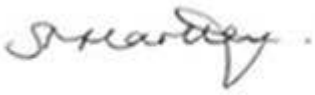
Birmingham and Solihull Mental Health NHS Foundation Trust

Domestic Violence and Abuse Policy

Policy number and category	**RS 03**	**Risk and Safety**
Version number and date	**2**	**May 2020**
Ratifying committee or executive director	**Clinical Governance Committee**	
Date ratified	**June 2020**	
Next anticipated review	**June 2023**	
Executive director	**Executive Director of Nursing**	
Policy lead	**Head of Safeguarding**	
Policy author *(if different from above)*	**Lynne Johnson, Named Nurse for Domestic Violence/Abuse**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

POLICY CONTEXT:

- BSMHFT are committed to promoting the safety and well-being of all adults with care and support needs, their families and significant others in their lives.
- This policy outlines the legislation, principles and values that will inform the practice of all mental health staff when working with adults, their families or relevant others where domestic violence and abuse is a feature.
- This policy and procedure is consistent with and should be applied in conjunction with both BSMHFT Children's Safeguarding and Adult Safeguarding policies and the NICE guidance and quality standard on domestic violence and abuse
- Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13 April 2011.

POLICY REQUIREMENT (see Section 2)

- This policy applies to staff and volunteers across all BSMHFT services working with service users and carers. All staff and volunteers should be aware of local and national policy and guidance on domestic violence and abuse and must follow such policy and guidance in all cases when the safety or welfare of adults with mental health problems, their families or significant others in their lives, is compromised due to domestic violence and abuse.
- All members of staff have an individual duty to safeguard and promote the welfare of adults with care and support needs and any relevant children; ensuring they take account and any relevant action, where risks of domestic violence and abuse are identified or suspected. This includes support staff such as subcontracted services.

CONTENTS

1: INTRODUCTION

1.1 Rationale

1.1.1 Domestic violence and abuse is a complex issue. It is a serious criminal, social and public health problem. It infringes fundamental human rights and carries far reaching consequences that damages people's lives, development, health and wellbeing. Psychiatric and psychological problems (including suicide attempts) are higher amongst those who are or have been subjected to violence and abusive experiences.

1.1.2 Domestic violence and abuse is most commonly gendered and is characterised by the misuse of power and control. It consists mainly of violence by men and against women and the gender of both the victim and the offender influences behaviour and the severity of the risk and harm experienced.

1.1.3 Although domestic violence and abuse is predominantly perpetrated by men on women; men can be victims of domestic violence and abuse and this needs to be acknowledged. It also occurs within the Lesbian, Gay, Bisexual and Transgender communities (LGBT).

1.1.4 All health services have a key role to play in the identification, assessment and response to domestic violence and abuse. Health services are often the one point of contact that all individuals will have at some point in their lives and are therefore ideally placed as professionals to routinely enquire, recognise and intervene in this situation. All health professionals have a duty of care to the individuals they have contact with.

1.1.5 BSMHFT is committed to promoting the safety and wellbeing of all adults (and relevant children) where domestic violence and abuse is a feature of their lives and their experience.

1.1.6 BSMHFT also has responsibilities to carers, family and significant others where domestic violence and abuse is being perpetrated by an adult receiving services from BSMHFT towards them.

1.1.7 This policy outlines the legislation, principles and values that informs the practice of all mental health staff that come into contact with or deliver mental health services to individuals within our communities where domestic violence and abuse is a feature.

1.1.8 This policy also outlines the responsibility of BSMHFT as an employer to all staff who are subject to domestic violence and abuse within their own life experience. Domestic violence and abuse not only impacts on the wellbeing of victims but it affects the financial strength and success of the organisations where they work. 75% of those experiencing domestic abuse are targeted at work (corporate alliance against domestic violence (2012)-CAADV). NHS employers and the Department of Health have engaged in the campaign against domestic violence and abuse recognising the benefits of addressing

this issue. Benefits not only for the individual but for: Organisations, productivity, savings on sickness and for direct patient care.

1.1.9 The Trust employs 4073 members of staff with a gender ratio of 2870 female (70.5%) and 1203 male (29.5%) and with diverse backgrounds. Staff are not immune from being victims of domestic violence and abuse themselves.

1.1.10 Due to the high prevalence of domestic violence and abuse across society, it is inevitable that some of our workforce will suffer domestic violence and abuse at the hands of someone close to them. It is also inevitable that there will be perpetrators amongst the workforce.

1.1.11 BSMHFT has a zero tolerance position towards domestic violence and abuse within or outside the work place. It is committed to treat this issue seriously, to understand the risks associated and to provide support for staff and take action against perpetrators.

1.1.12 BSMHFT therefore aims to create a work environment that will support staff experiencing domestic violence and abuse. It will do this by:

- assisting and supporting employees to be able to ask for help in addressing domestic violence;
- ensuring that employees seeking assistance are confident their situation will be handled sympathetically and confidentially;
- providing guidance to managers on how to support and assist employees asking for help in addressing domestic violence issues and how to deal with employees who are perpetrators of domestic violence. (Appendix 3).

1.1.13 The Department of Health and NHS Employers are founding members of the UK Corporate Alliance against Domestic Violence (UK CAADV). This alliance aims to encourage public and private sector employers to commit to promoting better awareness of domestic violence and abuse in their own workforce.

1.1.14 Where either the perpetrator or the victim is in a position of trust (working with adults with care and support needs or children and young people), the PIPOT (persons in a position of trust) policy should be referred to and followed. If there are concerns about a member of staff and their ability to safely fulfil their job role, advice can be sought from Operational Management, HR and BSMHFT Safeguarding Team.

1.2 Scope

1.2.1 This policy applies to staff and volunteers across all BSMHFT services working with service users and carers.

1.2.2 All members of staff and volunteers have an individual duty to safeguard and promote the welfare of adults with care and support needs and any relevant children as well as to take account and relevant action where risks of domestic violence and abuse are identified for relevant family members. This includes support staff such as subcontracted services.

1.3 Principles

1.3.1 Domestic violence and abuse is a gendered issue with women being the victims and men the perpetrators in the majority of cases. This fundamental principle must be acknowledged, identified and reflected in policy, guidance and practice.

1.3.2 This does not mean that men cannot be victims of domestic violence and abuse, and any individual who has this experience is deserving of full advice, support and protection.

1.3.3 All members of staff have an individual duty to safeguard and protect all adults with care and support needs where domestic violence and abuse is identified or suspected.

1.3.4 All staff have an individual duty to safeguard and promote the welfare of children and young people who are living with or experiencing domestic violence and abuse.

1.3.5 All members of staff have an individual duty to recognise, identify and take action where domestic violence and abuse is being perpetrated by individuals receiving care and support, towards their carers, family or significant others.

1.3.6 All clinical staff are expected to routinely enquire about all experiences of violence and abuse (past and current) including specifically domestic violence and abuse. This enquiry should be carried out within safe practice guidance, i.e. alone, not in earshot of partner or family, with time to explore and clarify.

1.3.7 All staff are expected to respond to possible and disclosed incidents of domestic violence and abuse as a safeguarding issue by ensuring an open and safe discussion; including an assessment of risk using the DASH (Domestic Abuse Stalking and Harassment) risk screening tool. See Appendix 2. Also have considerations of raising a safeguarding concern with the local authority and or referring to the local MARAC (Multi Agency Risk Assessment Conference).see:- ***Multi Agency Risk Assessment Conference (MARAC) Guidance for BSMHFT Practitioners.***

1.3.8 The individuals' rights to make informed choices about their circumstances which relate to any domestic violence and abuse experiences and their capacity to make such choices must be a consideration in line with adult safeguarding principles and practice. However, domestic violence and abuse is predominantly framed in a coercive and controlling dynamic which will have an impact on the individuals' decision making. This must be acknowledged and factored into all practitioners' thinking, discussion and action.

