Health and Domestic Violence: *What Can Be Done?*

A report of the implementation of a domestic violence protocol at three health sites in London

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Foreword

This report outlines the work and progress of the Standing Together Against Domestic Violence Health Project. The intended reader is anyone who is interested in initiating a similar project and/or to officials who may consider implementing some of the elements of this project across a wider range of health sites.

We have tried to provide in this report, a practical outline of the elements of the project that were successful and as well as aspects of the project that were challenging. We have also provided various appendixes that can be used as examples by other projects and initiatives.

We would like to thank the Policing and Reducing Crime Unit at the Home Office for their generosity and interest in this project.

We would also like to thank the medical professionals at the Charing Cross Hospital Accident and Emergency and the Charing Cross and Parsons Green Walk-in Centres for their enthusiasm, hard work, and commitment to producing and implementing their protocol. In particular, we would like to thank the following people:

- Mr Hugh Millington, Consultant, Charing Cross Hospital Accident and Emergency
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- Ms Deborah Carolan, Sister, Charing Cross Accident and Emergency
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- Ms Kate Harding, Charing Cross and Parsons Green Walk-in Centre
- Ms Emma Flewers, Charing Cross and Parsons Green Walk-in Centre
- Ms Wendy Cunningham, Charing Cross and Parsons Green Walk-in Centre

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Section One
Standing Together and the Health Project

About Standing Together Against Domestic Violence

Standing Together Against Domestic Violence (also referred to as Standing Together) is a coordinated, multi-agency response to domestic violence in the London Borough of Hammersmith and Fulham.

Standing Together aims to:

- Increase the safety of survivors of domestic violence
- Increase the safety of children who live with domestic violence
- Hold abusers accountable and responsible for their actions
- Ensure that the onus for doing so lies with the statutory and other agencies rather than with the survivor
- Acknowledge that each agency maintains its independence, and to ensure that all the agencies involved work in an integrated and coordinated way to achieve these objectives
- Provide accountability to the public, to survivors and to other agencies for the way in which domestic violence is handled
- Test and develop effective policies, procedures and practical measures which can be integrated into the ongoing work of agencies

Standing Together grew out of many years of vigorous multi-agency work in the Hammersmith and Fulham Domestic Violence Forum. Standing Together was launched in Fulham in November 1998 and was extended to the whole Borough of Hammersmith and Fulham in December 2000.

There is a round table Steering Committee in charge of operations, practice and monitoring. Members are held accountable by protocols agreed between each agency and Standing Together. All the Partners are represented on the Steering Committee, which is currently chaired by the Divisional Commander of the Met Police.

The Standing Together Partners are:

- Hammersmith and Fulham Police
- Crown Prosecution Service (West London Branch)
- London Probation Area
- London Borough of Hammersmith and Fulham
- ADVANCE (women's advocacy service)
- DVIP (perpetrator's intervention programme and women's service)

- Hammersmith Women's Aid
- Awareness in Practice
- Hammersmith and Fulham Law Centre
- Charing Cross Hospital Accident and Emergency

Observer Status:

- West London Magistrates Court
- Blackfriars Crown Court

About the Health Project

The Standing Together Health Project (referred to herein as the Health Project) was funded by the Home Office Crime Reduction Programme (CRP) and began in October 1999. It was originally funded for 18 months, until March 2002. This has been extended until March 2003. This report concentrates on the progress of the project in the first 18 months.

The Health Project was initiated and is managed by the Standing Together Steering Committee.

The Health Project aim

The aim of this project was to create institutional change with regard to the health care response to domestic violence at three pilot sites — Charing Cross Hospital Accident and Emergency (A&E), Charing Cross Walk-in Centre and Parsons Green Walk-in Centre.

Core targets

The essential elements of the project were to set up a multi-disciplinary team within Charing Cross A&E and to work with the Charing Cross and Parsons Green Walk-in Centre staff team to oversee the following:

- Draft and implement a protocol on domestic violence that includes screening, documentation and referral
- Training of staff on the above mentioned protocol
- Implement necessary monitoring and evaluation procedures so an outside evaluator can measure the change in practice and its outcomes
- Increase the profile of the issue of domestic violence within the medical facility

Staff support provided by the CRP grant

The Project grant provided for staff support to achieve the aim. The posts are:

- One full time ADVANCE Advocate available to take referrals from the Charing Cross Walk-in Centre and A&E 24 hours a day, 7 days a week
- One part time Workshop Facilitator employed by Domestic Violence Intervention Project (DVIP) to provide weekly workshops and support services to survivors referred by the Charing Cross and Parsons Green Walk-in Centres and the Charing Cross A&E
- One full time Development Worker to oversee the project as a whole and to provide technical assistance and training to the medical sites

Section Two
Key Activities Listed in the Grant

2.1 Form an interdisciplinary team nominated from the health centres (one Accident and Emergency and one Walk-in).

Summary

This intervention was achieved in both the Accident and Emergency (A&E) and Walk-in Centres.

How it was done

In the A&E, the Consultant agreed main aspects of the project and the protocol in principle and then assigned a team consisting of nurses of all grades and a registrar, and representatives from Social Services within the hospital. The Development Worker also met with administrative staff and Emergency Psychiatric Services but it was decided that they would not participate in the health team and would be briefed afterwards.

In the Walk-in the Lead Nurses agreed the main aspects of the protocol in principle and then the Development Worker worked with the entire staff team (approximately 15 Nurse Practitioners) to develop and implement the protocol.

Lessons learned

It is important to understand that at this stage, when domestic violence interventions are not targets within the health service, that any activity agreed to be taken on above and beyond normal staff duties. For this reason, the letters of support obtained to receive this grant were not as helpful when it came to working through the hierarchy of the Hammersmith Hospital Trust or the Riverside Community Healthcare Trust. It was the lead staff on the specific sites that ultimately agreed to the take on the extra responsibility and changes to practice. They understood that domestic violence was common among patients and were willing to take on additional work to address the problem.

Another initial lesson learned was the difficulty in creating a project that is specific to sites, which operate within larger entities. For example, the Charing Cross Walk-in Centre was initially approached to participate in this project but was resistant to participating unless the Parsons Green Walk-in Centre was to be included. This was because they share the same staff and essentially operate as one entity. Therefore, any new protocol would need to be applicable to both sites. This is why the project expanded to three sites. The Charing Cross Hospital A&E were easier to contain although throughout the year, they have suggested expansion to the other A&E within their Trust. Standing Together would welcome expansion in the future but would need to be confident that there would be adequate support services in place.

It would have been difficult to persuade the Walk-ins and the A&E to take on board this project without offering the services of the ADVANCE Advocate. This was essential to gain the confidence

of medical staff to ask patients directly about domestic violence. Importantly, ADVANCE advocacy came with the track record of working with the Police in Hammersmith and Fulham over the past three years and with services that are offered 24 hours a day, 7 days a week.

The Health Development Worker was instrumental in progressing the work of these teams by preparing, organising and staff the team meetings. She researched the interventions from the UK and abroad and presented them to the team to inform their decisions about which direction to take with the protocol. The Health Development Worker also produced the resource materials and the protocol based on the input of the health teams. The health teams would have been unlikely to produce the protocol and resource materials due to limits on their time.

It was useful to agree main aspects of the project and the protocol in principle with the decision makers in the A&E and Walk-in. It provided a framework in which to work with the A&E team and Walk-in staff.

The team approach was very helpful to get the full commitment of staff to the idea of the protocol, training, and implementation. Their input was essential to make the logistics of the protocol realistic. There was much debate about how, when and where things could be done which resulted in a well thought through protocol. However, the team approach was less helpful when it came to scheduling training in the A&E and problem solving generally. Towards the end of the projects, the Health Development Worker began to work directly with key nurses on the A&E and Walk-in staff to set training dates and to problem solve.

Another lesson learned is that the team may not always feedback to managers. Future work should consider a way to formally feedback to the senior staff/managers. The Development Worker started to liaise more with the Walk-in Manager towards the end of the project and began providing a written report to the Walk-in Steering Group. It is less the case in the A&E as the Consultant has been very approachable and easy to contact regularly.

2.2 Develop a procedure for health staff regarding domestic violence similar to the one they have to children at risk.

Summary

The A&E and the Walk-in have developed a protocol, which covers screening, assessment, documentation and referral — see Appendices 1 and 2.

How it was done

It took 13 meetings to achieve the protocol with the A&E. It has required minor changes since its final approval by the A&E Consultant. The process took approximately six months.

The Walk-in was able to develop and finalise their protocol with the first quarter of the grant. This is again due to their structured staff meetings. It was approved by their Steering Committee. Implementation of their protocol began April 12, 2001. In total 13 meetings have been necessary to develop the protocol and to iron out administrative difficulties over the grant period.

The Health Development Worker developed a poster, resource card and leaflet to aid the implementation of the protocol on the health sites — see Appendix 9. At the time of this printing, over 1000 leaflets have been distributed.

Lessons learned

The method used to develop the protocol was practical for the culture of the Health Service. The Health Development Worker drew from model protocols in other countries and created a series of worksheets for the health teams to work through in team meetings — see Appendix 4. These worksheets enabled staff to think through the main aspects and logistics of the protocol. The Health Development Worker recorded decisions and then drafted the protocol for their approval. It would have been unrealistic for the health team to draft the protocol or to review much of the literature from other countries, as they simply do not have the time. They were satisfied with the end result and felt a large sense of ownership over the decisions made.

With regards to implementation of the protocol, perhaps the most important lesson learned was the nurses can accomplish routine screening for domestic violence. They will not be able to screen every patient, particularly in the Walk-in when the patient rarely comes alone, but the patients respond well to being asked the screening question and this has had a positive effect on the nurses.

Implementation of the protocol requires an incremental approach as training of staff takes time. Also, administrative staffs are crucial as they create patient files and will potentially record the rate of screening and referral.

During the grant period, the Walk-in Centres transitioned onto a national computer system to record patient visits. All documentation of the domestic violence screening system was lost at this point as the computer system was unable to be adapted for local initiatives. Similarly, the A&E could not change their computer system to record the screening electronically. This issue is crucial to useful monitoring of domestic violence cases, but it is unlikely to be addressed.

2.3 Train a cross section of staff to "ask the question", how to respond to victims, how to make appropriate referrals, and to record and monitor this incident.

Summary

This intervention was achieved in both the A&E and Walk-in Centres.

How it was done

The A&E health team were trained in the first quarter. This was done over a series of meetings and through a two day conference in Croydon attended by three team members.

Once the protocol was approved, some difficulties in scheduling training for the A&E staff were experienced. It was not until the end of the initial grant period that the A&E staff began regular, weekly training. Priority was given to the Triage Nurses because they conduct the initial screening for domestic violence. We achieved six training sessions that has resulted in 49 nursing staff being trained.

At the Walk-in, all fifteen staff were trained over three dates (totalling seven hours) during the first quarter of the grant. Training was tailored to fit into their pre-existing weekly staff meetings.

Lessons learned

Nursing and administrative staff enjoy training on domestic violence as they see victims frequently. As all the literature suggests, they are apprehensive about what to do when discussing domestic violence with a patient but readily understand the dynamics of domestic violence and the various indicators of abuse.

