeking help**

They may be concerned with the negative consequence from the perpetrator who has likely warned them of what he/she will do to them or others if they seek help. They may know that the abuser will carry out these threats by times in the past when they have sought help from other sources. They may be operating under false presumptions about the kind of help you offer.

## Appendix 9

### INTER AGENCY REFERRAL, CHILDREN IN NEED / CHILD PROTECTION

THIS FORM MUST BE USED FOR REFERRALS OF A CHILD TO SOCIAL SERVICES WHEN THERE ARE CONCERNS ABOUT A CHILD'S WELFARE OR SAFETY, OR WHEN REQUESTING A SERVICE. IF THERE ARE IMMEDIATE CONCERNS FOR THE CHILD'S SAFETY OR WELLBEING A TELEPHONE REFERRAL MUST BE MADE TO THE CONTACT AND ASSESSMENT SERVICE. IF THE REFERRAL RELATES TO MORE THAN ONE CHILD PLEASE ENSURE INFORMATION IS INCLUDED ON ALL RELEVANT CHILDREN. PLEASE COMPLETE THIS FORM WITHIN 48 HOURS OF MAKING A TELEPHONE REFERRAL.

IF YOU DO NOT HAVE ANY RELEVANT INFORMATION FOR SPECIFIC SECTIONS PLEASE INDICATE.

#### FAMILY COMPOSITION (INCLUDING UNBORN BABY)

CHILD/YOUNG PERSON FAMILY NAME:	FIRST NAME:	GENDER:	DATE OF BIRTH:	ETHNIC CODE:	SCHOOL/NURSERY:

HOME ADDRESS:	
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#### PARENTS / CARERS – PLEASE INDICATE WHO HAS PARENTAL RESPONSIBILITY (PR) FOR THE CHILD/REN

FAMILY NAME:	FIRST NAME:	D.O.B	RELATIONSHIP TO CHILD	PARENTAL RESPONSIBILITY YES / NO	ETHNIC CODE (SEE BELOW)

#### WHO ARE THE BEST POINTS OF CONTACT FOR THE FAMILY, WHEN IS THE BEST TIME TO REACH THEM, AND HOW CAN THEY BE CONTACTED?

NAME:	RELATIONSHIP TO CHILD:	ADDRESS (IF DIFFERENT FROM ABOVE):	CONTACT NUMBER:	BEST TIMES:

#### ETHNIC CODES: (NB THESE CODES ARE BASED ON 2001 CENSUS. IF THE CODES USED BY YOUR ORGANISATION ARE DIFFERENT, PLEASE USE YOUR ORGANISATION'S CODES INSTEAD)

A	WHITE BRITISH	D	MIXED WHITE/BLACK CARIBBEAN
H	ASIAN/ASIAN BRITISH INDIAN	M	BLACK/BLACK BRITISH CARIBBEAN
R	CHINESE	B	WHITE IRISH
E	MIXED WHITE/BLACK AFRICAN	J	ASIAN/ASIAN BRITISH PAKISTANI
N	BLACK/BLACK BRITISH AFRICAN	S	ANY OTHER
C	ANY OTHER WHITE	F	MIXED WHITE/ASIAN
K	ASIAN/ASIAN BRITISH BANGLADESHI	P	ANY OTHER BLACK
Z	NOT STATED	G	ANY OTHER MIXED
L	ANY OTHER ASIAN		

RELIGION:	FIRST LANGUAGE:	INTERPRETER REQUIRED?	WRITTEN MATERIAL NEEDS TRANSLATING?	LITERACY ASSISTANCE REQUIRED?
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<p><b>REASON FOR THE REFERRAL:</b></p> <p>1. <b>MOTHER HAS DISCLOSED DOMESTIC VIOLENCE WHILST ATTENDING WIC</b></p> <p>2. <b>MOTHER HAS AGREED TO THIS REFERRAL TO SSD/ MOTHER HAS NOT AGREED TO REFERRAL. (DELETE AS APPROPRIATE)</b></p> <p>3. <b>HAS MOTHER ACCEPTED REFERRAL TO ADVANCE?</b></p> <p>4. <b>DO FAMILY ALREADY HAVE A SW ALLOCATED TO THEM/ IF YES – NAME OF SW: _____</b></p> <p>5. <b>NAME OF HEALTH VISITOR: _____</b></p> <p>6. <b>PERPETRATOR LIVING AT SAME ADDRESS/ PERPETRATOR NOT AS SAME ADDRESS. (DELETE AS APPROPRIATE)</b></p> <p>7. <b>IS IT SAFE FOR SW TO SEND DETAILS OF SUPPORT AVAILABLE, IN THE POST? Y/N</b></p> <p>8. <b>IF NO, CONTACT NUMBER: _____</b></p> <p>9. <b>PERPETRATORS NAME &amp; DOB: _____</b></p> <p>10. <b>SCHOOL OR HEALTH VISITOR : _____</b></p>
---