1.3.9 The principles of 'Making Safeguarding Personal' (adult safeguarding policy) do still apply when domestic violence and abuse is the safeguarding concern. Actions should be person led and outcome focused, however further discussion and assessment of risk is needed to inform the next steps.

1.3.10 If a referral to MARAC is indicated and following a safe discussion the person does not wish to consent, then a referral can still be made due to the level of risk identified.

1.3.11 The Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this.

2: **POLICY:**

2.1 Legislation and guidance

2.1.1 This policy is informed by:

- The Serious Crime Act 2015 (coercive control now carries a maximum penalty of 5 years under sec. 76);
- The Human Rights Act 1998;
- The Care and Support Statutory Guidance issued under The Care Act 2014, which extended the categories of abuse to include 'domestic violence and abuse', demonstrating a recognition of the significance of domestic violence and abuse and the impact on adults with care and support needs;
- The Children's Act 2004 (1989)
- HM Government 'Ending Violence against Women and Girls' strategy 2016-2020 (refreshed 2019)*''We know that these terrible crimes are disproportionately gendered which is why our approach must be framed within a violence against women and girls strategy. However, I recognise that men can also be victims of violence and abuse and the approach set out in this strategy will benefit all victims of these crimes.''*
- NICE guidance (50) 2014 and the NICE quality standard 2016 *'Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to domestic violence and abuse'.*
- Domestic Homicide Reviews (DHR) were introduced on a statutory basis under section 9 of the Domestic violence, crime and victims Act (2004). This provision was introduced in April 2011. *This was as part of the governments 'ending violence against women and girls original action plan in 2010 and was based upon the evidence that a domestic incident that results in a death, is rarely the first attack. It will often have been preceded by other physical, psychological and emotional abuse. Often coercive control and often known about by others (family friends and other agencies).*

2.1.2 The DHR is a multi-agency process intended to look at the domestic homicide and to facilitate all agencies to reflect on what contact they had, what they knew about and what action was taken with a view to learning any lessons and ultimately improving their responses to domestic abuse within the services offered.

2.1.3 The local Community Safety Partnerships are the responsible body for these reviews and are accountable to the Home Office.

2.1.4 BSMHFT has duties to participate in this process and is accountable for continuing development in identifying domestic violence and abuse, risk assessment and safeguarding. This includes being open, analytical and transparent; and having robust processes which enable lessons learned to be embedded and affect real practice change where needed.

2.1.5 All legislation and guidance pertaining to domestic violence and abuse clearly say that no one agency can address this complex issue alone and that true partnership working is the one key element that will bring about positive change.

2.2 Domestic violence and abuse within an equality framework

2.2.1 Overall, women are twice as likely as men to experience interpersonal violence and abuse, and the more extensive and repetitive the violence the more likely that it is experienced by women rather than men.

2.2.2 It is important that all staff have an understanding of the gender equality agenda and recognise that there are gender differences that need to be taken into account, i.e. differences in life experiences of violence abuse, access to resources and opportunities as well as women and men's experiences of mental ill health and their pathways into services. 'Gender neutral' views and services often fail to respond to the different experiences of violence, abuse and other disadvantages in the lives of women and men and as such are far less likely to meet women's needs. The under-pinning dynamic of coercive control needs to be understood within the gender equality framework and embedded societal norms that sustain it.

2.2.3 Domestic violence and abuse crosses all cultures and there is no evidence to suggest that it is more prevalent in any particular ethnic group. There are however cultural issues, values and attitudes that form different and challenging barriers for victims to disclose and to access support. This needs to be a consideration when asking about violence and abuse and when considering responses and intervention.

2.2.4 In the LGBT (lesbian gay bisexual and transgender) community the incidence of violence and homicide is roughly the same of that of the heterosexual community.

2.2.5 Older people have similar rates of domestic violence and abuse. This might be 'old abuse' from a longstanding relationship which has always been abusive or from new relationships formed which result in abusive behaviour.

2.2.6 Incidence of domestic abuse in the elderly can increase from age 80 to 89 and levels of violence can be very severe. Elder abuse can encompass many things and sometimes domestic abuse can get lost in the situation. It is important not to make assumptions and keep an open mind about worrying situations in the elderly population.

2.2.7 Disabled people experience disproportionately higher rates of domestic violence and abuse, for longer periods of time and more severe and more frequently. They are more likely to experience coercive control from 'carers'.

Alongside this, disabled people experience more barriers to accessing a range of support services. Their reliance on care increases the situational vulnerability to others controlling and abusive behaviour.

.

2.2.8 Young people have identified themselves that peer relationships, especially those that involve violence and abuse are among the main issues of unhappiness and anxiety in their lives. US Studies have shown also a strong association with experiencing domestic violence in adulthood. (NSPCC 2009).

2.2.9 'Working together to safeguard children' (2018) officially recognised the need for professionals to safeguard children from harm arising from their own relationships involving violence and abuse. The latest definition of domestic violence and abuse in 2012 recognised the need for the relationships of young people to be taken into account in their own right, by lowering the age from 18 to 16 years old.

2.3 Domestic violence and abuse and 'safeguarding'

2.3.1 Domestic violence and children

Domestic violence and abuse is a significant safeguarding and potential child protection issue. The issue of children living with domestic violence is now recognised as a matter of concern in its own right by both Government and key children's services and agencies. Nearly three quarters of children with a child protection plan nationally live in households where domestic violence occurs. The impact of domestic violence on an individual child will vary according to the child's resilience and the strengths and weaknesses of their particular circumstances, as well as a range of factors in respect of the violence.

2.3.2 The three key imperatives of any intervention for children living with domestic violence are:

- To protect the child/ren
- To empower the mother to protect herself and her child/ren
- To hold the abusive partner accountable for their violence and provide them with the opportunities to change.

2.3.3 Where it is known that a child/ren is living with domestic violence, it is important to assess the risk of harm to the mother and her child/ren.

2.3.4 **Domestic violence and adults with care and support needs**

The Care Act 2014 introduced domestic violence and abuse as a specific category of abuse so that for adults with care and support needs who are experiencing domestic violence and abuse they have access to a statutory safeguarding response (as per BSMHFT Adult Safeguarding Policy).

2.3.5 There is much evidence of the correlation of mental health problems and domestic violence and abuse therefore all staff must be aware of the dynamic involved within interpersonal relationships and the impact this may have on decision making. This includes the coercive control that often underpins all violence and abuse in these circumstances. All individuals receiving services from BSMHFT are entitled to interventions that are evidence based and able to take account of these challenges.

3: THE PROCEDURE:

3.1 Concerns, disclosures and assessments

3.1.1 All employees have a responsibility to recognise, identify and respond to concerns about domestic violence and abuse for service users and/or their families/carers.

3.1.2 This must take account that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

3.1.3 **All** assessment, risk assessments and reviews should routinely enquire about the structure of the individuals' family. The 'Think Family' approach gives opportunity to look at all individuals needs in the context of their life and the people around them including relevant children including all relational dynamics.

3.1.4 Many partners/family members or significant others can be identified as 'carers' so any concerns about domestic abuse need to take account of the added risks of the reliance and dependency element as well as the relational context which will have an impact.

