NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Domestic violence

Output: Prioritised quality improvement areas for development.

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Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for domestic violence. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development source referenced in this briefing paper is:

- Domestic violence and abuse (2014) NICE guideline PH50

2 Overview

2.1 Focus of quality standard

This quality standard will cover:

- adults and young people who are experiencing (or have experienced) domestic violence
- adults and young people who are perpetrating domestic violence and abuse.
- children and young people who are affected by domestic violence and abuse (that is, the violence or abuse is not perpetrated on them directly, but they witness or experience it), including those who are taken into care
- the general population (for the purposes of prevention generally).

This quality standard will not cover children who experience domestic violence perpetrated on them directly as this will be addressed in a future quality standard for child abuse and neglect.

2.2 Definition

The term domestic violence and abuse is used to refer to any incident or pattern of incidents of controlling behaviour, coercive behaviour or threatening behaviour, violence or abuse between family members or who are, or have been, intimate

partners. This includes psychological, physical, sexual, financial and emotional abuse. It also includes 'honour'-based violence and forced marriage.

2.3 Incidence and prevalence

At least 1.2 million women and 784,000 men aged 16 to 59 in England and Wales experienced domestic abuse in 2010/11 – 7.4% of women and 4.8% of men. At least 29.9% of women and 17.0% of men in England and Wales have, at some point, experienced it[1]. These figures are likely to be an underestimate, because all types of domestic violence and abuse are under-reported in health and social research, to the police and other services.

While both men and women may perpetrate or experience domestic violence and abuse. However, it is more commonly inflicted on women by men. This is particularly true for severe and repeated violence and sexual assault.

Domestic violence and abuse between parents is the most frequently reported form of trauma for children[2]. In the UK, 24.8% of those aged 18 to 24 reported that they experienced domestic violence and abuse during their childhood. Around 3% of those aged under 17 reported exposure to it in the past 12 months[3].

2.4 Management

Working in a multi-agency partnership is the most effective way to approach the issue of domestic violence at both an operational and strategic level. Initial and ongoing training and organisational support is also needed. Healthcare professionals not trained to identify domestic violence and abuse may mislabel and misdiagnose people's problems, leading to inappropriate plans or ineffective remedies. There is an ongoing debate about the effectiveness and desirability of screening, routine and targeted enquiries to identify people who are experiencing domestic violence and abuse. Currently there is insufficient evidence to recommend screening or routine enquiry in healthcare settings.

There is a lack of consistent evidence on the effectiveness of programmes for people who perpetrate domestic violence and abuse. There are currently national programmes dealing with behaviour-change among perpetrators aimed at heterosexuals. It is however unclear whether or not these programmes would also be effective for other groups.

Domestic violence and abuse costs in the UK in 2008 were an estimated £15.7 billion. This included over £9.9 billion in 'human and emotional' costs, more than £3.8 billion for the criminal justice system, civil legal services, healthcare, social services,

[1] Smith K (ed), Osborne S, Lau I et al. (2012) Homicides, firearm offences and intimate violence 2010/11: supplementary volume 2 to Crime in England and Wales 2010/11. London: Home Office

[2] Meltzer H, Doos L, Vostanis P et al. (2009) The mental health of children who witness domestic violence. Child and Family Social Work 14: 491–501

[3] Radford L, Corral S, Bradley C et al. (2011) Child abuse and neglect in the UK today. London: NSPCC

housing and refuges and more than £1.9 billion for the economy (based on time off work for injuries)[4].

2.5 National Outcome Frameworks

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors which affect health and wellbeing and health inequalities ***Indicators*** 1.11 Domestic abuse 1.12 Violent crime (including sexual violence)

Table 2 Adult Social Care Outcomes Framework 2015/16

Domain	Objectives and indicators
4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	***Overarching measure*** 4A The proportion of people who use services who feels safe ***Outcome measures*** **People are free from physical and emotional abuse, harassment, neglect and self-harm** **People are supported to plan ahead and have the freedom to manage risks the way that they wish** 4B The proportion of people who use services who say that those services have made them feel safe and secure *Placeholder 4C. Proportion of completed safeguarding referrals where people report they feel safe*

[4] Walby, S (2009) The Cost of Domestic Violence Up-date 2009 Lancaster University, www.lancs.ac.uk/fass/doc_library/sociology/Cost_of_domestic_ violence_update.doc

3 Summary of suggestions

3.1 Responses

In total 5 stakeholders responded to the 2-week engagement exercise 28/11/14-12/12/14.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 3 for further consideration by the Committee.