There is much enthusiasm and willingness to intervene but only if the medical staff felt trained, supported by management, and knew that they have a specialist to call (the ADVANCE advocate in this case). They also enjoyed having resources such as a poster to hang in the waiting area and leaflets to give to patients. This helped them feel that the patients would not be surprised to be asked about domestic violence if they had seen resources in the waiting area already.

The Health Development Worker had two very different experiences with scheduling training with the Walk-in and the A&E. The Walk-in had staff meeting time set aside weekly and training with them was not difficult. Because of this, the Walk-ins were able to develop and implement their protocol months ahead of the A&E. However towards the end of the grant period, when refresher training was needed, the staff meetings had begun to be cancelled due to staff shortages.

The A&E was more difficult to access due to the vacancy in the Teaching and Development post for much of the grant period. It was filled in January 2002 and the new Teaching and Development Sister, while very supportive and interested, had a backlog of competencies and targets that she was under pressure to meet. She requested that Standing Together provide short training sessions at midday when the shifts cross over and the nursing staff can get away from their floor duties.

Longer trainings are neither always preferable nor practical in medical settings. Small, informal training can be more effective. The Health Development Worker began training small groups of nursing staff for approximately one to one and a half hours during the time in the day when shifts cross over. They were generally small groups of between three to seven nursing staff. This allowed her to cover quite a bit of the training materials, in depth and allow time for staff to discuss their concerns freely and in an informal atmosphere. This approach to informal discussions allowed staff to feel open to discuss their concerns more than they would in a larger group.

The Health Development Worker was able to conduct much of the training on the health sites herself. Outside trainers were budgeted for but would not be recommended as essential because the aim of this kind of project is to build relationships with local domestic violence service providers. The ADVANCE Advocate attended as many training sessions as possible so that the medical staff could met the people to whom they would be referring.

One of the main requirements for the health trusts when writing the CRP grant was that Standing Together must include replacement costs so that staff could be brought in to cover on training days. However, we have found that replacement costs were not as necessary in practice. At the Walk-in, time was used during their weekly staff meetings when cover was already arranged and the A&E simply did not have the opportunity to set aside large amounts of time for training when they would have needed replacement staff.

The chronic problems with staffing the health service affected the project. There are huge staff turnovers. For example half of the staff trained at the Walk-in during the first quarter of the grant were gone a year later. Similarly, in the A&E, all of the staff that trained in July, except for one person, had left less than six months later. There is a steady stream of new staff, which will require regular ongoing training/orientation from Standing Together in the future.

Consistency is also difficult to achieve with agency nurses who are not required to attend staff meetings and do not always receive extra training or guidance on "extra" issues or projects like this one.

2.4 Identify problems in supplying prompt medical evidence for prosecutions and test solutions.

Summary

The quality of the medical evidence from the A&E and the Walk-in Centres is improved because of the new documentation form for domestic violence that is much more detailed and descriptive — see Appendix 3.

The A&E protocol states that in cases of domestic violence, a Senior Doctor should document the injuries and Polaroid cameras have been provided to the A&E to record injuries.

The Health Development Worker is still negotiating about the ideas that the Police and Crown Prosecution Service (CPS) have put forward about speeding up the process of supplying medical evidence. The main idea proposed is for the A&E Doctor to immediately dictate a statement after seeing a patient whose injuries were cause by domestic violence. The statement would then be supplied more promptly when requested. This will be progressed in the second grant period (2002/3).

In February 2002, Standing Together and the CPS initiated a research project conducted by Dr Susan Edwards that explores the possibilities of using expert witnesses for the *prosecution* of domestic violence cases. A separate report will be available from Standing Together towards the end of 2002.

Lessons learned

There is a willingness within the A&E to improve the quality of medical evidence. Medical staff are pleased with the new cameras and new documentation forms. There is a strong feeling that the forms will capture more detailed information about the injury as well as previous injuries so that the medical evidence is much more comprehensive.

The Walk-in Centres are less likely to provide medical evidence because they are staffed by Nurse Practitioners. Their protocol states that if a patient attends the Walk-in with injuries related to a crime, they will encourage the patient to attend the A&E. There are examples where the Walk-in has supplied medical evidence in the past and they have adopted a documentation form. However, the A&E protocol is more detailed with respect to documentation.

While the improvements at the Charing Cross Hospital A&E are welcome, there is more work to do to improve the quality of medical evidence to be supplied for Hammersmith and Fulham Police. Further, the Charing Cross Hospital A&E is only one of many sources of medical evidence.

2.5 Change role of Advocacy to accept direct referrals from health and offer wide range of Advocacy (housing, welfare, child safety, immigration).

Summary

Until the CRP health grant, ADVANCE only took referral directly from the Hammersmith and Fulham Police. These referrals have doubled every year of the project and reached over 600 in 2001. ADVANCE did not have to radically change their practice in order to receive referrals from the health sites but they doubled their staff size from two to four advocates with the CRP grants. As a result, here has been much work with ADVANCE during the grant period. Key areas include the following:

- A Service Level Agreement drafted and finalised.
- One week of training and orientation provided for new Advocates. A training manual produced — see Appendix 5.
- Designation of a lead Advocate for the health project which entailed coming to meetings and trainings.

Lessons learned

The Health Service would not have participated in the project without the involvement of ADVANCE. ADVANCE was able to easily incorporate work with the health sites. This has not required a major change in their practice as many of the systems have been set up already with the Police.

ADVANCE would have difficulty offering the same level of service to health sites further away. It was a coincidence that the Charing Cross Hospital A&E and Walk-in Centres were near to the ADVANCE office. This was not the case with Parsons Green Walk-in Centre and as a result, they could not offer that the Advocates come to the Walk-in personally but they were available over the phone.

ADVANCE being a new organisation and doubling its staff with the CRP grants has required a lot of support from the Development Workers. In particular, the data recording required with the CRP grants and the training needed has required the most amount of time.

The Service Level Agreement was essential to define the roles and responsibilities of ADVANCE as well as Standing Together. Similar agreements will be used in the future and have been incorporated into the regular practice of Standing Together.

The concept of a lead advocate for the health project was crucial, as it will leave a person to hand matters over to in case funding is not received in the future. It will lend consistency with the health sites and the Standing Together partnership.

There were less than expected referrals from the Walk-ins and the A&E to the Advocates. There have been approximately 12 referrals between April 2001 and March 2002 from the Walk-in Services. The A&E only began screening patients in March 2002. It is not be surprising that patients are not always ready to speak to an advocate on the day of their attendance in the A&E or Walk-in as they would not have come expecting to be asked about domestic violence. It may be that as this practice becomes more established that patients will come expecting to be asked and will readily accept help.

The medical staff and Standing Together believe that the screening has an impact regardless of referral rates because of the important message it sends to the victim. To date over 1000 Women's Aid leaflets have been taken from the Walk-in sites, which indicates a need for services. Perhaps the rate of referrals to ADVANCE would be much higher if their leaflets were left in the waiting area instead of the Women's Aid leaflets. This may be tested in the future. Other resources such as wallet size ADVANCE cards — see Appendix 9 — are left with medical staff for reference or in case a patient wishes more specific information. There are also wallet size cards designed for the A&E staff members outlining the protocol.

2.6 Group work for Survivors

Summary

DVIP has provided one workshop (conducted to a set programme) per week except in weeks with major holidays. An average of two to four people attended each workshop. The workshops were held in a comfortable space with crèche facilities. See Appendix 8 for the workshop programme.

DVIP Women's Service will be crucial to expansion of services with health as they can take referrals from the public generally. Copies of their leaflets are also left at A&E and the Walk-in sites.

During this period a Service Level Agreement between Standing Together and DVIP was drafted and finalised. DVIP have also designed a series of workshops modelled on the Duluth model on issues of empowerment.

2.7 Survivors Consultation

Summary

During this period Standing Together engaged in a formal process of consultation with survivors of domestic violence. The consultations were aimed at gathering feedback from women who have used the services of the courts, police, solicitors and health. Consultant Vicky Grosser was engaged to undertake the consultations and she was supported by Bhupinder Virdee, a women's support worker from DVIP throughout the consultations.

One formal consultation on health was conducted in February 2002. A separate report – *Survivors Speak* – that covers the findings and methodology of the consultations is available from Standing Together.

2.8 Monitor cases from first contact with health through interventions by Advocates to possible attendance in the DVIP women's group.

Summary

Progress on the monitoring of cases is as follows.

- Standing Together STATS database has been amended to document medical evidence provided by health and used in prosecution cases.

- The ADVANCE database was revised and records were transferred onto an Access database that would be easier and more tailored to their needs.
- The development worker created an Excel database for DVIP workers to record information about their referrals.
- The ADVANCE and DVIP case file forms were amended to document referrals from the health sites.
- The Walk-in patient forms were amended to document their screening. However this has recently been replaced with a national computer system that does not have a field for domestic violence. This is a new problem, which may or may not need to be addressed by Standing Together and the Walk-ins.
- The A&E will record screening on their patient card, not the computer system.

Lessons learned

It has not been easy for ADVANCE to complete the full requirements of the core data set requested by the Home Office. Additional support is needed to achieve data collection from ADVANCE.

It has been very difficult to change documentation within a Health Trust for just one section/department. Particularly, with the Walk-ins being part of national structure, it was very difficult to add domestic violence to their national computer system. This would require further development work.

2.9 Additionally, work done not specifically mentioned in the interventions of the grant application:

- Domestic Violence is included in the Health Improvement Plan for the borough (HIMP).

Section Three

Another Year

Standing Together is thankful to have received funding from the Home Office for an additional 12 months i.e. to 2003. This will allow interventions to be continued for the next 12 months.

Overall aim

To continue the work of the three pilot health sites and to explore opportunities within the Health Trusts to mainstream the domestic violence interventions developed over the last 18 months.

Note: "Trusts" refers to Hammersmith Hospital Trust and Hammersmith and Fulham Primary Care Group. The three health sites referred to are Charing Cross Hospital A&E, Charing Cross Walk-in Centre, and Parsons Green Walk-in Centre.

Specific interventions

- To continue victim's advocacy, provided by ADVANCE, ensuring that immediate referral from the health sites can be made 24 hours a day, 7 days a week.
- To ensure continuation of tracking from first contact with the health sites, through interventions by ADVANCE and/or DVIP and possibly the criminal/civil justice systems.
- To continue development within the three health sites.
- To work with key staff from each health site to continue training and implementation of the protocol developed in the first 18 months of the CRP project.
- To develop strategies identified for increasing efficiency of providing medical evidence for court cases.
- To work with ADVANCE to refine their risk assessment and safety planning procedures for all referrals including health referrals.
- To work with DVIP to promote their service within the Trusts.
- To develop interest within the Trusts to mainstream some of the interventions used at the pilot sites.
- Provide an overview of the success of the pilot sites to key Trust administrators.
- Determine if there is an interest in forming a working party to stand alongside the Standing Together Steering Group (which currently focuses mainly on criminal/civil domestic violence interventions).
- Formulate an action plan to begin mainstreaming some of the key domestic violence interventions within the Trusts.
- To provide more time and active participation of the Coordinator/Director of Standing Together and the Manager of ADVANCE.
- To continue the Survivor's consultation, focusing on public information and access to services.
- To promote and network the health project with other London boroughs and nationally.
- To organise an end of the project seminar for Standing Together.