3.1.5 If the concern or disclosure relates to a partner or family member of the client being the victim from the client; it is essential to attempt to see this person alone to establish their experience and perspective. A DASH risk checklist can be utilised and also the Carers engagement tool. Advice can be sought from the BSMHFT Named Nurse for Domestic Abuse and/or the carers' service.

3.1.6 Staff should always promote the adult's wellbeing within a safeguarding context. People have complex lives and being safe for that individual may be about maintaining a status quo.

3.1.7 It is evidenced that leaving an abusive relationship is the most risky time for serious harm or homicide to occur and that victims will often know the risks that their partner/ex-partner poses so it is essential to hear and take account of what is being said and to acknowledge that they will know this better than any agency staff.

3.1.8 **All clients should be asked routinely about domestic abuse** as part of their assessment, care reviews and included in their risk assessment because evidence suggests that one of the consequences of domestic abuse for victims is deterioration in their physical and mental health.

3.1.9 Gender dynamics and inequality perpetuate and sustain the normalisation of domestic violence and abuse; so consideration of 'traditional' and potentially stereotypical gender roles/attitudes and behaviours should be acknowledged in all assessments. All staff must be aware that abuse is abuse regardless of ethnic background, religion/belief or 'traditional' practice.

3.1.10 Some patients will find it difficult to disclose domestic abuse for a variety of reasons and may not describe their experience as abusive. Staff can help them to explore their experiences by using routine enquiry and think family principles as a way of them being able to eventually name it as abusive. Staff can ensure that domestic violence and abuse information and contact points are easily accessible or given if safe to do so.

3.1.11 Where domestic violence and abuse has been identified or suspected, all discharge plans from inpatient facilities should consider the risks posed either to or from the client and clear documentation must reflect this consideration and interventions planned or carried out. A clear handover to the community services/GP is essential.

3.1.12 People who are known to be experiencing domestic abuse or are at risk of domestic abuse, who fail to attend appointments, should be offered a further appointment and a home visit should be considered. The patient's GP should be notified of the failure to attend an appointment. Consideration must be given to informing other health and social care practitioners and the police of a disengagement with the Trust, as this may indicate an increase in risk of domestic abuse.

3.1.13 Where a patient who is known to suffer domestic abuse is discharged from BSMHFT care and treatment, a reference to their experience of domestic abuse must be included in any documentation sent to a GP or healthcare provider. This is to ensure that up to date information around domestic abuse risk is shared with other professionals who will continue to be involved with the patient.

3.1.14 Staff need to consider when assessing service users that victims of domestic abuse will frequently not identify that their lived experience features 'domestic abuse'. Therefore, enquiring about the context of their lives and their relationships is essential to build a comprehensive picture. The existence of coercive control, abuse and violence within relationships is frequently not recognised by the victim or by society as a whole.

3.1.15 Staff need to take all disclosures and concerns seriously and undertake a risk assessment with the person using the DASH risk checklist ensuring the person is seen alone and not within ear shot of the perpetrator. This is used with the victim to establish a level of risk that the person is living with, which can then guide actions and intervention.

3.1.16 If the completed DASH risk checklist has indicated that a high risk threshold has been reached then a referral to the Multi Agency Risk Assessment Conference (MARAC) needs to be considered. BSMHFT Safeguarding Team will support in this.

3.1.17 If it is known or suspected that a serious assault has occurred, consideration must be given to making a third party report to the Police. (advice can be sought from the Named Nurse for Domestic Abuse).

3.1.18 Any visible or described injuries must be documented clearly and consideration of a third party report being made to the police even where the person is saying

they do not want to make a report themselves. People are still entitled to support even if they do not at that time want to press charges or even report the incident.

3.1.19 The person having 'capacity' is not a barrier to intervention. Advice can always be sought from the Named Nurse for Domestic Abuse or any other member of the safeguarding team. It is not acceptable to just take a 'do nothing approach' purely because the person is deemed to have capacity and is not able to engage in support themselves at the time.

3.1.20 All disclosures of domestic violence and abuse are now reportable within the Trust; an eclipse form should be completed and clear documentation made in the client's record. This should include naming partners and ex partners (as well as the names and date of births of relevant children, as per child safeguarding policy) to ensure there is an awareness of who the client is at risk from/to and what action has been taken.

3.1.21 It is often difficult for service users or their families to disclose abuse or neglect due to complex dynamics/fear or the pressure of close relationships and it may be that they do not recognise their situation as abusive. Therefore, it is vital that all assessments and on-going interventions include the context of family relationships, involved friends/carers and significant others (including any children and young people) and that any concern is explored effectively. Any concern identified must consider children's safeguarding also (see relevant policy).

3.1.22 Where a client is known to have perpetrated domestic violence and abuse previously, this should inform risk concerns about any future relationships they enter into and interventions should include holding them to account for the abusive/controlling behaviour**. (Please see Guidelines for BSMHFT Mental Health practitioners working with Men who are also Perpetrating Domestic Violence – Appendix 4).** Also ensuring contact with any new partner, establishing if there are any children and potentially considering whether a Claire's law disclosure request would be appropriate. See appendix 5 - Domestic violence Disclosure Scheme (Claire's law).

3.1.23 Staff should be aware that any family member or partner who is offering care and support to a client, should be offered a carers assessment. This is an ideal opportunity to explore further the dynamics of relationships and identify any concerns about domestic violence and abuse.

3.1.24 Staff also need to be aware that it can be challenging for family and significant others to disclose all that is happening due to their fears about what could happen i.e. a hospital admission, children's services involvement etc; and where there is any feature of coercive control this can seriously impact on their ability to be able to openly relay information on any relapse symptoms and compliance with medication. When family are disclosing fear and concern about mental health presentation and other behaviours this needs to be taken seriously, heard and any actions taken need to be in this context.

3.2 Information sharing and confidentiality in relation to domestic violence and abuse

3.2.1 Information Governance policy/procedures promote appropriate sharing of information and should not be a barrier to sharing information where there is known (or a concern) about serious risk in relation to domestic violence and abuse or other safeguarding concerns impacting on the safety and welfare of children and young people or any client, their family and/or significant other.

3.2.2 You should share information in order to prevent:

- A serious crime
- A danger to a person's life
- A danger to others
- Danger to the community
- Danger to the health of the person

For further guidance see (Striking the Balance, 2012), and (BSMHFT 'Confidentiality Policy' IG1)

3.3 Training

3.3.1 Domestic violence and abuse training is incorporated into Safeguarding Adult Training (level 1 and 2) and is part of the Trust's Fundamental Training Programme.

3.3.2 All staff and volunteers are required to complete Level 1 e-learning at commencement of employment and thereafter every 3 years.

3.3.3 All managers or persons who conduct clinical staff supervision are required to complete level 2 training within 6 months of commencement of employment and every 3 years thereafter.

3.3.4 All Clinical staff qualified or unqualified are required to complete level 2 training within 6 months of commencement of employment and every 3 years thereafter.

3.3.5 Compliance with training as detailed above is monitored and is reported to the Strategic Safeguarding Committee and via the Clinical Governance Committee to Trust Board.

3.4 Governance

3.4.1 The Strategic Safeguarding Committee is a multi-agency group which provides assurance to the Trust Integrated Quality Committee that the Trust is meeting its responsibilities with regards to domestic violence and abuse.

4: Responsibilities

This should summarise defined responsibilities relevant to the policy.