<p><b>DOES THE CHILD / YOUNG PERSON HAVE A DISABILITY / SPECIAL NEEDS?</b>  <b>IF YES PLEASE ATTACH DETAILED INFORMATION</b></p> <p><b>DOES THE PARENT / CARER HAVE A DISABILITY / SPECIAL NEEDS?</b></p>
---

**SIGNIFICANT OTHERS NOT LIVING AT HOME ADDRESS:**

NAME:	D.O.B	RELATIONSHIP:	ADDRESS:

**OTHER AGENCIES INVOLVED:**

GP:	ADDRESS:	TELEPHONE NUMBER:

AGENCY:	CONTACT NAME:	TELEPHONE NUMBER:	WORK UNDERTAKEN:

**ASSESSMENT**

**1 CHILD'S DEVELOPMENT NEEDS.** THIS INCLUDES HEALTH, EDUCATION, IDENTITY, SELF-CARE SKILLS, SOCIAL PRESENTATION, FAMILY & SOCIAL RELATIONSHIPS AND EMOTIONAL & BEHAVIOURAL DEVELOPMENT:

--

**2 PARENTING CAPACITY.** THIS INCLUDES BASIC CARE, ENSURING SAFETY, EMOTIONAL WARMTH, STIMULATION, GUIDANCE AND BOUNDARIES, STABILITY AND ANY ISSUES LIKELY TO EFFECT PARENTING CAPACITY:

--

**3 FAMILY AND SOCIAL ENVIRONMENT FACTORS.** THIS INCLUDES COMMUNITY RESOURCES, FAMILY'S SOCIAL INTEGRATION, INCOME, EMPLOYMENT, HOUSING, WIDER FAMILY HISTORY AND FUNCTIONING:

--

**IS THE FAMILY / YOUNG PERSON AWARE OF THE REFERRAL?  
DATE DISCUSSED?**

REFERRER'S NAME:

SIGNED:

AGENCY:

ADDRESS:

TELEPHONE NUMBER:

DATE OF TELEPHONE REFERRAL:

DATE:

CC: AS AGREED WITHIN INDIVIDUAL AGENCIES

PLEASE ENSURE YOU ALSO COPY YOUR COMPLETED REFERRAL FORM TO RELEVANT PROFESSIONALS AS AGREED WITHIN YOUR AGENCY

Hammersmith & Fulham Children's Services – Contact and Assessment Service

Floor 4

77 Glenthorne Road

LONDON W6 OLJ

TEL 020 8753 5392

FAX 020 8753 5880

**REFERRAL FEEDBACK SHEET**

<b>Referrer's Name:</b>
<b>Agency:</b>
<b>Address:</b>

Date of referral:

<b>NAME OF CHILD</b>	<b>ADDRESS</b>

**THANK YOU FOR YOUR REFERRAL (PLEASE TICK AS APPROPRIATE):**

- 1. **NO FURTHER ACTION NEEDED – CASE CLOSED**
- 2. **UNDERTAKE AN INITIAL ASSESSMENT**
- 3. **UNDERTAKE A CHILD PROTECTION (SECTION 47) ENQUIRY**

<b>COMMENTS:</b>
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<b>SIGNATURE OF WORKER:</b>
<b>PRINT NAME:</b>
<b>DATE:</b>

**WHEN A WORKER IS ALLOCATED THEY WILL BE IN CONTACT WITH YOU. PLEASE LET US KNOW IF YOU HAVE FURTHER CONCERN ABOUT THE FAMILY OR YOU WISH TO DISCUSS THE ACTION TAKEN.**

HAMMERSMITH & FULHAM CHILDREN'S SERVICES  
CONTACT AND ASSESSMENT SERVICE  
FLOOR 4  
GLENTHORNE ROAD  
LONDON W6 OLJ  
TEL NO 020 8753 5392  
FAX NO 020 8753 5880



*Domestic Abuse: Best Practice Papers Number 1  
Written by and for practitioners and trainers working  
with all aspects of domestic abuse*

GOOD PRACTICE CHECKLIST  
FOR INTERPRETERS  
WORKING WITH  
DOMESTIC VIOLENCE  
SITUATIONS

In the spring of 2008, Standing Together against Domestic Violence carried out a piece of collaborative work on domestic violence with CITAS, the Hammersmith-based organisation that provides community engagement through interpreting, translation, outreach and advocacy in over 55 languages. It is clear that there is a need to use professionals who are well trained in interpreting, and not to make use of family and friends to interpret in domestic violence situations. In our consultation, we identified and have aimed to fill an information gap in terms of guidance for Interpreters themselves about issues they need to be aware of when interpreting for a range of agencies dealing with domestic violence survivors or perpetrators.