Section Four

Final Conclusion

The Health Development Worker found a huge willingness to address domestic violence with front line staff. However, any concrete changes can only be made when national targets on domestic violence are set and by institutionalising some of these interventions throughout the Health Trust. This may necessitate not having such ambitious protocols but begin with mainstreaming domestic violence into training and awareness and documentation within the Trust.

Standing Together looks forward to a continued positive working relationship with the staff and management of the health sites and to developing this work throughout the Borough in partnership with members of the Steering Committee, the Health Trusts and the Primary Care Trust.

Appendix I

Protocol for the Charing Cross and Parsons Green Walk-in Centres

RIVERSIDE COMMUNITY HEALTH CARE TRUST
CHARING CROSS AND PARSONS GREEN WALK-IN CENTRES

POLICY TITLE: INTIMATE PARTNER VIOLENCE

GUIDING PRINCIPLES:

Charing Cross and Parsons Green Walk-in Centres believe that all people are entitled to the right to live free from violence or threat of violence from current or former partners. Because healthcare staff may be the first professionals to whom an abused person turns to for help, the medical staff have an opportunity and responsibility to provide appropriate and sensitive interventions. Charing Cross and Parsons Green Walk-in Centres are committed to developing and implementing policies and procedures for identifying, treating and referring victims of intimate partner violence.

PURPOSE OF THIS PROTOCOL:

- To effectively treat all injuries and illnesses
- To provide and communicate a safe environment for the patient
- To identify intimate partner violence through screening and through recognition of possible indicators of abuse
- To offer specialist advice, support, and safety planning at the Walk-in Centre or after discharge
- Document all information correctly and thoroughly
- Provide referral information during the healthcare contact

DEFINITIONS:

Intimate Partner Violence is an ongoing, debilitating experience of physical, psychological, and/or sexual abuse involving force or threat of force from a current or former partner associated with increased isolation from the outside world and limited personal freedom and accessibility to resources. A victim of intimate partner violence is anyone who has been injured or has been emotionally or sexually abused by a person with whom he or she has had a primary relationship.

LEGAL CONSIDERATIONS:

Physical violence and threats are a criminal offence and a person may seek relief through the criminal justice system as well as civil remedies such as injunctions and non-molestations orders (see appendix 2 for resource numbers). Medical staff are not under a legal obligation to report instances of intimate partner violence. For physicians or other health care professionals, reporting abuse to law enforcement should be done with the abused person's knowledge and consent. Only the abused person can assess the danger and relative risk of

reporting the violence verses not reporting the violence to the authorities. All other reporting requirements such as for child abuse must be followed as per child protection guidelines.

CONfiDENTIALITY:

It is vital to stress to the abused person that all interviews regarding intimate partner violence shall be conducted in private and that anything that is disclosed to a member of staff at the Walk-in Centre will not be disclosed to the abuser or any person accompanying the victim to the Walk-in Centre without his/her consent. It should also be stressed that the medical staff will not call outside statutory or voluntary agencies without his/her consent. It should be stated that the only breach in confidentiality with the patient would be if staff were concerned for the welfare of his/her children.

PROCEDURE:

Conduct initial screening for intimate partner violence in the clinical room

Who to screen?

- All female patients will be screened who are above the age of 16 regardless of their presenting medical concern.
- Male patients that exhibit indicators of abuse (see appendix i).
- Use a common sense approach regarding how often to ask regular patients. The nurse does not have to ask a patient seen and screened the day before but is encouraged to ask a patient if he/she is coming in for a new problem.

Assurance of Privacy and Confidentiality

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

- ensure that the door to the clinical room is shut
- attempt to speak to the patient alone and may consider asking visitors (including visitors of the same sex) to wait outside for a few minutes
- *not* ask the IPV screening question if 1) the patient is accompanying by another adult 2) the patient is accompanied by children (unless the child is an infant)

However if the patient discloses abuse in front of a friend or family member accompanying her to the Walk-in Centre, the nurse should refer to this protocol for assessment and referral of the patient.

How to ask the screening question

The nurse should ask the following question in a way that is most comfortable for him/her. Any nurses who feel uncomfortable asking this question should seek aid from other nurses or the ADVANCE Advocate because it is crucial that the patient feels that the nurse is not embarrassed to talk about this issue.

Following are general guidelines:

- The screening question should begin by framing the question so that the patient understands that this is a question asked of every female patient and that her confidentiality is assured. In the case of men who exhibit indicators of abuse, the

nurse should state that when patients come to the Walk-in with certain conditions, this question is asked.

- A direct question should follow. Studies show that people will disclose more often if asked directly. Remember if the nurse is not able to speak directly about this issue, then neither will the patient. See recommendations in the boxes below for how to ask the question.
- If the patient requires a translator, call Language Line. Do not use the patient's children to translate regarding abuse. Be aware when using a translator that the definition of abuse may change according to the language. Try to be as clear a possible with the translator about what you mean.
- Use gender-neutral terms such as "partner" instead of "girlfriend" or "boyfriend," "husband" or "wife." Do not assume that you are speaking to someone in a heterosexual relationship.

<u>Examples of framing the question:</u>

- I hope that you don't find this intrusive but we ask every woman about problems in the home.

- In addition to your health concerns, we are also asking all women about the possibility for abuse since we have found the violence is so common in women's lives.

- I don't know if this is a problem for you but many women experience problems with their partners. It is a hard thing to bring up so we are asking everyone as a matter of course…

- For men with indicators of abuse, the nurse would say, "Your injuries (or the situation you described to me) sometimes can be caused by abuse in the home…"

<u>End with stating:</u>

- Please be assured that whatever you say will be kept confidential but if you are being abused, we want to give you a chance to talk about it.

- For a patient with an obvious indicator of abuse- "Has this injury been caused by your partner or someone that you know?"

<u>Examples of asking a direct question:</u>

- Do you ever feel frightened of your partner? Do you feel that you are in danger?

- Have you been physically hurt by your partner? Has your partner ever threatened to hurt you or someone you care about?

- Are there any problems with your partner? Do you ever argue or fight? Do the fights become physical? Are you ever afraid?

Do you feel controlled and isolated by your partner? Does your partner belittle and insult you?

How to document the screening:
A record of screening should be documented on the patient card. The tick box resembles the following:

Screening: __Yes __No
__DV+ __DV- __DV?

- Tick "Yes" if the nurse is able to ask the screening question. If unable to ask, tick "No".
- If the patient discloses current or former abuse by a partner, tick "DV +"
- If the patient denies abuse by a partner, tick "DV -"
- If the nurse suspects intimate partner violence but it has been denied by the patient, tick both "DV-" and "DV?"
- If the nurse is unable to ask the screening question but indicators of abuse are present, tick "DV?"

ASSESS THE PATIENT AND OFFER INTERVENTION

THE OVERALL ROLE OF THE NURSE

The goal for the nurse in a situation where the patient has disclosed intimate partner violence is to assess for immediate danger within the Walk-in, to reassure the patient and to refer to appropriate services as quickly as possible.

The nurse should set boundaries with the patient that communicates concern but also that there are more specialised services who can help and that the nurse is not able to do more than empathize and facilitate the referral.

Success is asking the screening question no matter what the response or what help is accepted by the patient. This sends a strong message to the patient that intimate partner violence is serious. Just asking may change the patient's thinking about what is happening to him/her. It also sends the message that there is help available. The patient may not accept help on the day but may keep the local resource numbers and call for help in the future.

IF ABUSE IS IDENTIfiED

Make an initial statement to show concern for the patient but proceed to ascertain a couple of things as quickly as possible.

- **Assess immediate danger-** Ask, “Are you safe now?” Find out if the abuser is with the patient at the Walk-in Centre. If the abusive partner is in the Walk-in Centre, be careful not to leave any written information in the clinical room that would alert the abuser that intimate partner violence has been discussed.
- If the patient indicates danger, offer to call the Police and to wait in the Walk-in.
- Ask the patient if there is an existing protection order or anything staff at the Walk-in Centre should be aware of.
- Ask the patient if she would like the reception staff to be notified not to pass along any messages to callers asking about her.
- As with any situation, if there is an immediate threat to the patient or staff, notify the Police.
- **Determine if the injuries need to be documented by a doctor-** If the patient has injuries that were a result of a physical assault by his/her partner, advise the patient that it may be in his/her best interest to have their injuries documented by a doctor for future use in court. The three main options would be to see a GP, go to A&E, or call the police and be seen by a FME. If the patient agrees that it is best to go elsewhere, offer written information (see below) and tell that patient that there are special advocates who are able to help her at Charing Cross A&E and the Hammersmith and Fulham Police if he/she chooses either of those places. If not, encourage her to consider calling an agency for support given on the list of local resources.

RESPOND TO THE PATIENT

- Let her know that abuse is something that you are concerned about and it can impact on her health so you would like to offer some help and/or some information while she is here today.
- Each nurse will respond in his/her own style to this situation but the nurse should not ask a question or make a comment that could be perceived as judgmental such as, “Why are you staying in a situation like this?”
- The best statements to make are along the lines of the following:
    - I am not here to force you to do anything that you don’t want to do.
    - You do not deserve to be abused.
    - I am concerned about your safety and the safety of your children.
    - You have rights and options.
    - There is help for you if you want it.
- Be aware of your surroundings when speaking to the patient about abuse. Try to assure privacy as much as possible such as communicating with her in a way that is not overheard.

Offer options

Charing Cross Walk-in
Inform her that an Advocate from ADVANCE can be reached. Explain that the Advocate is someone who can inform his/her of her rights and options and the Advocate will not force his/her to do anything that he/she does not want to do.

- The Advocate can come to speak with her at the Walk-in Centre (this is available M-F, between the hours of 10:00-5:00 PM). To do this, beep the Advocate on 020 7385 0409.
- From 5:00 to 10:00 PM and on weekends, the Advocate can be reached by mobile to speak with the patient directly. The on-call numbers are provided monthly and can be found on the notice board.
- If the patient would only like to speak with the Advocate briefly over the phone to set up another time to meet, use the same numbers as listed above.
- If the patient does not want to speak to the Advocate on the day, the nurse can offer the leaflet about ADVANCE, which contains their daytime telephone number. The patient could call ADVANCE at a convenient time.
- The nurse can also offer to leave a message with the Advocate and have the Advocate call the patient. In this case the details needed would be the patient's name, contact numbers, and when it is safe to call the patient.
- If she does not want to speak with an Advocate, give her the written information on domestic violence if it is safe for her to take away with her. Tell her that she can call the numbers listed at any time.