Post(s)	Responsibilities	Ref
All Staff and Volunteers	Responsible for ensuring that they understand and comply with the Trust's policy on domestic violence and abuse and follow good practice around routine enquiry, risk assessment and intervention. Registered staff are responsible for their own actions, including taking responsibility for any concerns with regards to domestic violence and abuse that they identify and for supporting un-registered staff in raising concerns.	
Executive Director	The Executive Director of Nursing is the Executive Lead responsible for safeguarding adults which includes domestic violence and abuse. It is their responsibility to inform the Trust Board of the domestic violence and abuse safeguarding activity and risks.	
Named Professionals	The Head of Safeguarding takes the strategic lead in supporting the organisation to meet its duties and responsibilities around domestic violence and abuse. The named nurse is responsible for promoting good professional practice; acting as an expert reference point for all staff and other agencies for the purpose of liaison and linking with specific multi agency boards and meetings to provide advice, expertise, complete audits and reviews and to support delivery of training, supervision and support.	
Associate Directors, Clinical Directors Clinical Managers, Matrons and other senior clinicians	Responsible for ensuring that operational staff including team managers are cognisant and compliant with current safeguarding policy and practice including the domestic abuse policy and that this is all embedded operationally. They are responsible for ensuring that local supervision is provided and includes domestic abuse issues. They are also responsible for the dissemination of information from the Strategic Safeguarding Committee and delivering against the safeguarding annual work	

	programme which will include the domestic violence and abuse agenda.	
Team Managers	Must ensure that policy is understood and followed as appropriate to each staff member's role and function and that new staff are advised at induction. They are responsible for acting as a team reference point for domestic violence and abuse. They are responsible for ensuring that all staff are up to date with training, for cascading information, the provision of required data and the implementation of audit. They are responsible for ensuring safe recruitment and workforce issues are compliant with safeguarding requirements and will offer support and supervision/competency assessments.	
Human Resources	Responsible for developing guidance for managers for when staff disclose domestic abuse. This should acknowledge the prevalence, lay out support and safety actions available and take account of the impact on an individual's ability to function effectively in the workplace. It must also give guidance if the member of staff is a perpetrator. Links as necessary to the PIPOT policy	

5: Development and Consultation process consisting of:

An outline of who has been involved in developing the policy and procedure including Trust forums and service user and carer groups.

Consultation summary		
Date policy issued for consultation	30.04.20	
Number of versions produced for consultation	1	
Committees / meetings where policy formally discussed	**Date(s)** **30.04.20 PDGM** **02.06.20 ratifying committee**	
Safeguarding Strategic Committee		
Where received	**Summary of feedback**	**Actions / Response**

6: Reference documents

none

7: Bibliography:

Adult Safeguarding and Domestic abuse – a guide to support practitioners and managers (**ADASS- local government association 2013**)

Birmingham Domestic Abuse Prevention Strategy Changing Attitudes Changing lives (2018-2023)

https://www.birmingham.gov.uk/downloads/file/10086/domestic_abuse_prevention_strategy_2018_-_2023

Corporate Alliance against Domestic Violence (**CAADV) (2012**)

Disability and Domestic Abuse- risk, impacts and response (**public health England 2015)**

Domestic Violence and Abuse: how Health Services, Social Care and the organisations they work with can respond effectively (**NICE public health guidance 50)**

Domestic Violence and Abuse (**NICE Quality standard 2016**)

Ending Violence against Women and Girls 2016-2020 (HM Government) **https://assets.publishing.service.gov**

Information for Local Areas on the Change to the definition of Domestic Violence and Abuse (**Home office 2013**)

Hidden Hurt –Violence, Abuse and disadvantage in the lives of women (**Sara Scott and Sally McManus DMSS research for agenda 2016)**

Managing and supporting employees experiencing domestic Abuse – A guide for employers (**EHRC/CIPD 2013**)

Partner exploitation and violence in teenage intimate relationships (**NSPCC 2009)**

Safelives – **www.safelives.org.uk**

Respect – guidelines for working with Domestic Violence perpetrators **www.respect.uk.net**

SeriousCrimeAct2015 **www.legislation.gov.uk**

SCIE Guidance

Solihull Domestic Abuse Strategy (2016-2020)
https://www.solihull.gov.uk/Portals/0/StrategiesPlansPolicies/Domestic-Abuse-Strategy.pdf

Striking the Balance' – practical guidance on the application of the Cauldicott Guardian Principles to Domestic Violence and MARACs (DoH 2012)

The Human Rights Act 1998
http://www.legislation.gov.uk/ukpga/1998/42/contents

The Care act 2014
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

The Children's Act 2004
http://www.legislation.gov.uk/ukpga/2004/31/contents

West Midlands Domestic Violence and Abuse standards (2015)

Working Together to Safeguard Children 2018
https://assets.publishing.service

8: Glossary:

The definition of domestic violence and abuse states: -

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

- Psychological
- Physical
- Sexual
- Financial
- Emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation or other abuse that is used to harm, punish, or frighten their victim.

This definition highlights the importance of recognising coercive control as a complex pattern of overlapping and repeated abuse perpetrated within a context of power and control. (Home office 2013- information for local areas on the change in definition).

This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group (Home Office, 2012).

Living with domestic violence and abuse raises significant public health, child and adult protection issues.

The costs in providing services to support people experiencing domestic violence impact on the Criminal Justice System, Health Care, Social Services, Housing and Civil Legal and are estimated at some £3.1 billion per year.

'Violence and abuse can lead to an increased risk of poor mental health, injuries, chronic physical conditions, unwanted and complicated pregnancy, sexually transmitted infections and substance misuse, and the effects can last a lifetime and into subsequent generations.' (DOH 2010).

There is an increased risk of domestic abuse starting and, or, escalating when a women is pregnant.

Forced marriage: The government define forced marriage as a marriage in which one or both spouses do not (or, in the case of some adults with care and support needs) cannot consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure (HM Government 2009).

Honour based violence: The terms "honour crime" or "honour based violence" or "*izza*t" embraces a variety of crimes of violence (mainly but not exclusively against women), including assault, imprisonment and murder where the person is being punished by their family or community. They are being punished for actually or allegedly, undermining what the family or community believes to be the correct code of behaviour. The person shows they have not been properly controlled to conform by their family and this is to the "shame" or "dishonour" of the family (HM Government 2009).

Female genital mutilation (FGM): WHO (2000) defines FGM as 'procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons'.

An estimated 103,000 women aged 15-49 with FGM born in countries in which it is practised were living in England and Wales in 2011, compared with the estimated 66,000 in 2001.

The overall numbers of women aged 15-49 who were permanently resident in England and Wales but born in FGM practising countries increased from 182,000 in 2001 to 283,000 in 2011.

Numbers of women born in the countries in the Horn of Africa, where FGM is almost universal and where the most severe Type III form, infibulation, is

commonly practised, increased by 34,000 from 22,000 in 2001 to 56,000 in 2011.

The numbers of women from countries in East and West Africa, where FGM Types I and II, clitoridectomy with or without excision of the labia minora, are very common, also increased by 10,000 over the same period.

MARAC – Multi Agency Risk assessment Conference

DASH – Domestic Abuse Stalking and Harassment.

9: Audit and assurance

Assurance of compliance with this policy is the responsibility of the Safeguarding Strategic Committee and is detailed within the safeguarding Quality Assurance Framework.

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
Members of staff meet their individual duty as part of assessment and other care reviews to:- recognise, Identify, routinely enquire and take appropriate action with regards domestic violence and abuse – whether the client is a victim or a perpetrator of domestic violence and abuse	Named nurse for Domestic violence and abuse	Case management document audit Safeguarding advice line record audit Eclipse notifications	Annual	Strategic Safeguarding Committee

10: Appendices:

Appendix 1 - Equality Analysis Screening Form
Appendix 2 - DASH risk checklist
Appendix 3 - HR Guidance for Managers – Domestic Abuse and Violence
Appendix 4 - Guidelines for BSMHFT Mental Health practitioners working with men who are also perpetrating domestic violence
Appendix 5 - Domestic Violence Disclosure Scheme (Claire's Law)

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	**Domestic Violence and Abuse Policy**		
Person Completing this proposal	**Lynne Johnson**	**Role or title**	**Named Nurse for Domestic Abuse**
Division	**Safeguarding**	**Service Area**	**Corporate**
Date Started	**Dec 2019**	**Date completed**	**Jan 2020**

Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.