The work involved:

- Consulting domestic violence practitioners and Community Interpreters about what they think would be good practice when Interpreters are working for a range of agencies in situations where domestic violence has been disclosed or is suspected.
- Designing and running two training sessions for Community Interpreters on the dynamics of domestic violence and best practice. Twenty-nine interpreters from Hammersmith and Fulham, covering 24 languages, attended one

session, and eighteen of them were able to attend for a second session the following week.

- Using the results of the consultation to draw up a Domestic Violence Good Practice Guidance Checklist for Interpreters.

We are very pleased to share this Checklist with other agencies and interpreters in other boroughs, and have put it on the Standing Together website for free downloading.

Domestic violence training for Interpreters

If you would like to discuss running domestic violence training for Interpreters in your area or your agency, please contact Standing Together. Details are at the end of this Guidance. The quotes are from Interpreters who attended the training.

*'I enjoyed the training sessions. The trainers were very knowledgeable, and colleagues turned the training into interactive sessions. This brought about further discussion and made this training even more informative.'*

<sup>1</sup>

## 1. The Interpreter's approach:

An important point to note is that Interpreters should discuss with, and obtain, the permission of the interviewing officer before making a proactive intervention with the service user. The Public Service Interpreters' Code of Conduct defines standards.

- 'Compassionate interpreting' was recommended. What might this look like in practice? For example:
  - Being non-judgemental
  - Being professional
  - Being patient (not pressurising the survivor to take a particular course of action)
  - Demonstrating empathy with survivors of domestic violence (in demeanour/ tone/pace)
  - Listening carefully and not making assumptions – there is no typical victim/survivor or perpetrator
- Interpreting accurately, seeking clarification on any points that are unclear
- Using the right phrase and meaning and translating accurately
- Being prepared to take action if there is inappropriate behaviour by the staff member in the interview
- The interpreter can only stop the interviewing officer for a 'technical point'. However, it was suggested that if the interviewing officer was making inappropriate comments, then the interpreter can ask the officer to rephrase questions on the basis that the client would not understand the particular question
- Sharing any concern you have about the client's safety and risk factors with the professional
- The interpreter can share any cultural factors, safety concerns or evidence of domestic violence during the briefing time with the interviewing officer before the interview

- A non-judgemental approach, good training and professionalism can be more important than finding an interpreter of the same sex
- However, a same sex interpreter may make disclosure easier for survivors.

*'Before coming to the domestic violence training I never thought it was as broad a subject as it is. Knowing the facts and best practice to adopt is sure to help me in my career.'*

## 2. Before the interview

- Be sure you are knowledgeable about the issue/dynamics of domestic violence
- Think carefully about the words and their meaning in conveying key messages about domestic violence
- Understand the barriers faced by domestic violence survivors that may prevent disclosure of the abuse
- Knowledge of local and national support agencies is helpful to signpost survivors, (with the agreement of the staff member)
- The interview should be held in a private and safe place. Some interpreters reported that domestic violence interviews have been conducted in front of other members of the family, but it is felt that this is never safe practice. Babies and very young children may have to be in the same room.
- The interpreter cannot themselves ensure that the interview is conducted in a safe place. However, if there are any safety concerns, then the interpreter can ask the officer to step outside to talk about the concern OR write their concern on a piece of paper and give it to the interviewing officer.

### 3. During the interview

- Remind yourself of the known risk factors in relation to domestic violence
- Use training to help you to recognise inappropriate comments/victim-blaming behaviour
- Challenge or raise concerns with the interviewing officer directly
- Consider how an interpreter may challenge or raise any concerns without upsetting the interviewing officer. In most public service interpreting, concerns can only be raised after the interview.
- Make a formal complaint if necessary
- Formal complaints can be made after the interview
- Do not give advice to the survivor or perpetrator but, with the permission of the interviewing officer, you could provide up-to-date information about support agencies and those who work with perpetrators, and the national phone numbers
- Any information on domestic violence services can only be given to the client after the interview and with the permission of the officer

#### 4 Behaviour towards survivors

- Show empathy and respect, for example by demonstrating you are:
  - Genuine and warm
  - Respectful and with a positive approach according to cultural norms, but this does not mean excusing abuse
  - No physical contact with the client