Parsons Green Walk-in

Unfortunately, the Advocate cannot come to Parsons Green because of resource limitations. However, the nurse can offer the following to patients at Parsons Green Walk-in:

- Explain that there is an Advocacy service that is available at Charing Cross Walk-in, Charing Cross A&E, and through the Hammersmith and Fulham Police. Explain that an Advocate is someone who can offer her specialist advice and recommend that she go to one of the above places if needed.
- Explain that there are other ways to receive help. Offer any of the four Women's Aid brochures that outline general domestic violence information (named "The Myths" and "Breaking Free", "Housing," and "Legal Options") and also offer the brochure of local resources. Especially point out
- DVIP (Domestic Violence Intervention Project) as a place that he/she can go for general information and advice.
- Remember it may not be safe for her to take away written information. Offer the business sized card with local resource numbers on it because it may be easier to hide.

If the patient does not want immediate help or guidance, tell the patient you understand this may not be the best time for her to talk but that she does not deserve to be abused. Tell that

patient that if she would like the written information in the future, he/she can drop in and pick it up.

Document

For patients who disclose intimate partner violence but wish to stay in the Walk-in Centre for treatment, explain that you will fill in the Domestic Violence Assessment Form and that it will be kept confidential in her medical file and may be useful to her in the future for court proceedings. Fill in the Domestic Violence Assessment Form. Ensure that the patient file is kept in an area where the abuser does not have access to it.

IF THE PATIENT IS NOT IDENTIfiED AS 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 wallet card or brochure.

POSSIBLE INDICATORS OF DOMESTIC VIOLENCE

POSSIBLE PRESENTING COMPLAINTS

1. Complains of abuse directly
2. "Falls"
3. "Stranger" assault
4. Chronic pain syndrome, headaches
5. Overdose/ suicide attempts or ideation
6. Anxiety, depression, multiple somatic complaints
7. Miscarriage/vague gynaecological complaints (e.g. pelvic pain)
8. Psychosomatic complaints

POSSIBLE INDICATORS OF ABUSE FROM PATIENT'S HISTORY

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

POSSIBLE BEHAVIOURAL INDICATORS OF ABUSE

1. Patient evasive/guarded
2. Patient embarrassed with poor eye contact
3. Patient depressed with injuries
4. Patient denies abuse too strongly
5. Patient has charged/fearful behaviour with partner
6. Patient defers to partner
7. Partner hovers
8. Patient minimizes injury or demonstrates inappropriate responses

HIGH RISK INJURIES

1. Mid-arm injuries (defensive)
2. Strangulation marks
3. Injuries to areas not prone to injury by falls
4. Weapon injuries or marks
5. Symmetrical injuries
6. Old, as well as new injuries
7. Bites and burns (scald and cigarette)
8. Injuries to multiple sites
9. Poor nutrition

COMMON INJURIES

1. Black eyes
2. Dental injuries
3. Mid face injuries
4. Breast/ abdominal/internal injuries
5. Injuries hidden by clothing

RESOURCES (NOTE: THESE NUMBERS MAY HAVE CHANGED SINCE PUBLICATION IN JULY '02)

ORGANISATIONS YOU MAY CALL OFTEN

STANDING TOGETHER AGAINST DOMESTIC VIOLENCE

NICOLE JACOBS, HEALTH DEVELOPMENT WORKER	0208 748 5473
BERYL FOSTER, CO-ORDINATOR	0208 748 5717

ADVANCE (ADVOCATES)

BEAR MONTIQUE, COORDINATOR	OFfiCE 0207 385 0409
SOPHIE WALDEIGH	PAGER 07625461450
LOLA LAKOJA	(SEE NOTICE BOARD FOR ON CALL NUMBERS)

Police

EMERGENCY	999
FULHAM POLICE SWITCHBOARD	0207 385 1212
HAMMERSMITH POLICE SWITCHBOARD	0208 563 1212
SHEPHERDS BUSH POLICE SWTICHBOARD	0208 740 1212
HAMMERSMITH COMMUNITY SAFETY UNIT	0208 246 2436
FULHAM COMMUNITY SAFETY UNIT	0208 246 2985
KENSINGTON AND CHELSEA VULNERABLE PERSONS UNIT	0208 246 2985
WESTMINSTER VULNERABLE PERSONS UNIT	0207 321 6766
EALING DOMESTIC VIOLENCE UNIT	0208 246 9428
CRIMESTOPPERS	0800 555 111

DOMESTIC VIOLENCE INTERVENTION PROJECT (DVIP)

WOMEN'S ADVICE SERVICE	0208 748 6512
VIOLENCE PREVENTION PROGRAMME	0207 563 7983

For Refuge Accommodation

REFUGE 24 HOUR HELPLINE	0870 599 5443
WOMEN'S AID NATIONAL HELPLINE	0345 023 468

OTHER SERVICES

RIVERSIDE DROP-IN (MONDAYS 10:00-12:30)	0208 741 4772
WOMEN'S RESOURCE CENTRE	0207 729 4011
VICTIM SUPPORT	0208 748 6200
COCOON (SELF HELP GROUP RUN BY SURVIVORS)	0208 749 7211

FOR ABUSED MEN

SURVIVORS	0207 833 3737

FOR THE ELDERLY

Age Concern	0207 386 9085
Agewell (community learning and leisure)	0207 385 7339

GAY AND LESBIAN

PACE (COUNSELLING SERVICE)	0207 700 1323
PINK PRACTICE (COUNSELLING SERVICE)	01535 635444
SURVIVORS OF LESBIAN ABUSE (SOLA)	0207 328 7389
LESBIAN AND GAY SWITCHBOARD	0207 837 7324

VOLUNTARY ORGANISATIONS FOR SPECIfiC ETHNIC GROUGPS

AASHA BANGLADESHI WOMEN'S PROJECT	0207 386 1881
ARAB WOMEN'S GROUP	0208 563 0850
ABAYOMI (COUNSELLING FOR AFRICAN CARIBBEAN PEOPLE)	0208 741 3335
AL-HASANIYA MOROCCAN WOMEN'S CENTRE	0208 969 2292
BENGALI WOMEN'S PROJECT	0207 388 6200
CHINESE WOMEN'S REFUGE GROUP	0207 837 7297
CHINESE INFORMATION AND ADVICE CENTRE	0207 692 3471
EALING TRAVELERS PROJECT	0208 741 9094
ETHIOPIAN COMMUNITY IN BRITAIN	0207 749 4116
HORN OF AFRICA COMMUNITY GROUP	0208 741 1119
HAMMERSMITH AND FULHAM ASIAN ASSOCIATION	0208 746 2701
IRANIAN ASSOCIATION	0208 748 6682
JEWISH WOMEN'S AID	0207 837 1600
KHANUM WOMEN'S GROUP (FOR BLACK AND ETHNIC MINORITY WOMEN)	0207 381 5068
LATIN AMERICAN WOMEN'S AID	0207 336 0888
NEWHAM ASIAN WOMEN'S PROJECT	0208 552 5524
SIMBA (ACTIVITIES FOR AFRICAN CARIBBEAN PEOPLE)	0208 740 6879
SOMALI INFORMATION CENTRE	0208 964 4540
SOMALI WOMEN'S CENTRE	0207 328 7389
SOUTHALL BLACK SISTERS	0800 591 203
VIETNAMESE ASSOCIATION	0208 742 9745

ALCOHOL ADVICE CENTRES

ACCEPT SERVICES	0207 371 7477
RIVERSIDE SUBSTANCE MISUSE ALCOHOL SERVICE	0208 846 7870
TURNING POINT	0208 997 0022
ETHNIC ALCOHOL COUNSELLING IN HOUNSLOW	0208 577 6059
THE BEDFORD CENTRE	0208 567 1215
THE WOMEN'S ALCOHOL CENTRE	0207 226 4581
RUGBY HOUSE PROJECT	0207 837 9323

Children

Shepherds Bush Families Project (for homeless families and families in temporary accommodation	0208 749 2371
Askham Family Centre	0208 749 6936
Fulham Parents and Children (FULPAC)	0207 385 6317
Childline	0800 1111
Children's Legal Service	01206 873 820
NSPCC Child Protection Helpline	0800 800 500
Parent line	01702 559 900
Barnardo's Young Women's Project	0207 700 2253
Amica (self help for women who have experienced difficulties with child contact and custody)	01227 369 800

Drug Advice Centres

Druglink	0208 749 6799
Riverside Substance Misuse Service	0208 846 6611
The Griffin Project (residential programme for HIV and drug users)	0207 373 9826
The Basement Project (for ages 16-30)	0207 373 2334
Tasha (tranquilliers)	0208 569 9933
Blackliners (for Black or Asian people affected by HIV)	0207 738 7468
NAZ Project (HIV and sexual health working with South Asian, Turkish, Arab and Irani communities)	0208 741 1879
Release (legal helpline)	0207 729 5255
National Drugs helpline	0800 776 600

Housing

London Borough of Hammersmith and Fulham Housing Association Emergency Housing Unit	0208 576 5404
Housing Aid Services	0208 753 1436
Ebony Sistren Housing Association	0208 740 0220
Shepherds Bush Housing Association	0208 996 4242
Shelter Advice Line	0800 446 441
Women's Link	0207 248 1200

Immigration

Immigration Advice Service	0207 378 9191
Refugee Council	0207 346 6777
Joint Council for the Welfare of Immigrants	0207 251 8706

Legal

Hammersmith and Fulham Community Law Centre	0208 741 4021
North Kensington Law Centre	0208 969 7473
Paddington Law Centre	0208 960 3155
Fulham Legal Advice Centre	0207 731 2401
Rights of Women	0207 251 6577
Justice for Women	0208 430 3699

Mental Health

Women's Action for Mental Health	0208 749 9446
Bridge Centre for Women's Emotional Wellbeing	0208 749 9451
The Forward Project (for Black men and women)	0208 749 6796
Women and Girls Network (for those who have experienced violence)	0207 610 4678

Welfare, benefit, housing and employment advice

Shepherds Bush Advice Centre	0208 753 5910
Fulham Citizens' Advice Bureau	0207 385 1322
Threshold Housing Advice Centre	0208 740 5046
Money Advice Unit	0207 610 3008

General

Hammersmith and Fulham Council

Community Safety Unit	0208 576 5660
Social Services	0208 576 5404

Support

samaritans	0345 909090

To obtain additional resources

women's resource centre	0207 729 4011
london borough of hammersmith and fulham's information centre - hammersmith	0208 753 2615
london borough of hammersmith and fulham's information centre - fulham	0208 753 3914

INFORMATION ABOUT INTIMATE PARTNER VIOLENCE

DOMESTIC VIOLENCE IS:

- A PATTERN OF VIOLENT AND COERCIVE TACTICS
- COMMITTED BY ONE INTIMATE PARTNER AGAINST ANOTHER
- A PATTERN OF CONTROLLING BEHAVIORS THAT CONSISTS OF
- PHYSICAL SEXUAL AND/OR PSYCHOLOGICAL ABUSE OR ASSAULTS
- A LEARNED PATTERN OF BEHAVIOUR
- DESTRUCTIVE TO ALL THOSE AROUND THE ADULT AND CHILD SURVIVOR (FAMILY, FRIENDS, CO-WORKERS, ETC.)

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
- 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 SURVIVORS BEHAVIOUR

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

Intimate Partner Violence and Health

- ✓ Domestic Violence does have health related consequences that extends 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 (Jezierski, 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 prevelent than medical case notes indicate (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*
- *the British Association of A&E Medicine.*

The Royal College of Nursing have 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.