The policy details the responsibilities of BSMHFT to promote and safeguard the well-being of all adults and relevant children where domestic violence and abuse is a feature of their lives and their experience. The policy also outlines the responsibility of BSMHFT as an employer to all staff that are subject to domestic violence and abuse within their own life experience. The procedure outlines the steps for staff dealing with domestic abuse.

Who will benefit from the proposal?

Service users and their families. BSMHFT staff and volunteers

Impacts on different Personal Protected Characteristics – *Helpful Questions:*

Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*	*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*

Please click in the relevant impact box or leave blank if you feel there is no particular impact.

Personal Protected Characteristic	No/Minimum Impact	Negative Impact	Positive Impact	Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.
Age			✓	The policy highlights the increase in domestic abuse in older age groups. An increased awareness of this issue can help with

				promoting professional curiosity in staff members to help identify abuse in older people
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability			✓	The policy highlights the disproportionately higher rates of domestic violence and abuse with disabled people, and the increased frequency and duration of this abuse. An increased awareness of this issue can help with promoting professional curiosity in staff members to help identify abuse in disabled people ensuring there risks are needs are identified.
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender			✓	The policy outlines the research and evidence base detailing there are more female victims than male. The policy outlines the importance of staff have an understanding of gender differences when identifying and responding to domestic abuse. For example the differences in life experiences of violence, abuse, access to resources and opportunities
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships			✓	Increased identification of domestic abuse would generally offer increased opportunities to support patients and family. This is likely to reduce the likelihood of serious incidents in marriage and civil partnerships. The procedure outlines the partnership approach to 'safeguarding' within Multi Agency Risk Assessment Conferences (MARAC) with its particular focus on reducing the risk of serious harm or death of identified victims of high risk domestic violence and abuse. Adhering to the domestic abuse

				policy and procedure will be demonstrated in an increased referral rate to MARAC.
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity			✓	The policy highlights increased risks of domestic abuse during pregnancy and maternity
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity			✓	The policy highlights that the victims of domestic violence and abuse are not confined to any ethnic group. However it is recognised in so called honour-based violence and Female Genital Mutilation
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief			✓	
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation			✓	The policy highlights domestic abuse occurring in the Lesbian, Bisexual, Gay and Transsexual (LBGT) relationships and that assumptions made about the LBGT community can lead to victims of domestic abuse being isolated and not seeking help
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				

Transgender or Gender Reassignment			✓	The policy highlights domestic abuse occurring in the Lesbian, Bisexual, Gay and Transsexual (LBGT) relationships and that assumptions made about the LBGT community can lead to victims of domestic abuse being isolated and not seeking help
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights			✓	The policy raises awareness of domestic violence and abuse and the details of how to respond will help ensure people's rights enshrined in article 2,3,5 and 8 are protected
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				

If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)

	Yes	**No**	No negative impacts identified	
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.

If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.

If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**

Action Planning:

How could you minimise or remove any negative impact identified even if this is of low significance?

Not applicable – no negative impacts identified
How will any impact or planned actions be monitored and reviewed?
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at hr.support@bsmhft.nhs.uk. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

Ending domestic abuse

SafeLives Dash risk checklist
Quick start guidance

You may be looking at this checklist because you are working in a professional capacity with a victim of domestic abuse. These notes are to help you understand the significance of the questions on the checklist. Domestic abuse can take many forms but it is usually perpetrated by men towards women in an intimate relationship such as boyfriend/girlfriend, husband/wife. This checklist can also be used for lesbian, gay, bisexual relationships and for situations of 'honour'-based violence or family violence. Domestic abuse can include physical, emotional, mental, sexual or financial abuse as well as stalking and harassment. They might be experiencing one or all types of abuse; each situation is unique. It is the combination of behaviours that can be so intimidating. It can occur both during a relationship or after it has ended.

The purpose of the Dash risk checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a Marac meeting in order to manage their risk. If you are concerned about risk to a child or children, you should make a referral to ensure that a full assessment of their safety and welfare is made.

The Dash risk checklist should be introduced to the victim within the framework of your agency's:

- Confidentiality policy
- Information sharing policy and protocols
- Marac referral policies and protocols

Before you begin to ask the questions in the Dash risk checklist:

- Establish how much time the victim has to talk to you: is it safe to talk now? What are safe contact details?
- Establish the whereabouts of the perpetrator and children
- Explain why you are asking these questions and how it relates to the Marac

While you are asking the questions in the Dash risk checklist:

- Identify early on who the victim is frightened of – ex-partner/partner/family member
- Use gender neutral terms such as partner/ex-partner. By creating a safe, accessible environment LGBT victims accessing the service will feel able to disclose both domestic abuse and their sexual orientation or gender identity.

Revealing the results of the Dask risk checklist to the victim

Telling someone that they are at high risk of serious harm or homicide may be frightening and overwhelming for them to hear. It is important that you state what your concerns are by using the answers they gave to you and your professional judgement. It is then important that you follow your area's protocols when referring to Marac and Children's Services. Equally, identifying that someone is not currently high risk needs to be managed carefully to ensure that the person doesn't feel that their situation is being minimised and that they don't feel embarrassed about asking for help. Explain that these factors are linked to homicide and serious harm and that if s/he experiences any of them in future, that they should get back in touch with your service or with the emergency services on 999 in an immediate crisis.

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

Resources

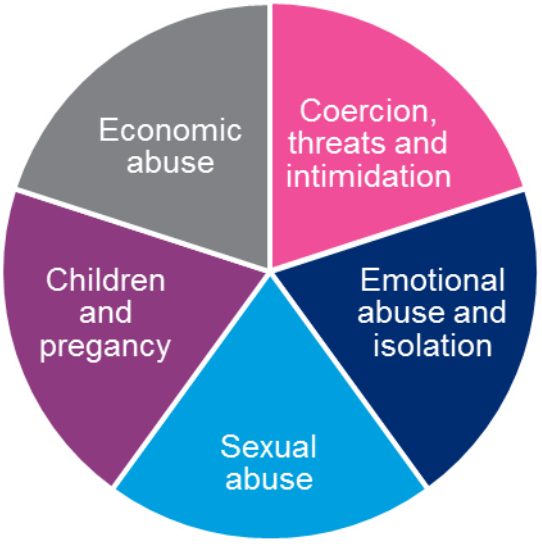
Be sure that you have an awareness of the safety planning measures you can offer, both within your own agency and other agencies. Be familiar with local and national resources to refer the victim to, including specialist services. The following websites and contact details may be useful to you:

- **National Domestic Violence Helpline** (tel: 0808 2000 247) for assistance with refuge accommodation and advice.
- **'Honour' Helpline** (tel: 0800 5999247) for advice on forced marriage and 'honour' based violence.
- **Sexual Assault Referral Centres** (http://www.rapecrisis.org.uk/Referralcentres2.php) for details on SARCs and to locate your nearest centre.
- **Broken Rainbow** (tel: 08452 604460 / web: www.brokenrainbow.org.uk) for advice for LGBT victims) for advice and support for LGBT victims of domestic abuse.