Full details on the suggestions provided are given in appendix 1 for information.

Table 3 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Integrated care • Develop an integrated commissioning strategy	R , SCM, ST
Identification • Asking about domestic violence	PHE, R, RCOG, SCM, ST
Specialist services • Referral to specialist services • Children and young people	PHE, RCN, RCOG, R SCM
Training • Training	PHE, RCN, RCOG, SCM, ST
Additional areas • Disabilities • Female genital mutilation • Identifying child abuse • Interpreters • Legislation • Record domestic violence • Social media	RCN, ST
PHE, Public Health England R, Respect RCOG, Royal College of Obstetricians and Gynaecologists RCN, Royal College of Nursing SCM, Specialist Committee Member ST, Standing Together	

4 Suggested improvement areas

4.1 Integrated care

4.1.1 Summary of suggestions

Develop an integrated commissioning strategy

Stakeholders highlighted that a co-ordinated integrated strategy can save lives and reduce harm in service users who experience domestic violence. They felt that an integrated commissioning strategy should cover health and social care services in order for a service user to receive effective care. Stakeholders gave examples of how this could be practically implemented, by having a specialist advocacy and support service and taking part in Multi Agency Risk Assessment Conferences (MARACs). This multi-agency approach would also help to ensure provision of services for service users with particular needs such as those with significant drug and alcohol problems.

4.1.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 4 to help inform the Committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Develop an integrated commissioning strategy	**Participate in a local strategic multi-agency partnership to prevent domestic violence and abuse** NICE PH50 Recommendation 2 **Develop and integrated commissioning strategy** NICE PH50 Recommendation 3 **Commissioning integrated care pathways** NICE PH50 Recommendation 4 **Provide specialist advice, advocacy and support as part of a comprehensive referral pathway** NICE PH50 Recommendation 12

Develop an integrated commissioning strategy

NICE PH50 - Recommendation 2

Local authorities, health services and their strategic partners (including the voluntary and community sectors) should:

- Ensure senior officers from the following services participate in a local strategic partnership to prevent domestic violence and abuse, along with representatives of frontline practitioners and service users or their representatives:
    - health services and the local authority (including the chairs of local safeguarding boards for adults and children)
    - public health
    - sexual violence services
    - housing
    - schools and colleges
    - police and crime commissioners
    - community safety partnerships
    - criminal justice agencies (including probation)
    - the Children and Family Court Advisory and Support Service
    - specialist voluntary, community and private sector organisations.
- Ensure health and social care practitioners are actively involved in both operational and strategic multi-agency initiatives (for example, multi-agency risk assessment conferences).
- Regularly review membership of the partnership to ensure it is relevant and inclusive.

<u>NICE PH50 - Recommendation 3</u>

Local strategic partnerships on domestic violence and abuse, commissioners, clinical commissioning groups and local authorities should:

- Establish an integrated commissioning strategy. This should include input from domestic violence and abuse services, other relevant services and from people who have experienced domestic violence and abuse. The strategy should:
- meet the health and social care needs of those who experience domestic violence and abuse (including young people)

- meet the needs of children and young people who are affected by domestic violence and abuse
- address the perpetrator's behaviour and health needs
- meet the needs of all local communities.
- Ensure the strategy is based on the following principles:
- aligned or, where possible, integrated budgets and other resources
- one partner takes the strategic lead and oversees delivery on behalf of the local strategic partnership
- services address all levels of risk and all degrees of severity of domestic violence and abuse
- services are based on evidence-based commissioning principles and the local needs assessment and mapping exercise (see recommendation 1).
- agencies work together to deliver services.
- Monitor implementation of the strategy and evaluate its effectiveness for different groups. Include both quantitative data on outcomes and qualitative data (such as feedback from service users).