Barriers to Leaving an Abusive Relationship

Fear

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

Resources

- Lack of social support
- Lack of support from institutions
- Lack of a housing alternative
- Lack of money
- Does not want to leave her 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 such as ones in probation or DVIP) can 'fix' him
- That all men are violent and that violence should be expected in a relationship
- That she 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 in a crime
- Love for the perpetrator
- Feelings of person incompetence

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 HER LIFE THAT IN ANTICIPATING TALKING WITH YOU, SHE MAY WORRY ABOUT WHAT TO SAY. SHE MAY BE WORRIED THAT YOU WILL USE WHAT SHE TELLS YOU TO HURT HER OR HER CHILDREN.

2. **FEAR OF BEING JUDGED OR VIEWED AS LESS THAN HUMAN**
   THE SURVIVOR MAY BE CONCERNED THAT YOU WILL JUDGE HER HARSHLY BECAUSE SHE NEEDS HELP AND IS EMBARRASSED ABOUT WHAT HAS HAPPENED TO HER. THIS IS PROBABLY THE RESPONSE SHE HAS RECEIVED FROM OTHER AND HAS INTERNALIZED THOSE VIEWS. SHE MAY VIEW HERSELF IN A NEGATIVE WAY BECAUSE SHE NEEDS HELP.

3. **CONCERNED ABOUT CONfiDENTIALITY**
   THE SURVIVOR MAY BE CONCERNED WITH CONfiDENTIALITY FOR MANY REASONS. SHE MAY BE CONCERNED THAT OTHER AGENCIES WILL BE AWARE OF HER PERSONAL INFORMATION OR THAT INFORMATION WILL 'GET OUT ON THE STREET' AND IN PARTICULAR, BACK TO THE PERPETRATOR.

4. **CONCERN ABOUT BEING PRESSURED**
   SHE MAY FEAR THAT YOU WILL PRESSURE OR MAKE HER DO SOMETHING THAT SHE DOES NOT WANT TO DO. SHE MAY FEAR THAT WE WILL BE PRESSURED TO MAKE A DECISION THAT THEY ARE NOT SURE THEY CAN COMPLY WITH OR THAT SHE WILL HAVE TO GIVE YOU INFORMATION THAT SHE IS NOT COMFORTABLE WITH PROVIDING.

5. **CONCERNED ABOUT THE NEGATIVE CONSEQUENCES OF SEEKING HELP**
   SHE MAY BE CONCERNED WITH THE NEGATIVE CONSEQUENCE FROM THE PERPETRATOR WHO HAS LIKELY WARNED HER OF WHAT HE WILL DO TO HER OR OTHERS IF SHE SEEKS HELP. SHE MAY KNOW THAT HE WILL CARRY OUT THESE THREATS BY TIMES IN THE PAST WHEN SHE HAS SOUGHT HELP FROM OTHER SOURCES. SHE MAY BE OPERATING UNDER FALSE PRESUMPTIONS ABOUT THE KIND OF HELP YOU OFFER.

Appendix 2

Protocol for the Charing Cross Accident and Emergency Department

HAMMERSMITH HOSPITALS NHS TRUST

CHARING CROSS HOSPITAL ACCIDENT AND EMERGENCY

POLICY TITLE: INTIMATE PARTNER VIOLENCE

I. **GUIDING PRINCIPLES:**
Charing Cross A&E believes that all people are entitled to the right to live free from violence or threat of violence from current or former partners. Because healthcare providers may be the first professionals to whom an abused person turns to for help, the medical staff have an opportunity and responsibility to provide appropriate and sensitive interventions. Charing Cross A&E is committed to developing and implementing policies and procedures for identifying, treating and referring victims of intimate partner violence.

II. **PURPOSE OF THIS PROTOCOL:**
   a. To effectively treat all injuries and illnesses
   b. To provide and communicate a safe environment for the patient
   c. To identify intimate partner violence through screening and through recognition of possible indicators of abuse
   d. To offer specialist advice, support, and safety planning at the A&E or after discharge
   e. To document correctly and thoroughly and offer photographic evidence to be taken
   f. To provide referral information during the healthcare contact

II. **DEFINITIONS:**
Intimate Partner Violence is an ongoing, debilitating experience of physical, psychological, and/or sexual abuse involving force or threat of force from a current or former partner associated with increased isolation from the outside world and limited personal freedom and accessibility to resources. A victim of intimate partner violence is anyone who has been injured or has been emotionally or sexually abused by a person with whom he or she has had a primary relationship.

III. **LEGAL CONSIDERATIONS:**
Physical violence and threats are a criminal offence and person may seek relief through the criminal justice system as well as civil remedies such as injunctions and non-molestations orders (see appendix 2 for resource numbers). Medical staff are not under a

legal obligation to report instance of intimate partner violence. For physicians or other health care professionals, reporting abuse to law enforcement should be done with the abused person's knowledge and consent. Only the abused person can assess the danger and relative risk of reporting the violence verses not reporting the violence to the authorities. All other reporting requirements such as for child abuse must be followed as per A&E protocol.

IV. **CONFIDENTIALITY:**

It is vital to stress to the abused person that all interviews regarding intimate partner violence shall be conducted in private and that anything that is disclosed to a member of staff at the A&E will not be disclosed to the abuser or any person accompanying the victim to the A&E without his/her consent. It should also be stressed that the medical staff will not call outside statutory or voluntary agencies without the victim's consent. It should be stated that the only breach in confidentiality with the patient would be if staff are concerned for the welfare of children involved.

Triage Nurse's Role — Conduct initial screening for intimate partner violence at triage.

Who to screen?

- All female patients will be screened who are above the age of 16 regardless of their presenting medical concern.
- Male patients that exhibit indicators of abuse (see appendix I) will be screened at triage.

Assurance of Privacy and Confidentiality

The nurse should attempt to speak to the woman in private at triage. The nurse will:

- ensure that the door to the triage room is shut
- ensure that any visitors (including visitors of the same sex) are asked to leave and told that this is a routine policy
- not ask the IPV screening question if 1) the patient is accompanying by another adult 2) the patient is accompanied by children (unless the child is an infant)

However, if the patient discloses abuse in front of a friend or family member accompanying her to the A&E, the nurse should refer to this protocol for assessment and referral of the patient.

If unable to speak to the patient alone in triage, the nurse should make additional attempts to assess privately. This may be to interview the patient in the X-ray room or another private area such as the gynaecological side room in minors or the relative's room.

How to ask the screening question

The nurse should ask the following question in a way that is most comfortable for him/her. Any nurses who feel uncomfortable asking this question should seek aid from other nurses or the ADVANCE Advocate because it is crucial that the patient feels that medical staff is not embarrassed to talk about this issue.

Following are general guidelines:

- The screening question should begin by framing the question so that the patient understands that this is a question asked of every female patient and that her confidentiality is assured.
- A direct question should follow. Studies show that people will disclose more often if asked directly. Remember if medial staff are not able to speak directly about this issue, then neither will the patient. See recommendations in the boxes below for how to ask the question.
- If the patient requires a translator, call Language Line. Do not use the patient's children or friends to translate regarding abuse. Be aware when using a translator that the definition of abuse may change according to the language. Try to be as clear a possible with the translator about what you mean.

Use gender-neutral language such as, "partner". Do not assume that you are speaking to someone in a heterosexual relationship.

Examples of framing the question:

- (When first starting) You may have seen our poster. We are asking a new screening question to do with violence in the home.
- I hope that you don't find this intrusive but we ask every woman about problems in the home.
- In addition to your health concerns, we are also asking all women about the possibility for abuse since we have found the violence is so common in women's lives.
- I don't know if this is a problem for you but many women experience problems with their partners. It is a hard thing to bring up so we are asking everyone as a matter of course…

End with stating:

- Please be assured that whatever you say will be kept confidential but if you are being abused, we want to give you a chance to talk about it.

Examples of asking a direct question:

- Do you ever feel frightened of your partner? Do you feel that you are in danger?
- Have you been physically hurt by your partner? Has your partner ever threatened to hurt you or someone you care about?
- Are there any problems with your partner? Do you ever argue or fight? Do the fights become physical? Are you ever afraid?
- Do you feel controlled and isolated by your partner? Does your partner belittle and insult you?

How to document the screening:
A stamp will be place in every female patient card at reception. There will also be a stamp in the triage room. The stamp will resemble the graphic below.

___ DV Current

___ DV None Π ___Unable to ask

___ DV Previous

- If the patient discloses current abuse by a partner, tick "DV Current."
- If the patient discloses previous abuse by a partner, tick "DV Previous."
- If the patient denies abuse by a partner, tick "DV none."
- *If the patient is unable t o be asked, due to his/her medical condition or if not alone with the nurse, tick "Unable to ask."*
- *If the nurse suspects intimate partner violence but it has been denied or he/she is unable to ask, the nurse will tick the middle of the graphic to indicate to the Named Nurse and the Doctor that they should attempt to address abuse if possible.*

IF ABUSE IS IDENTIfiED:

Assess immediate danger

- Mark "Domestic Violence" as mechanism of injury.
- Ask, "Are you safe now?" Find out if the abuser is with the patient at the A&E. If the abusive partner is in the A&E, observe for danger of the patient leaving prior to being seen. Offer a private place to wait if possible.
- If children, ask about their whereabouts. If with the abuser, she may be concerned about their welfare and leave before being treated.
- Notify the Named Nurse to expedite treatment if possible. Assign a Named Nurse even if the patient will be treated in the Minors Bay.
- If the patient indicates danger, offer to call the Police, and/or Security and to move her to a safe location to wait.
- Ask the patient if there is an existing protection order or anything staff at the A&E should be aware of.
- Ask the patient if she would like the reception staff to be notified not to pass along any messages to callers asking about her.

- As with any situation, if there is an immediate threat to the patient or staff, notify Security and/or the Police.

Respond to the patient

- Let the patient know that she will have the opportunity to speak with someone in private (after triage) and that she will not be asked to do anything that she does not want to do but that you can offer help.
- Let her know that abuse is something that you are concerned about and it can impact on her health so you would like to offer some help and/or some information while she is here today.

NAMED NURSE'S ROLE

IF ABUSE IS IDENTIFIED AT TRIAGE:

Administrative

- A Named Nurse will be assigned.
- Seek a Senior Doctor for assessment.
- Aim to place the patient in a room with a door if possible.
- Add the Domestic Violence Assessment Form to the medical file if not done already by reception.
- Take special care at your handover during the shift change to introduce the new Named Nurse to the patient and to fully brief the Named Nurse on safety concerns and plan of action.

Validate

After treating the patient's presenting medical concerns, convey that you can see that she has disclosed that she may need some help or information about abuse.

- Be aware of your surroundings when speaking to the patient about abuse. Try to assure privacy as much as possible such as communicating with her in a way that is not overheard.
- Validate the patient's feelings. Let her know that she is not responsible for the abuse and express concern about her safety.

Offer options

Inform her that an Advocate can be reached and that you:

- would be glad to arrange the Advocate to come speak with her at the A&E (M-F, 10:00-5:00)
- can call the Advocate from the A&E and allow them to speak over the phone (24 hours a day, 7 days a week)

Explain that the Advocate is someone who can inform her of her rights and options and the Advocate will not force her to do anything that she does not want to do.