Asking about types of abuse and risk factors

Physical abuse

We ask about physical abuse in questions 1, 10, 11, 13, 15, 18, 19 and 23.



- Physical abuse can take many forms from a push or shove to a punch, use of weapons, choking or strangulation.
- You should try and establish if the abuse is getting worse, or happening more often, or the incidents themselves are more serious. If your client is not sure, ask them to document how many incidents there have been in the last year and what took place. They should also consider keeping a diary marking when physical and other incidents take place.
- Try and get a picture of the range of physical abuse that has taken place. The incident that is currently being disclosed may not be the worst thing to have happened.
- The abuse might also be happening to other people in their household, such as their children or siblings or elderly relatives.
- Sometimes violence will be used against a family pet.
- If an incident has just occurred the victim should call 999 for assistance from the police. If the victim has injuries they should try and get them seen and documented by a health professional such as a GP or A&E nurse.

Sexual abuse

We ask about whether the victim is experiencing any form of sexual abuse in question 16.

- Sexual abuse can include the use of threats, force or intimidation to obtain sex, deliberately inflicting pain during sex, or combining sex and violence and using weapons.
- If the victim has suffered sexual abuse you should encourage them to get medical attention and to report this to the police. See above for advice on finding a Sexual Assault Referral Centre which can assist with medical and legal investigations.

Coercion, threats and intimidation

Coercion, threats and intimidation are covered in questions 2, 3, 6, 8, 14, 17, 18, 19, 23 and 24.

- It is important to understand and establish: the fears of the victim/victims in relation to what the perpetrator/s may do; who they are frightened of and who they are frightened for (e.g. children/siblings). Victims usually know the abuser's behaviour better than anyone else which is why this question is significant.
- In cases of 'honour' based violence there may be more than one abuser living in the home or belonging to the wider family and community. This could also include female relatives.
- Stalking and harassment becomes more significant when the abuser is also making threats to harm themselves, the victim or others. They might use phrases such as "If I can't have you no one else can…"

- Other examples of behaviour that can indicate future harm include obsessive phone calls, texts or emails, uninvited visits to the victim's home or workplace, loitering and destroying/vandalising property.
- Advise the victim to keep a diary of these threats, when and where they happen, if anyone else was with them and if the threats made them feel frightened.
- Separation is a dangerous time: establish if the victim has tried to separate from the abuser or has been threatened about the consequences of leaving. Being pursued after separation can be particularly dangerous.
- Victims of domestic abuse sometimes tell us that the perpetrators harm pets, damage furniture and this alone makes them frightened without the perpetrator needing to physically hurt them. This kind of intimidation is common and often used as a way to control and frighten.
- Some perpetrators of domestic abuse do not follow court orders or contact arrangements with children. Previous violations may be associated with an increase in risk of future violence.
- Some victims feel frightened and intimidated by the criminal history of their partner/ex-partner. It is important to remember that offenders with a history of violence are at increased risk of harming their partner, even if the past violence was not directed towards intimate partners or family members, except for 'honour'-based violence, where the perpetrator(s) will commonly have no other recorded criminal history.

Emotional abuse and isolation

We ask about emotional abuse and isolation in questions 4, 5 and 12. This can be experienced at the same time as the other types of abuse. It may be present on its own or it may have started long before any physical violence began. The result of this abuse is that victims can blame themselves and, in order to live with what is happening, minimise and deny how serious it is. As a professional you can assist the victim in beginning to consider the risks the victim and any children may be facing.

- The victim may be being prevented from seeing family or friends, from creating any support networks or prevented from having access to any money.
- Victims of 'honour' based violence talk about extreme levels of isolation and being 'policed' in the home. This is a significant indicator of future harm and should be taken seriously.
- Due to the abuse and isolation being suffered victims feel like they have no choice but to continue living with the abuser and fear what may happen if they try and leave. This can often have an impact on the victim's mental health and they might feel depressed or even suicidal.
- Equally the risk to the victim is greater if their partner/ex-partner has mental health problems such as depression and if they abuse drugs or alcohol. This can increase the level of isolation as victims can feel like agencies won't understand and will judge them. They may feel frightened that revealing this information will get them and their partner into trouble and, if they have children, they may worry that they will be removed. These risks are addressed in questions 21 & 22.

Children and pregnancy

Questions 7, 9 and 18 refer to being pregnant and children and whether there is conflict over child contact.

- The presence of children including stepchildren can increase the risk of domestic abuse for the mother. They too can get caught up in the violence and suffer directly.
- Physical violence can occur for the first time or get worse during pregnancy or for the first few years of the child's life. There are usually lots of professionals involved during this time, such as health visitors or midwives, who need to be aware of the risks to the victim and children, including an unborn child.
- The perpetrator may use the children to have access to the victim, abusive incidents may occur during child contact visits or there may be a lot of fear and anxiety that the children may be harmed.
- Please follow your local Child Protection Procedures and Guidelines for identifying and making referrals to Children's Services.

Economic abuse

Economic abuse is covered in question 20.

- Victims of domestic abuse often tell us that they are financially controlled by their partners/ex-partners. Consider how the financial control impacts on the safety options available to them. For example, they may rely on their partner/ex-partner for an income or do not have access to benefits in their own right. The victim might feel like the situation has become worse since their partner/ex-partner lost their job.

- The Citizens Advice Bureau or the local specialist domestic abuse support service will be able to outline to the victim the options relating to their current financial situation and how they might be able to access funds in their own right.

We also have a library of resources and information about training for frontline practitioners at http://safelives.org.uk/practice-support/resources-frontline-domestic-abuse-workers-and-idvas

Other Marac toolkits and resources

If you or someone from your agency attends the Marac meeting, you can download a **Marac Representative's Toolkit** here: http://safelives.org.uk/sites/default/files/resources/Representatives%20toolkit_0.pdf. This essential document troubleshoots practical issues around the whole Marac process.

Other **frontline Practitioner Toolkits** are also available from http://safelives.org.uk/practice-support/resources-marac-meetings/resources-people-referring. These offer a practical introduction to Marac within the context of a professional role. Please signpost colleagues and other agency staff to these toolkits where relevant:

A&E
Ambulance Service
BAMER Services
Children and Young People's Services
Drug and Alcohol
Education
Fire and Rescue Services
Family Intervention Projects
Health Visitors, School Nurses & Community Midwives
Housing
Independent Domestic Violence Advisors
LGBT Services
Marac Chair
Marac Coordinator
Mental Health Services for Adults
Police Officer
Probation
Social Care Services for Adults
Sexual Violence Services
Specialist Domestic Violence Services
Victim Support
Women's Safety Officer

For additional information and materials on Multi-agency risk assessment conferences (Maracs), please see the http://safelives.org.uk/sites/default/files/resources/The%20principles%20of%20an%20effective%20MARAC%20%28principles%20only%29%20FINAL.pdf. This provides guidance on the Marac process and forms the basis of the Marac quality assurance process and national standards for Marac.

Ending domestic abuse

SafeLives Dash risk checklist

Aim of the form

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

How to use the form

Before completing the form for the first time we recommend that you read the full practice guidance and FAQs. These can be downloaded from: http://safelives.org.uk/sites/default/files/resources/FAQs%20about%20Dash%20FINAL.pdf. Risk is dynamic and can change very quickly. It is good practice to review the checklist after a new incident.