NICE PH50 - Recommendation 4

Commissioners of health and social care services should:

- Ensure there are integrated care pathways for identifying, referring (either externally or internally) and providing interventions to support people who experience domestic violence and abuse, and to manage those who perpetrate it.
- Ensure people who misuse alcohol or drugs or who have mental health problems and are affected by domestic violence and abuse are also referred to the relevant health, social care and domestic violence and abuse services.
- Ensure all service pathways have consistent, robust mechanisms for assessing the risks facing adults who experience domestic violence and abuse and any children who may be affected. This includes ensuring those affected by, and the perpetrators of, the violence and abuse are kept separate from each other when receiving support.

NICE PH50 - Recommendation 12

Health and social care commissioners, health and wellbeing boards and practitioners in specialist domestic and sexual violence services (see Who should take action?) should:

- Provide all those currently (or recently) affected by domestic violence and abuse with advocacy and advice services tailored to their level of risk and specific needs. This includes providing support in different languages, as necessary.
- Ensure practitioners are aware of how discrimination, prejudice and other issues, such as insecure immigration status, may have affected the risk that people using their services face.
- Ensure specialist support services meet national standards of good practice.
- Ensure specialist advice, advocacy and support forms part of a comprehensive referral pathway (see recommendation 4).
- Ensure the support is offered (although not necessarily delivered) in settings where people may be identified or may disclose that domestic violence and abuse is occurring. Examples include: accident and emergency departments, general practices, refuges, sexual health clinics and maternity, mental health, rape crisis, sexual violence, alcohol or drug misuse and abortion services.

4.1.3 Current UK practice

Develop an integrated commissioning strategy

The Co-ordinated Action Against Domestic Abuse (CAADA) report, A place of greater safety found that while the use of Independent Domestic Violence Advisors (IDVAs) and Multi-Agency Risk Assessment Conferences (MARACs), reduced domestic violence risk, local areas are not always able to resource this level of support, and therefore provision of these integrated commissioning strategies are varied[5].

[5] Co-ordinated Action Against Domestic Abuse (2012).A place of greater safety.

4.2 Identification

4.2.1 Summary of suggestions

Asking about domestic violence

Stakeholders highlighted that asking service users about domestic violence provides the first opportunity to identify and detect domestic violence, which in turn can help to prevent domestic violence in the future. Asking these questions contributes to a reduction in stigma as well as enabling full disclosure. Stakeholders felt that men as well as women should be asked about domestic violence and that all services should ask about domestic violence, including but not limited to, antenatal, postnatal, alcohol or drug misuse and mental health services.

4.2.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Asking about domestic violence	**Ensure trained staff ask people about domestic violence and abuse** NICE PH50 Recommendation 6 **Identify and, where necessary, refer children and young people affected by domestic violence and abuse** NICE PH50 Recommendation 10

Asking about domestic violence

<u>NICE PH50 – Recommendation 6</u>

Health and social care service managers and professionals should:

- Ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse. The enquiry should be made in private on a one-to-one basis in an environment where the person feels safe, and in a kind, sensitive manner.

- Ensure people who may be experiencing domestic violence and abuse can be seen on their own (a person may have multiple abusers and friends or family members may be colluding in the abuse).

- Ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults'

services ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.

- Ensure staff know, or have access to, information about the services, policies and procedures of all relevant local agencies for people who experience or perpetrate domestic violence and abuse.

- Ensure all services have formal referral pathways in place for domestic violence and abuse. These should support: people who disclose that they have been subjected to it; the perpetrators; and children who have been affected by it

NICE PH50 – Recommendation 10

Providers of services where children and young people affected by domestic violence and abuse may be identified and those responsible for safeguarding children should:

- Ensure staff can recognise the indicators of domestic violence and abuse and understand how it affects children and young people.