If she does not want to speak with an Advocate, give her the written information on domestic violence if it is safe for her to take away with her. Tell her that she can call the numbers listed at any time and that you understand this may not be the best time for her to talk but that she does not deserve to be abused.

If admitted to the hospital, the patient can be referred to Social Services for support.

Document
Explain that you will fill in the Domestic Violence Assessment Form and that it will be kept confidential in her medical file and may be useful to her in the future for court proceedings. Fill in the Domestic Violence Assessment Form 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.

IF THE PATIENT IS NOT IDENTIfiED AS 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 WALLET CARD OR BROCHURE. IF ABUSE IS IDENTIfiED, REFER TO ABOVE PROTOCOL.

PHYSICIAN'S ROLE

- Evaluate and treat injuries and medical concerns. All patients who have indicated abuse will receive a complete physical exam, including neurological exam and x-rays if indicated, looking for evidence of old and new fractures.
- Consider intimate partner violence in all female patients and be aware of high-risk indicators.
- When advised by the nurse that abuse exists:
- Validate the feelings of the patient and indicate that you understand that she is not to blame.
- Be supportive but not directive on what she should or should not do.
- Emphasize safety and the risk of further violence.
- Let her know that the Advocate can talk with her about her rights and options.
- When the patient has not admitted abuse but the Physician or Nurse is suspicious of abuse, attempt to facilitate disclosure with questions such as, "Your injuries concern me. Injuries such as these are often caused by abuse. Could this be happening to you?" "Help is available."
- If the patient acknowledges abuse, notify the Named Nurse to initiate a referral to the Advocate or to give some written information.
- If injuries exist as a result of abuse, encourage photographs. A primary purpose of photos is to allow useful evidence to be available to the patient if needed in the future.

- If patient has obvious or suspected abuse but cannot communicate or acknowledge abuse (i.e. unconscious or impaired), notify the Named Nurse.
- Document the history and physical exam with attention to objective findings.
- Consider admitting patients who are in eminent danger but cannot be placed in a refuge or emergency accommodation.

Photographic Evidence

- When the injury lends itself to photographic documentation, the physician or nurse may take a photo.
- Consent for photos should be obtained according to hospital policy.
- When using the Polaroid camera, note the following on the back of each photo by filling in the sticker provided in the camera bag:

Date:_________________________________
Location:______________________________
Patient name:___________________________
Medical record number:_________________
Photographer's initials:__________________
Part of the body photographed:____________
Patient's initials:_______________________

- Multiple photos should be taken to include close-ups of the injury as well as distant photo of the injury. These photos should be affixed to the medical record or stored as part of the medical record according to hospital policy.
- Instruct the patient to speak to the Advocate or to come back to the A&E in the following days if the injury becomes more pronounced so that further pictures can be taken.

Referral Guidelines

The Advocate's number and on call rota is located on the notice board at central station. The leaflets on domestic violence are located at central station or the triage room.

If the patient agrees to speak with an Advocate, staff can offer the following:

- The Advocate can come to the A&E and see the patient within an hour (during weekdays from 10:00 AM to 5:00 PM).
- The nurse can allow the patient to speak with the Advocate over the phone (from the A&E) for an initial contact. This is available 24 hours a day, 7 days a week.
- The nurse can pass along basic details for the Advocate to call the patient. 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 number to the patient along with a brochure (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.
- 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.

If the patient has indicated abuse but declines to speak with an Advocate

- The nurse should express concern for the patient's safety and indicate that there is help available if she would ever need it.
- Offer written materials to the patient. Offer a specific leaflet on domestic violence if it is safe for her to take it. If not, you can offer a more general brochure and point out the numbers for domestic violence services.
- Do not leave leaflets in the area especially if the perpetrator is with the patient or if there is another adult with the patient and you are unsure of their relationship.

Abuse of men

- For men who present with injuries, consider the high-risk criteria indicated in Appendix 1.
- If high-risk criteria are present, ask about the possibility of abuse. Be sure to use language that is gender neutral (partner rather than wife or girlfriend). The Triage Nurse or the Named Nurse would ideally do this.
- Document and refer as stated above. ADVANCE will take an initial referral for men but will likely refer them on to specialist services.

(Same appendixes as the Walk-in Centre protocol please see pages 16-30)

Appendix 3

Documentation form used at Charing Cross Hospital A&E

INTIMATE PARTNER VIOLENCE ASSESSMENT FORM IPV1

BASIC INFORMATION

1. Date:______________________________
2. Patient Name:________________________
3. Is patient pregnant ___Yes ___No
4. How did the injuries occur?
   (try to use patient's own words)

   ____

   ____

5. Is assaulted, what is the patient's description of the assault? (example- struck with fists or object, kicked, thrown)

   ____

   ____

6. Does the patient allege intimate partner violence/domestic violence?
   ___Yes ___No
7. If yes,
   a. the name of the alleged assailant
   ____
   b. the relationship to the patient
   ____

SAFETY PLAN

Assess Patient Safety

___Yes ___No Is your partner with you today?
___Yes ___No Are you afraid to go home?
___Yes ___No Has abuse increased in frequency over the last year?
___Yes ___No Does your partner threaten to harm you or him/herself?

What are you most concerned about?

*(*Note for indications that the patient might leave early and make sure you have given referral information.)*

Review Patient Referrals

We can call a service called ADVANCE to speak with you now or to set up an appointment for later.

___Yes ___No Would you like me to call ADVANCE now?

Would you rather me contact ADVANCE and ask them to call you at a certain time? If yes fill in below:

Day of week:______________________
Good time to call:___________________
Number to call:_____________________

___Yes ___No Resource materials given

___Yes ___No Does the patient want to call the Police?

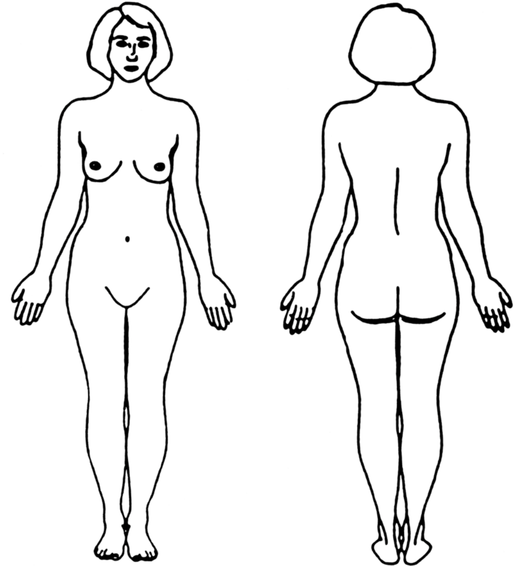
Has the patient talked with any other agencies about abuse in the past? (If yes, which ones?)

Signature of Nurse:__________________________________ Date:________________

DOCTORS - FILL IN THIS SIDE
Physical findings for intimate partner violence:

Notes:

Indicate where injury was observed:



	Bruise	Abrasion	Laceration	Bleeding	Tenderness
Head					
Ears					
Nose					
Cheeks					
Mouth					
Neck					
Shoulder					
Arms					
Hands					
Chest					
Back					
Abdomen					
Genitals					
Buttocks					
Legs					
Feet					

Consent for photographs given by patient: (patient signature) ___________________________

Photographs taken __ Yes __ No

Signature of Doctor: _____________________________________ Date: ________________

Appendix 4

Worksheets used in the Team Meetings with the A&E to develop the protocol (Condensed)

PROPOSED OUTLINE OF PROTOCOL FOR DOMESTIC VIOLENCE

- I. GUIDING PRINCIPLES
- II. POLICY (GENERAL STATEMENT)
- III. DEFINITIONS
- IV. LEGAL CONSIDERATIONS AND REPORTING REQUIREMENTS
- V. PROCEDURE (WITH ROLES FOR NURSES, DOCTORS AND OTHER STAFF)
  - a. SCREENING
  - b. ASSESSMENT
  - c. INTERVENTION
  - d. DOCUMENTATION
  - e. REFERRAL
- VI. ABUSE OF MEN
- VII. SECURITY FOR STAFF
- VIII. TRAINING
- IX. APPENDIX (HIGH RISK INDICATORS, QUESTIONS TO ASSIST DISCLOSURE)

CREATING A MODEL RESPONSE TO DOMESTIC VIOLENCE
CHARING CROSS A&E

WORKSHEET 1
WHAT DO WE CURRENTLY DO?

1) **What do we currently do when we suspect domestic violence is a factor?**

2) **What are our strengths in dealing with cases of domestic violence?**

WORKSHEET 2
SCREENING

1) **Who should be screened for domestic violence?**
RECOMMENDATION- THE SCREENING WILL OCCUR WITH ALL WOMEN OVER THE AGE OF FOURTEEN, WHETHER OR NOT SYMPTOMS OR SIGNS ARE PRESENT AND WHETHER OR NOT THE PROVIDER SUSPECTS ABUSE HAS OCCURRED.

2) **Who to conduct the screening?**
RECOMMENDATION- THIS MUST BE SOMEONE WHO IS ABLE TO SPEAK WITH THE PATIENT IN A PRIVATE SETTING.

3) **How should the screening occur?**
RECOMMENDATION- THE SCREENING IS DONE AS PART OF A FACE-TO-FACE ENCOUNTER WITH A PERSON WHO IS DIRECT AND NON-JUDGEMENTAL. IT SHOULD TAKE PLACE IN PRIVATE WITHOUT FRIENDS OR RELATIVES OF THE PATIENT'S PRESENT. THE PATIENT IS TOLD OF THE CONFIDENTIALITY OF THE CONVERSATION AND THE LIMITS OF THAT CONFIDENTIALITY. USE INTERPRETERS IF NEEDED RATHER THAN A PATIENT'S FRIEND OR FAMILY MEMBERS.

4) **How will screening be documented?**
RECOMMENDATION- CHANGE THE MEDICAL CHART TO INCLUDE SCREENING QUESTION AND RECORD SCREENING OUTCOMES.
Examples:

Screening Question printed here
DV +_____ DV-_____ DV unk_____

Screening Question printed here
DV previous_____ DV current_____
DV none_____ Do not wish to answer_____

5) **What should the screening question be?**
RECOMMENDATION – FRAMES THE QUESTION SO THAT THE PATIENT UNDERSTANDS THAT YOU ASK THIS QUESTION OF EVERYONE AND THAT YOU CONSIDER DOMESTIC VIOLENCE TO BE A WIDESPREAD AND PREVALENT ISSUE WITH MANY PATIENTS. THEN FOLLOW UP WITH A DIRECT AND SIMPLE QUESTION.