Recommended referral criteria to Marac

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

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

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

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

[1] For further information about Marac please refer to the 10 principles of an effective Marac: http://www.safelives.org.uk/marac/10_Principles_Oct_2011_full.doc

What this form is not

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

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

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

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

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

Other ☐					
Total 'yes' responses					

For consideration by professional

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

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

Practitioner's notes

This document reflects work undertaken by SafeLives in partnership with Laura Richards, Consultant Violence Adviser to ACPO. We would like to thank Advance, Blackburn with Darwen Women's Aid and Berkshire East Family Safety Unit and all the partners of the Blackpool Marac for their contribution in piloting the revised checklist without which we could not have amended the original SafeLives risk identification checklist. We are very grateful to Elizabeth Hall of CAFCASS and Neil Blacklock of Respect for their advice and encouragement and for the expert input we received from Jan Pickles, Dr Amanda Robinson and Jasvinder Sanghera

HR Guidance for Managers – Domestic Abuse and Violence

Role

It is part of a line manager's duty of care under health and safety obligations to provide support and assistance to employees asking for help to address domestic abuse or violence issues which are having an impact on their health. There is also a dual responsibility to deal with employees concerning whom there may be allegations that they have committed acts of domestic abuse or violence. This is even more important considering the access these individuals may have to vulnerable service users, posing a transferable safeguarding risk which may impact the workplace, particularly if they are employed in a position of trust within the organisation. The procedure for dealing with such issues is contained within the Trusts "Managing Allegations Against People in a Position of Trust Policy". A summary of the key duties are also described below.

Responsibilities

Providing Managerial Support

If a manager suspects that an employee is experiencing domestic abuse or violence due to changes in their behaviour, work performance, unexplained absences from work, changes in the way they appear or dress or any other indicators that they may be experiencing these issues, they should in the first instance facilitate a conversation with the employee. This should be held in a private area to discuss these issues further. The aim of the conversation will be to identify and implement appropriate support.

This conversation should be handled in a sensitive, non-judgemental and supportive manner whilst respecting the employee's personal boundaries. Even if a manager disagrees with the decisions being made regarding an employee's relationship, it is important to understand that a victim of domestic abuse may make a number of attempts to leave their partner before they are finally able to do so and their personal safety may be a paramount factor within this. The role of a manager is not to deal with the abuse itself but to make clear the support that is available to them. Examples of this support are specified below:

1. Advice from the Trusts Safeguarding department and in particular the named nurse for Domestic Violence (0121 301 1100)
2. Referral to PAM Assist the Trusts Occupational Health for confidential counselling advice or support through the Employee Assistance Programme a 24/7 advice line which can be accessed by calling 0800 882 4102 or via the website at www.pamassist.co.uk.
3. Sharing details of support organisations such as the 24-hour National Domestic Violence Freephone Helpline for England 0808 2000 247 or Refuge via www.refuge.org.uk
4. Considering any reasonable changes which can be made to the work place taking into account service needs:
   a) changing a phone extension or email address if an employee is receiving harassing messages
   b) agreeing with the employee what to tell colleagues and how they should respond to unexpected visits or telephone calls to the workplace, including any arrangements for record keeping relating to these incidents.
   c) ensuring the employee does not work alone or in an isolated area
   d) checking arrangements for getting safely to and from home
   e) looking into the possibility of an alternative site/base of work if possible.

Managing Allegations Against Staff

Contact the Associate Director of Operations/Head of Service for your area and the Human Resources and Safeguarding departments immediately for advice about how to manage the allegations received.

NB: It is important that you take your duty of care as a line manager seriously and fulfil all the expected requirements above. If you have any questions or concerns please do not hesitate to contact a member of the HR or Safeguarding Team for further support/assistance.

Guidelines for BSMHFT Mental Health practitioners working with men who are also perpetrating domestic violence

This guidance has been adapted from RESPECT guidelines for working with male perpetrators of Domestic Violence and Abuse

This guide is for BSMHFT staff who are working with male mental health clients who are abusive to their female partners. It recognises that women may occasionally abuse men in relationships, and that domestic violence does takes place in gay or lesbian relationships. However these guidelines are about holding male perpetrators of violence against women accountable as this is the majority of domestic violence.

(Any violence and abuse concerns for any person warrants further exploration and action as appropriate).

This guide should be read in conjunction with the Domestic Violence and Abuse policy and the good practice guidance for domestic violence and abuse.

****In all circumstances ensuring that the safety of women and children is the primary goal of all work with male perpetrators – 'Respect' Statement of Principles and Minimum Standards of Practice (2004)****

The work of the Domestic Abuse Intervention Project in Duluth, Minnesota has identified power and control as the main factor in male violence towards women. The Duluth 'Power and Control' and 'Equality' wheels demonstrate that violence is learnt behaviour and is not inherent. So it can be unlearnt and behaviour changed.

Mental health practitioners may encounter perpetrators of domestic violence as direct service users of BSMHFT or through women and/or children family members whom you know or suspect to be affected by domestic abuse.

RESPECT guideline for working with men who are also domestic violence perpetrators suggests the following approach:-

1. Look/Listen
2. Ask
3. Assess risk
4. Respond
5. Refer
6. Record

Look/Listen

Ask about their families, their partners and their relationships. Explore the context and ask directly if there can be contact with these others.

Seeing the significant other alone would be the ideal way to give opportunity for safe disclosure should there be domestic violence and/or abuse.

Some men referred may identify their abusive behaviour directly and ask for help to deal with their 'anger'. This may have been prompted by a crisis such as a particularly bad assault, an arrest or ultimatum from the abused partner. Such men – even though they have come voluntarily – are unlikely to admit responsibility for the seriousness or extent of the abuse, and may try to "explain" the abuse, minimise or blame other people or factors. Even those who are concerned enough about the abuse to approach an agency may present with other related problems such as drugs, alcohol, stress or depression, and may not refer directly to the abuse.

Some men may say they are victims of their (female) partner's violence. While any such allegations must be treated seriously and further exploration would be necessary; research indicates that a significant number of male victims are also likely to be perpetrators of domestic abuse. (men's advice line)

This approach is about engaging men about their abusive behaviour and holding them accountable whilst offering appropriate intervention, support and advice with regards any mental health or substance use issue.
Any direct discussion about abusive behaviour should **not** take place with the victim present or as part of any form of 'couples' or 'joint family' work.

A referral to a specialist domestic violence perpetrator programme would be an ideal option however these are not freely available locally. (Please seek further advice from the safeguarding team).

RESPECT do have a helpline that professionals can call for advice and support and also for individuals to call directly. This is for both male and females. See resources section.

Ask

A practitioner's response to any disclosure, however indirect, could be significant for encouraging responsibility, identifying a family at risk and potentially motivating a man towards change.

If the man presents with problems such as drinking, drug use, psychosis, stress or depression, for example, but does not refer to his abusive behaviour, these are useful questions to ask:

"How is this drinking/drug use/stress at work/depression/paranoia affecting how you are with your family?"
"When you feel like that what do you do?"
"When you feel like that, how do you behave?"
"Do you find yourself shouting/smashing things……?"
"Do you ever feel violent towards a particular person?"
"It sounds like you want to make some changes for your benefit and for your partner/children. What choices do you have? What can you do about it? What help would you like to assist you to make these changes?"

NB: Be **aware that substance use or any form of mental health issue are not the cause of domestic violence and abuse; so intervention for these issues alone will not necessarily reduce or stop the abusive behaviour**

Coercive control is the underpinning dynamic of domestic abuse – so even when no physical violence is apparent asking about the context of their relationships is crucial.

If the man has stated that domestic abuse is an issue, these are useful questions to ask:

"It sounds like your behaviour can be frightening; does your partner say she is frightened of you?"
"How do you think the children are affected?"
''Do you feel you need to control when and where your partner goes''
"Have the police ever been called to the house because of your behaviour?"
"Are you aware of any patterns – is the abuse getting worse or more frequent?"
"How do you think alcohol or drugs affect your behaviour?"
"What worries you most about your behaviour?"