#### 4 Behaviour towards perpetrators

- Avoid unwitting collusion with perpetrators and excuses for abuse
- Avoid casual conversation with the perpetrator after the interview

*'The training gave me a better understanding of the difference between an unhappy relationship and an abusive relationship.'*

### 4. After the interview

- Do not give out your personal details
- It is the duty of the interviewing office to ensure the safety of their client, but you may, with the officer's permission, check that the survivor feels safe now e.g. to go home. If it is not safe, ask the interviewing officer to address this by re-assessing the risks and safety measures.
- The interpreter needs permission from the officer to ask survivors about their safety
- After the interview, interpreters may be asked by the officer about some cultural aspects e.g. body language, if both interpreter and client are from the same culture, and can give the officer their view/understanding. However this is necessarily a matter of the interpreter's opinion, not necessarily that of the client.

### 5. Confidentiality and safety

What to do if a domestic violence survivor or perpetrator does not want certain information to be disclosed to the interviewing officer:

#### Survivor:

- Make the survivor aware of the confidentiality agreement before the start of the interview
- Respect the survivor's desire for confidentiality
- Try to persuade the client to make fuller disclosure in their own best interest
- Try to hold a dialogue/explore the client's fear, with the consent of the interviewing officer, and inform the client what the interviewer will do with the information given

Perpetrator:

- With the consent of the interviewing officer:  
Make the perpetrator aware of the confidentiality agreement before the start of the interview This could be modelled on the clause in the Integrated Domestic Abuse Programme (IDAP) contract or another similar one, see some suggested elements below.
- Inform the client at the start of the interview that making a full disclosure is in their own best interest
- Try to identify/explore the client's concerns about disclosure, and inform the client what the interviewer will do with the information given (this should be included in the confidentiality agreement/ contract with the perpetrator).

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Confidentiality Contract with Domestic Violence Perpetrators: suggestions for key elements to be included

- Limited confidentiality offered
- No confidentiality offered in relation to:
  - any disclosure about domestic violence incidents (past/recent & towards current/ previous partners)
  - lack of motivation to change towards non-violent relationships
  - information relevant to known indicators of risk of harm to survivors. This would include drug/alcohol use, criminal history, history of experiencing abuse as a child, employment problems, breaches, etc, which perpetrators may wish to keep confidential. Interpreters would need briefing on those risk factors in training
  - information indicative of risk of harm to children and others

- Confidentiality may be offered by the interviewing officer's agency in relation to comments made by the perpetrator about the survivor or previous partners that are assessed as not being indicative of risk of harm or of lack of motivation to change his behaviour
- No information shared with agencies that are actively supporting the survivor about her experiences of domestic violence will be shared with the perpetrator. This will need to be made explicit in the perpetrators' confidentiality agreement.

---

IMPORTANT national phone numbers:

- National Domestic Violence  
24-hour Helpline 0808 2000 247
- Respect helpline for male  
perpetrators who want to  
stop their abuse 0845 122 8609

*'I will be better equipped when working in a domestic violence situation – with knowledge of local and national support agencies to give out to victims or perpetrators if needed.'*

#### Credits and thanks

This Guidance was put together by Pinky Pradhan (Intern) and Peta Sissons (Training and Information Officer), Standing Together against Domestic Violence. Thank you to all those who commented on the drafts and made useful suggestions.

You are most welcome to use and copy this Guidance, but please credit Standing Together against Domestic Violence 2008 if you do and give our website address for more information about our work.

[www.standingtogether.org.uk](http://www.standingtogether.org.uk)

If you have any comments or feedback on this Guidance, please send them to [p.sissons@standingtogether.org.uk](mailto:p.sissons@standingtogether.org.uk)

CITAS recruits qualified Interpreters to enable the health and social care sectors in the borough to meet the needs of the diverse communities they serve.

#### CITAS

Palingswick House  
241 King Street London W6 9LP T: 0845  
521 0405  
F: 0845 521 0406  
E: [interpreting@ citas.org.uk](mailto:interpreting@ citas.org.uk)  
W: [www.citas.org.uk](http://www.citas.org.uk)

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Registered Charity No. 1088844

#### Contact information

Standing Together  
Against Domestic Violence Standing  
Together coordinates the operational  
partnership and response of a wide  
range of agencies to the crime of  
domestic violence in the London Borough  
of Hammersmith & Fulham.

Room 44D, 4th Floor  
Polish Centre  
238 – 246 King Street  
London W6 0RF  
T: 020 8748 5717  
E: [admin@standingtogether.org.uk](mailto:admin@standingtogether.org.uk)  
W: [www.standingtogether.org.uk](http://www.standingtogether.org.uk)