EXAMPLES OF FRAMING THE QUESTION:
- WE ASK THIS OF EVERY PATIENT BECAUSE WE HAVE FOUND THAT VIOLENCE IS SO COMMON IN MANY PEOPLE'S LIVES…
- I DON'T KNOW IF THIS IS A PROBLEM FOR YOU BUT WE ASK THIS OF EVERY PATIENT…
- SOME PEOPLE ARE TOO AFRAID OR UNCOMFORTABLE TO BRING THIS UP SO WE ASK THIS OF EVERY PATIENT…

EXAMPLES OF ASKING DIRECT VERBAL QUESTIONS:
- ARE YOU IN A RELATIONSHIP WITH A PERSON WHO PHYSICALLY HURTS OR THREATENS YOU?
- HAS YOUR PARTNER OR EX-PARTNER EVER HIT YOU OR PHYSICALLY HURT YOU?
- DID SOMEONE CAUSE THESE INJURIES? WAS IT YOUR PARTNER?

6) **If the patient says no to the screening question but you suspect abuse, what should happen?**

Creating a Model Response to Domestic Violence
Charing Cross A&E

Worksheet 3
Assessment and Intervention

1) **What are the essential elements of assessment and intervention that can be done by the physician, nursing staff and others?**
   Recommendation for assessment-
   - Assessment of immediate threat. For example, is the victim's partner with her at A&E?
   - What should happen if there is an immediate threat?
   - Chief complaint/History of present illness
   - Physical examination and preservation of evidence
   - Mental health assessment

   Recommendation for intervention-
   - Validation
   - Providing information about domestic violence and safety planning
   - Contacting the Police and/or ADVANCE

2) **Who should conduct the assessments?**

3) **Are there specific assessments that should be carried out given your setting? (Mental health, suicide or homicide assessments)**

4) **Are there on-site staff that can carry out more in-depth interventions with those patients wanting further assistance?**

5) **What interventions can you offer?**
   - ADVANCE
   - Informational brochure

Creating a Model Response to Domestic Violence
Charing Cross A&E

Worksheet 4
Documentation

1) **What forms need to be changed to include a) screening has taken place and the outcome of that screening b) outcome of the assessment?**
   Recommendation- Adapt form similar to assessment form attached.

2) **What is the process to change these forms? Who or what key staff need to take part in the review?**

CREATING A MODEL RESPONSE TO DOMESTIC VIOLENCE
CHARING CROSS A&E

WORKSHEET 5
Training Programme

1) **Who or what key staff should get training on domestic violence and the protocol?**

2) **How often should staff receive training?**

3) **How will new staff be incorporated into the training programme?**

4) **When can the initial training take place? What times are allotted for education and in-service training?**

5) **What materials should we have in place before the training takes place (protocols, posters, brochures)?**

6) **Where would the training take place?**

CREATING A MODEL RESPONSE TO DOMESTIC VIOLENCE
CHARING CROSS A&E

WORKSHEET 6
Resource Materials

1) **What resources are needed for the A&E? (for staff and for patients)**

2) **Are there specific communities that need additional service or outreach materials?**

3) **Where would you like to distribute the materials?**

CREATING A MODEL RESPONSE TO DOMESTIC VIOLENCE
CHARING CROSS A&E

WORKSHEET 7
MONITORING THE RESPONSE

1) **What kind of quality assurance mechanisms would you like to develop? Are there any other mechanisms that we should put in place other than what we will do for the Home Office?**

Appendix 5

Induction and Training for new Domestic Violence Advocates (ADVANCE)

Day One:

10:00-12:30
What is ADVANCE and what is Standing Together?
This session will include:
- The purpose and philosophy of ADVANCE
- The structure of ADVANCE- how it is managed
- The history of ADVANCE and Standing Together
- The structure of Standing Together
- A brief description of the partners in Standing Together
- The projects of Standing Together – health and civil

(12:30-1:30 Lunch)

1:30-3:00
Domestic Violence Basics
This session will include:
- The facts- statistics on domestic violence locally and nationally
- Myths and Realities about domestic violence
- Power and Control- the cause of domestic violence (and what are not the causes)
- Forms of abuse
- Barriers to leaving
- Characteristics of battering
- Lethality of batterers

3:00-5:00
- Free to do advocacy work.
- Get settled in new office and desk

Day Two:

10:00-12:00
The Effects of Domestic Violence
- This session will include:
- Stages in a survivor's experience
- The effects of survivors
- Help seeking
- The healing process

12:00-1:00 Lunch

1:00-3:00
Cultural Competency
This session will include:
- Basic assumptions
- Forms of oppression
- The relationship of sexism to other forms of oppression
- Local resources

3:00-5:00
- Building orientation
- Continue getting settled and organising room

Day Three:

10:00-12:00
An Advocate's Job Description
This session will include:
- Qualities of a good advocate
- Empowerment advocacy
- Client centred advocacy
- For helpful interventions for working with survivors
- The facilitative relationship
- Principals of interviewing
- Active listening
- Problem solving - the core of case management

12:00-1:00 lunch

1:00-4:00
Negotiation, diplomacy and handling conflict
Setting ground rules for handling conflict within the work environment

4:00-5:00
- Setting up extra case files (copying forms and assembly of case files)

Day Four:

10:00-12:00
Setting the Stage for Effective Crisis Intervention
This session will include:
- Intake
- Out of hours on call cover and rota
- Safety planning
- Assessing the police response
- Ethical commitments - confidentiality

12:00-1:00 Lunch

1:00-3:00
ADVANCE Policies and Protocols
This session will include:
- Documentation of case files
- Staff scheduling, office cover
- Office procedures
- Grievance procedure
- HWA/ ADVANCE policies

3:00-5:00
The ADVANCE Database
This session will include:
- Why is the database important?
- Procedures for data entry
- Practice of data entry

Day Five:

10:00-11:00
Hammersmith Police Station
- To meet CSU for a general briefing on how the CSU works and to meet the staff there.

1:00-2:30 - Standing Together lunch

Day Six:

2:00-5:00
Hammersmith Law Centre and Standing Together Civil Law Development Worker
- Presentation on Civil Law and the Standing Together Civil Law Project.

Day Seven:

9:00-11:00
Standing Together Operations Meeting
11:00-1:00
Standing Together Steering Committee

Day Eight:

1:00-2:00
West London Magistrates Court
- To meet with the Court Clerk who will give you a tour of the court and who will answer questions that you have about of the Magistrate Court works.

Appendix 6

Recording forms used at ADVANCE

CLIENT DETAILS- SECTION 1

NAME________________________________ OK to call at home? ❑ **Yes** ❑ **No**

PHONE #____________________________ **MOBILE#**______________________

ADDRESS____

POSTCODE______________________ **OTHER #**_________________________

CONFIDENTIALITY: The Advocate has discussed with this client the following aspects of confidentiality:

- ❑ ***GENERAL POLICY (& THE LIMITS OF)***
- ❑ ***DATA COLLECTION, STATS AND THE ADVANCE DATABASE***

SIGNATURE OF CLIENT________________________***DATE***________________
OR
INITIALS OF ADVOCATE______________________***DATE***_________________

ETHNIC ORIGIN: ❑White ❑European ❑Black ❑Asian ❑Chinese ❑Arabic

AGE:___**GENDER**: ❑Male ❑Female **DISABILITY**: Mental ❑Yes ❑No
Physical ❑Yes ❑No

PERPETRATORS NAME:____

ADDRESS:____

CHILDREN:

NAME____**AGE**________________
NAME____**AGE**________________
NAME____**AGE**________________

WHERE ARE THE CHILDREN LIVING? ❑NA ❑With client ❑With perpetrator
❑With both ❑With family or friends ❑Looked after in foster/residential care
❑Elsewhere_________________

DOES THE PERPETRATOR HAVE ACCESS TO THE CHILDREN? ❑NA ❑Yes
❑Yes, contact order ❑Yes, informal agreement ❑No

EMPLOYMENT STATUS: ❑Full time ❑Part time ❑Self employed ❑Student
❑Full time carer ❑Training scheme ❑Unemployed ❑Retired
HOUSING: ❑Owner occupied ❑Private rented ❑B&B ❑Refuge ❑Friends/Relatives
❑Council/Housing Association
(Officer's Name______________________#________________)
OWNER/TENANT: ❑Client ❑Perpetrator ❑Both

CRIMINAL JUSTICE DETAILS- SECTION 2

TIME REFERRED ❑DAY ❑ NIGHT **DATE OF INCIDENT** ___________

REFERRING OFFICER/MEDICAL STAFF____________________________________

REFERRED TO POLICE ❑Yes (fill in Section 2) ❑No ❑NA
REFERRED TO A SOLICITOR ❑Yes (fill in Section 3) ❑No ❑NA
REFERRED TO DVIP ❑Yes ❑No ❑NA
REFERRED TO THE LAW CENTRE ❑Yes ❑No ❑NA
REFERRED TO REFUGE ❑Yes ❑No ❑NA

OFFICER ON CASE____

WERE CHILDREN PRESENT? ❑Yes ❑No ❑NA
PERPETRATED ARRESTED? ❑Yes ❑No
BAILED WITH CONDITIONS? ❑Yes ❑No

BAIL CONDITIONS:❑No contact with the client ❑To reside at a different address to client
❑Not to go to______________________ ❑Other_________________________

STATEMENT GIVEN BY CLIENT? ❑Yes ❑No

FME SEEN? ❑Yes ❑No **PHOTOGRAPHS TAKEN?** ❑Yes ❑No

SOCIAL SERVICES INVOLVEMENT? ❑Yes ❑No

CHARGED WITH? ❑CA ❑ABH ❑GBH ❑BOP ❑HAR ❑CD
❑Other____________

CASE ACCEPTED BY CPS? ❑Yes ❑No
COURT DATES:____

CIVIL INJUNCTION DETAILS-

IS THERE AN EXISTING CIVIL INJUNCTION? ❑Yes ❑No

IS CLIENT GOING TO APPLY FOR AN INJUNCTION? ❑Yes ❑No

IF SO, WHICH SOLICITOR?__________________________#_____________________
IF NOT, WHY? ❑Could not afford to hire solicitor ❑Other

WAS A POWER OF ARREST APPLIED FOR? ❑Yes ❑No

DATES OF COURT FOR INJUNCTIONS:____________________________________
COURT LOCATION____

CASE OUTCOME:
❑Injunction *not* granted
❑Injunction granted *without* power of arrest
❑Injunction granted *with* power of arrest
❑***Civil case details entered on STATS***

HISTORY/SAFETY PLANNING DETAILS- SECTION 4

TYPE OF ABUSE/ CURRENT INCIDENT:
❑Physical ❑Sexual ❑Emotional/Mental ❑Financial

TYPE OF ABUSE/ PAST: ❑Physical ❑Sexual ❑Emotional/Mental ❑Financial

ABUSE OF CHILDREN: ❑Physical ❑Sexual ❑Emotional/Mental ❑ Financial

RELATIONSHIP STATUS: ❑Married ❑Partners ❑Separated ❑Divorced

LIVING ARRANGEMENTS:
❑Living together ❑Previously lived together ❑Never lived together