If a man responds openly to these prompting questions, more direct questions relating to heightened risk factors <u>may</u> be appropriate:

"Do you feel unhappy about your partner seeing friends or family - do you ever try to stop her?"
''How often do you call/text your partner throughout the day?''
"Have you assaulted your partner in front of the children?"
"Have you ever assaulted or threatened your partner with a knife or other weapon?"
"Did/has your behaviour changed towards your partner during pregnancy?"

The information you gather will be the basis for your decision making about how best to engage and what kind of help is required - either for the man, the partner/family members or to manage risk.

Assess Risk

It is important that risk is assessed prior to decision making and risk assessment should ideally be informed by the woman's experience. However research has shown there are significant indicators of heightened risk that can be considered from direct contact and practitioner knowledge of the man. Risk can be fluid and can escalate very quickly so this must be a continuous process and reviewed regularly.

Some factors that indicate risk and potential for escalation:

- Recent or imminent relationship breakdown
- Past history of domestic violence and abuse (with previous partners and/or other family members)
- Past history of violence to strangers/acquaintances
- Breaches of injunctions or other such orders
- Substance use
- History of increased violence when mentally unwell
- Partner pregnant or recently given birth
- History of use of weapons and or threats to kill
- Attitudes that support or condone domestic violence and abuse (including specific role privilege/inequality)
- Minimisation and denial of domestic abuse history
- Recent escalation of assaults/control of a partner/family member.

Respond

Domestic abuse is a serious issue and all Mental Health practitioners involved have a role to play in providing good responses, which hold perpetrators responsible. Your response to the man and any disclosures could affect the extent to which he accepts responsibility for his behaviour and, therefore, for the need to change. You can say things to a perpetrator that could make a difference and you could influence the situation.

Your response can also support safeguarding for the woman and family and ensuring a multi-agency approach for the whole family is applied.

In any dealings with perpetrators you should adopt the following good practice response. This is not a 'cure' or a 'treatment' but principles to observe within your own work context, which are both safe and constructive.

- Be clear that violence and abuse is unacceptable.
- Be clear that this behaviour is a choice.
- Acknowledge any accountability shown by the man.
- Be respectful and empathic – but do not collude.
- Be clear that you may need to talk to other agencies – however if you feel this would increase risk do not disclose at that point.
- Be aware of grooming – even professionals can be groomed!
- Be positive about offering appropriate support and intervention with regards mental health and substance use issues.
- Always try and see the partner/family member separately – at least for some time.
- Be aware so as not to increase risk.
- Do not use the woman's disclosure of violence and abuse to challenge the man and if her disclosure is the only route of knowing there is violence and abuse – do not share this disclosure with him.
- The woman's/family's safety is paramount.

- If the woman also needs mental health support ensure this is from a different practitioner and ensure this is a joined up approach.

Look after yourself – ensure you have the knowledge, support and the supervision.

Refer

RESPECT suggest that the best way to attempt to alter men's abusive behaviour is to attend a structured male perpetrator programme, which includes education, as well as challenging behaviours and beliefs about gender and relationships in order to effect change in their thinking/attitudes and behaviour.

However –Locally these are not freely available. (Seek advice from the Trust safeguarding team)

Men who perpetrate domestic abuse should not be referred to anger management courses.

Perpetrator programmes are often misunderstood by professionals as being synonymous with anger management programmes. In reality, they are very different and a lack of understanding could lead to an inappropriate and possibly dangerous referral being made. This is not to suggest that anger management programmes are not useful, simply that they are **not** suitable for perpetrators of domestic abuse.

Where anger management programmes focus on techniques to manage stress and anger, communication and emotional intelligence, perpetrator programmes focus on working with men to acknowledge and change their abusive behaviour, tackling issues such as male domination, sexual respect and the impact domestic abuse has on children (Hester et al. 2007).
Perpetrator programmes that are safe and effective and accredited always have a service that works alongside with the women associated to ensure safety and manage risk.

The purpose of attempting to engage with an abusive man is not only about assisting him to change his attitudes and behaviour, but to ensure that his behaviour and his responsibility for it are at the centre of a multi-agency response. Some men will not change even if they have the opportunity to attend a perpetrator programme.

Communication with other agencies involved with a family is important and, when children are involved, essential. If a man refuses to engage, or does not change his abusive behaviour, the response of other agencies involved with that family may need to change in response to this. For example, risk management measures may need to be put in place or changes made to safety plans for the woman and/or children.

It may be possible to refer a man to a generic service for associated needs. **The primary role of such a service is not to address the violence and it must be remembered that the safety of the victim and any children must always remain paramount.**

While alcohol/substance use/mental health problems are neither an excuse nor a cause of domestic abuse there are links and, for some abusive men, it is appropriate to refer to relevant support services and their engagement in these may reduce his risk of using physical violence and the level of violence used. However evidence has shown that other forms of abuse potentially remain i.e. coercive control issues; therefore ongoing safety work and monitoring is needed.

Record

It is important to keep detailed records if a man discloses abusive behaviour or we have information about such behaviour via another source (i.e. police, probation, MARAC, Children's services). This is important information which will enable continuity of care and risk management. Good records may also help in any future legal proceedings which the woman or the police/Crown Prosecution Service may take. Add an appropriate risk alert on the electronic record.

History of domestic abuse behaviour is an indicator for all future relationships.

RESOURCES

- **RESPECT**

The Respect Phone line **0845 122 8609** welcomes calls from frontline workers coming into contact directly or indirectly with perpetrators of domestic violence and abuse (not only male abusers) or people that they suspect may be perpetrating domestic violence. The Respect Phone line is funded by the Home Office and is available for England, Wales and Northern Ireland.

Opening Hours
Monday, Tuesday, Wednesday and Friday 10am-1pm and 2pm-5pm
You can also email with your enquiry: info@respectphoneline.org.uk or visit: www.respectphoneline.org.uk

- **MY TIME DOMESTIC VIOLENCE PERPETRATOR PROGRAMME**

0121 7666699
Address – 236 Bristol road, Birmingham,B5 7SL
Email: mytimeinfo@richmondfellowship.org.uk

- **MENS ADVICE LINE**

help and support for male victims of domestic abuse
Email: info@mensadviceline.org.uk
Call freephone **0808 801 0327**

For advice and support talk to colleagues and line manager- for further specialist support contact the Trust Safeguarding team -0121 301 1100.

Domestic Violence Disclosure Scheme (Claire's Law)

The Right to Ask: From 8 March 2014, this scheme was implemented across England and Wales, following a one year pilot. An individual can ask the police to check whether a new or existing partner has a violent past, under 'the Right to Ask'.

If records show that an individual maybe at risk of domestic abuse from a partner, the police can make a decision to disclose information if it is legal, proportionate and necessary to do so.

The Right to Know: this enables an agency to apply for a disclosure if the agency believes an individual is at risk of domestic abuse from their partner. As above this is acted on by police if legal, proportionate and necessary to do so.

Further advice is available from the Trust Named Nurse for Domestic Abuse or other members of the safeguarding team; Or to request a Claire's law disclosure under either category complete the referral form on line:-
https://west-midlands.police.uk/your-options/clares-law-domestic-violence-disclosure-scheme

Please note, the police are the lead agency regarding disclosure and that staff do not just give information about a potential perpetrator to the new or potential partners. This is to ensure that disclosure is undertaken safely with a risk assessment and within the legal framework and with domestic abuse support as necessary.