- Ensure staff are trained and confident to discuss domestic violence and abuse with children and young people who are affected by or experiencing it directly. The violence and abuse may be happening in their own intimate relationships or among adults they know or live with.

- Put clear information-sharing protocols in place to ensure staff gather and share information and have a clear picture of the child or young person's circumstances, risks and needs.

- Develop or adapt and implement clear referral pathways to local services that can support children and young people affected by domestic violence and abuse.

- Ensure staff know how to refer children and young people to child protection services. They should also know how to contact safeguarding leads, senior clinicians or managers to discuss whether or not a referral would be appropriate.

- Ensure staff know about the services, policies and procedures of all relevant local agencies for children and young people in relation to domestic violence and abuse.

- Involve children and young people in developing and evaluating local policies and services dealing with domestic violence and abuse.

- Monitor these policies and services with regard to children's and young people's needs.

4.2.3 Current UK practice

Asking about domestic violence

The Office for National Statistics Report “Focus on: Violent Crime and Sexual Offences” notes that domestic violence is substantially underreported in face to face interviews. Only 9% of respondents reporting domestic abuse in the self-completion component of the survey also reported domestic abuse in face-to-face interviews. The Office for National Statistics suggest one factor for this this under reporting maybe due to the lack of privacy inherent in face-to-face interviews[6]. This therefore increases the need for service users to be asked about domestic violence and for service users to be seen on their own.

In relation to maternity services the Eight Report of the Confidential Enquiries into Maternal Deaths in the UK, found that between 2006 and 2008 34 women who died from any cause had features of domestic abuse, demonstrating the importance of identifying domestic violence in maternity services with the report highlighting the need to be vigilant, especially in high index of suspicion[7].

[6] The Office for National Statistics (2013). Focus on: Violent Crime and Sexual Offences, 2011/12
[7] Centre for Maternal and Child Enquiries (2011). Saving Mothers’ Lives Reviewing maternal deaths to make motherhood safer: 2006–2008.

4.3 Specialist services

4.3.1 Summary of suggestions

Referral to specialist services

Stakeholders highlighted that specialist referral pathways should be in place to ensure that service users see a specialist domestic violence practitioner (which can include refuge services). These should be tailored to an individual depending on their level of risk of domestic violence. Having these referral pathways in place will also improve identification of domestic violence. Stakeholders added that these referral pathways need to be in place for perpetrators as well victims to ensure that they receive the appropriate intervention.

Children and young people

Stakeholders highlighted that children and young people who have been affected by domestic violence required support from specialist services. This is due to the fact that children and young people who experience domestic violence are not only at high risk of abuse themselves but are also at a higher risk of negative health and wellbeing as well potentially becoming victims or perpetrators of domestic abuse themselves. Interventions from specialist services can reduce this risk.

4.3.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Referral to specialist services	**Tailor support to meet people's needs** NICE PH50 Recommendation 8 **Help people who find it difficult to access services** NICE PH50 Recommendation 9 **Provide specialist advice, advocacy and support as part of a comprehensive referral pathway** NICE PH50 Recommendation 12 **Commission and evaluate tailored interventions for people who perpetrate domestic violence and abuse** NICE PH50 Recommendation 14
Children and young people	**Identify and, where necessary, refer children and young people affected by domestic violence and abuse** NICE PH50 Recommendation 10 **Provide specialist domestic violence and abuse services for children and young people** NICE PH50 Recommendation 11

Referral to specialist services

NICE PH50 - Recommendation 8

Managers and staff working in domestic violence and abuse services and staff in all health and social care settings (see Who should take action?) should:

- Prioritise people's safety.
- Refer people from general services to domestic violence and abuse (and other specialist) services if they need additional support.
- Regularly assess what type of service someone needs – immediately and in the longer term.
- Think about referring someone to specialist domestic violence and abuse services if they need immediate support. This includes advocacy, floating support and outreach support and refuges. It also includes housing workers, independent domestic violence advisers or a multi-agency risk assessment conference for high-risk clients.
- Think about referring someone to floating or outreach advocacy support or to a skill-building programme if they need longer-term support. Also explore whether they would like to be referred to a local support group.