LENGTH OF RELATIONSHIP (month/year when relation ship began):_____________

WHEN WAS THE FIRST INCIDENT OF VIOLENCE? (month/year):______________

ESTIMATED # OF INCIDENTS TOTAL__ INCIDENTS IN THE PAST YEAR______

FREQUENCY OF INCIDENTS IN THE PAST YEAR: ❑More ❑Less ❑Same

SEVERITY OF INCIDENTS IN THE PAST YEAR: ❑More ❑Less ❑Same

ARE THERE PREVIOUS CONVICTIONS FOR DV? ❑Yes ❑No Number______

ARE THERE PREVIOUS CONVICTIONS FOR DV FROM A DIFFERENT PARTNER? ❑Yes ❑No Number______

HAS HE MADE ANY THREATS THAT WORRY HER? ❑Yes ❑No
(DETAILS)____

**Assessment of Circumstances/
Priority for Casework**
Review her circumstances in the following areas:
❑CJS progress in her case (arrest, charge, bail)
❑Housing/Refuge needs
❑Debts
❑Social Services
❑Medical
❑Children/Family
Civil Remedies
❑Immigration
❑Other_________________________

Agencies that she has disclosed domestic violence to in the past:
- ❑ Police
- ❑ Refuges
- ❑ Housing
- ❑ Social Services
- ❑ Health Professional
- ❑ Religious Leader
- ❑ Private Counsellor
- ❑ Other_______________

❑ **ENTERED INTO THE REFERRAL BOOK**
❑ **CLIENT DETAILS ENTERED ON STATS**
❑ **CLIENT DETAILS ENTERED ON THE ADVANCE DATABASE**

Appendix 7

Example of manual recording form at Walk-in Centre

DATE ______________ PATIENT LOGGING SHEET **PG. 1**

	FIRST VISIT Y/N ?	**IF NO, ONG/ NEW PROB?**	**HOW DID YOU HEAR OF WIC? (New P. only)**	**WHERE WOULD YOU GO IF NO WIC?**	**CATEG ORIES**	OUT-COMES	**DV SCR ? asked? Y or N**	**Answer to DV screening** +/-/?	**MEDS? SWAB? Y/N**	**REF**	**GP SEEN**	**GP LETT**
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												
9.												
10.												
11.												
12.												
13.												
14.												
15.												
16.												
17.												
18.												
19.												
20.												

<table>
<tr><td>DV SCREENING QUESTION ASKED?
❑ Yes ❑ No</td><td rowspan="2">MEDICATION DISPENSED</td></tr>
<tr><td>SCREENING RESULT
❑ DV+ ❑ DV - ❑ DV?</td></tr>
<tr><td colspan="2">REMEMBER TO NOTE: PMH, ALLERGIES, MEDICATIONS, TTB STATUS, FH,SH</td></tr>
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<tr><td colspan="2"></td></tr>
<tr><td>NURSE SIGNATURE</td><td>DATE</td></tr>
</table>

Appendix 8

Example of DVIP Workshop Programme (Weekly topics)

1. What is domestic violence?
2. What about me? Exploring the effects on women and ways to survive.
3. Why does he hurt me? Exploring why men are violent.
4. The perpetrator programme information session.
5. How can I be safer? Making plans to protect myself and my children.
6. Domestic violence isn't just physical. Exploring non-physical abuse.
7. What about my children? How his violence and abuse towards me affects them.
8. I'm worried about my children. How can I help them?
9. Can men change? How will I know if it's enough?
10. Choosing to leave or stay — knowing what's right for me.
11. Facing up to the truth about what he really did to me.
12. He's responsible for his violence — so why do I feel like it's my fault?
13. Sexual intimacy and respect — can they survive alongside abuse?
14. How to beat the system and get what I want from agencies.
15. I've got rights! Exploring my rights and how to get my needs met.
16. Sometimes it's hard to be a woman — pressures and expectations.
17. Expressing my angry feelings safely.

Appendix 9

Resource Materials for the Health Sites

Hammersmith and Fulham Local Resources

- Fulham Police 0207 385 1212
- Hammersmith Police 0208 563 1212
- Council Switchboard 0208 748 3020
- Council – emergency out of hours 0208 748 8588
- HWA Outreach Project 0794 961 2694
- Age Concern 0207 386 9085
- Citizens' Advice Bureau 0207 385 1322
- Money Advice Unit 0207 610 3008
- Shepherds Bush Advice Service 0208 753 5910
- Emergency Housing 0208 753 4144
- Social Services 0208 753 2795
- Community Law Centre 0208 741 4021
- DVIP 0208 748 6512

Front

London-wide Resources

- Refugee Council 0207 346 6777
- Immigration Advice Service 0207 378 9191
- Samaritans 0207 734 2800
- Childline 0800 1111
- NHS Direct 0845 4647
- Lesbian and Gay Switchboard 0207 837 7324
- WAFE (helpline) 0845 702 3468
- Shelter Advice Line 0800 800 4444
- Women's Link 0207 248 1200
- NSPCC Helpline 0800 800 500
- Employment Rights Advice Service 0207 431 7385
- Refuge 0870 599 5443

Back

This card allows the medical staff to give out information to patients who cannot take obvious domestic violence help brochures away with them.

They can point out the last number on each site of the card to encourage patients to call for help.

RESOURCES

Services for women

Refuge 24 hour help line	0870 599 5443
Women's Aid help line	0845 702 3468
HWA Outreach Project	07949 612694
DVIP (local telephone advice and support groups)	0208 748 6512
Riverhouse Drop in	0208 741 4772
Cocoon (self hel p group run by survivors of abuse)	0208 741 4772
Victim Support	0207 385 6868
Newham Asian Women's Project	0208 552 5524
Jewish Women's Aid	0800 591 203

Services for abused men

DVIP	0208 563 7983
Survivors (sexual abuse for men)	0207 833 3737

Gay and Lesbian Services

SOLA (survivors of Lesbian Abuse)	0207 328 7389
Lesbian and Gay Switchboard	0207 837 7324

Services for children

FULPAC (Fulham Parents and Children)	0207 385 6317
Children's Legal Services	0120 687 3820
Amica (self hel p network for women who have experienced difficulties with child custody and contact	0122 736 9800
NSPCC (Child Projection 24-hour help line)	0800 800 500
Childline	0800 1111
Barnardo's Young Women's Project (for females 18 and Under)	0207 700 2253
Reunite (child abduction)	0207 375 3440

General

Women's Resource Centre (database of women's Organisations)	0207 377 0088
Samaritans	0207 734 2800

RESOURCES

Police

For police in an emergency	999
Community Safety Unit Hammersmith & Fulham Police	0208 246 2436

Legal advice

Hammersmith and Fulham Law Centre (free advice)	0208 741 4021
Rights of Women	0207 251 6577

Benefit, housing, debt advice

Sheperds Bush Advice Centre	0208 753 5913
Citizens Advice Bureau	0207 385 1322

Housing

Emergency Housing Unit	0208 576 5404
Shelter Advice Line	0808 800 4444
Women's Link	0207 248 1200

Immigration

Hammersmith and Fulham Law Centre	0208 741 4021
Refugee Council	0207 346 6777
Immigration Advice Service	0207 378 9191

There are many other services that specialise in areas such as legal advice, housing, welfare advice, children, health, support, counselling, and alcohol and drug dependency. There are also many organisations that provide services to specific ethnic groups.

Call the London Borough of Hammersmith and Fulham's Information Centre for a more detailed list of resources on:

0208 753 2615 (Hammersmith)
or
0208 753 3914 (Fulham)

It can happen to anyone, but there is

HOPE

Threats
forced sex
ABUSE
hitting
blame
NEGLECT
name calling
Isolation
intimidation
GUILT

Do you feel unsafe in your own home?

Are you ever frightened by your partner?

ADVANCE can help

What is intimate partner violence?

Intimate Partner Violence is power and control of one person over another. It is the use of violence or threat of violence to control another.

Is your partner…

* jealous of time you spend with others?
* easily upset by daily troubles such as children making noise or things breaking?
* controlling how much money you spend or how much money you have?
* unpredictable in mood swings, one minute loving and the next mean?
* cruel to people or animals and not caring about emotional suffering?

Does your partner…

* control or try to control where you go or how long you stay?
* prevent you from taking care of yourself such as sleeping, eating properly, or seeking medical care?
* make accusations of affairs, threaten or swear at you?
* say cruel or hurtful things to you, humiliate you privately or in front of others?
* threaten you or hurt you physically?
* make you feel afraid?
* break objects, smash the wall with fists, or throw objects?

Please consider…

* You are not alone
* You are not to blame
* You cannot change your partner's behavior
* Ignoring violence is dangerous
* Break the silence – don't remain isolated
* There is life after an abusive relationship
* You have rights

What is ADVANCE?

ADVANCE serves survivors of intimate partner violence referred by the Hammersmith and Fulham Police, the Charing Cross A&E and the Charing Cross Walk-in Centre.

We are a voluntary agency that specialises in giving support and advice to people who are experiencing emotional or physical violence from their partners.

We are here to offer information, support and advice. Our aim is to support yo u in what you would like to do. We can assure you strict confidentiality and the right to make your own decisions about your situation. We could help you to gain protection against your violent partner.

How does ADVANCE work?

The Hammersmith and Fulham Police and/or your nurse or doctor at Charing Cross Walk-in Centre or A&E can put you in touch with us 24 hours a day, 7 days a week. They will know our out of hours number.

On Monday to Friday, from 10:00 – 6:00, we can be reached on

0207 385 0409

What support can you expect?

We will speak with you and find out your individual concerns. We are able to offer a range of advice on the following issues:

1. Safety planning
2. Problem solving about your situation
3. What to expect when contacting the police
4. What to expect when contacting a solicitor
5. Information on obtaining protection through the courts

We can help with accessing:

* Access to refuge accommodation or emergency housing
* Benefits and financial issues
* Children's services
* Immigration concerns
* Support networks
* Legal aid

No matter what your situation, we will help you to find solutions and alternatives to these and other concerns you may have.

If you are not ready to contact us, remember in the future you can call us or any of the resources on the back of this page. We are all here to help.

DEFINITION

Domestic violence is an ongoing, debilitation experience of physical, psychological, and/or sexual abuse involving force or threat of force from a current or former partner associated with increased isolation from the outside world and limited personal freedom and accessibility to resources.

A&E Protocol:
5 Steps Forward

Step 1: *Screen all adult female patients & males with indicators of abuse at triage.*

- Talk to patient alone and in private.
- Ask simple, direct questions such as:

"Because violence is so common in many people's lives, I've begun to ask all my patients about it routinely."

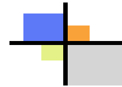
"Are you in a relationship with a person who physically hurts you or threatens you?"

"Did someone cause these injuries?"

Back

Resource pocket card used by A&E staff to remind them of the protocol and ADVANCE referral number.

Front



A&E Protocol:
5 Steps Forward

Step 2: *Send important messages to the victim:*

- You are not alone.
- You are not to blame.
- There is help available.
- You do not deserve to be treated this way.

Step 3 : *Assess Safety*

- Is your partner here with you?
- Where are the children?
- Do you have any immediate concerns?

Step 4 : *Action and Referral*

- Assign a named nurse
- Get senior doctor to document injuries
- Refer to ADVANCE

Mon-Fri 10am-6pm - call **7385 0409**
For all other hours —check notice board in triage room and/or central station
ADVANCE is there 24 hours a day/ 7 days a week. Please call them.

Step 5: *Document Findings*

Use the Domestic Violence Assessmentl (IPV1) found in the triage room.

You can make a difference!