- If there are indications that someone has alcohol or drug misuse or mental health problems, also refer them to the relevant alcohol or drug misuse or mental health services (see recommendation 13).

NICE PH50 - Recommendation 9

Commissioners and service providers in the statutory, private, voluntary and community sectors (see Who should take action?) should:

- Help people who may find domestic violence and abuse services inaccessible or difficult to use. This includes: people from black and minority ethnic groups or with disabilities, older people, trans people and lesbian, gay or bisexual people. It also includes people with no recourse to public funds.

- Identify any barriers people from these groups may face when trying to get help. Do this in consultation with local groups that have an equality remit (including organisations representing the interests of specific groups), and in line with statutory requirements.

- Introduce a strategy to overcome these barriers.

- Train staff in direct contact with people affected by domestic violence and abuse to understand equality and diversity issues. This includes those working with people who perpetrate this type of violence and abuse. Specifically:

    - Ensure assumptions about people's beliefs and values (for example, in relation to 'honour') do not stop staff identifying and responding to domestic violence and abuse.

    - Ensure staff know where to seek specialist advice, for example, for people with no recourse to public funds or for people with HIV.

    - Ensure staff are aware that lesbian, gay, bisexual and trans people are also at risk of forced marriage and that 'honour'-based violence might be triggered by someone's gender identity or sexuality.

    - Ensure interpreting services are confidential (often a concern in small communities where a minority language is spoken).

    - Ensure professional interpreters are used. Do not use family members or friends. In some areas this will mean using a national interpreting service or one based in another locality.

NICE PH50 - Recommendation 12

Health and social care commissioners, health and wellbeing boards and practitioners in specialist domestic and sexual violence services (see Who should take action?) should:

- Provide all those currently (or recently) affected by domestic violence and abuse with advocacy and advice services tailored to their level of risk and specific needs. This includes providing support in different languages, as necessary.

- Ensure practitioners are aware of how discrimination, prejudice and other issues, such as insecure immigration status, may have affected the risk that people using their services face.

- Ensure specialist support services meet national standards of good practice.

- Ensure specialist advice, advocacy and support forms part of a comprehensive referral pathway (see recommendation 4).

- Ensure the support is offered (although not necessarily delivered) in settings where people may be identified or may disclose that domestic violence and abuse is occurring. Examples include: accident and emergency departments, general practices, refuges, sexual health clinics and maternity, mental health, rape crisis, sexual violence, alcohol or drug misuse and abortion services.

NICE PH50 - Recommendation 14

Health and wellbeing boards and commissioners who commission perpetrator interventions should:

- Commission robust evaluations of the interventions to inform future commissioning.

- Identify, and link with, existing initiatives that work with people who perpetrate domestic violence and abuse.

- Commission tailored interventions for people who perpetrate domestic violence and abuse, in accordance with national standards and based on the local needs assessment (see recommendation 1).

- Ensure interventions primarily aim to increase the safety of the perpetrator's partner and children (if they have any). Ensure this is monitored and reported. In addition, staff should report on the perpetrators' attitudinal change, their understanding of violence and accountability, and their ability and willingness to seek help.

- Link perpetrator services with services providing specialist support for those experiencing domestic violence and abuse (including children and young people). For example, link ongoing risk assessments of the perpetrator with safety planning and support provided by specialist services.

See also recommendations 2–4.

Children and young people

NICE PH50 - Recommendation 10

Providers of services where children and young people affected by domestic violence and abuse may be identified and those responsible for safeguarding children should:

- Ensure staff can recognise the indicators of domestic violence and abuse and understand how it affects children and young people.
- Ensure staff are trained and confident to discuss domestic violence and abuse with children and young people who are affected by or experiencing it directly. The violence and abuse may be happening in their own intimate relationships or among adults they know or live with.
- Put clear information-sharing protocols in place to ensure staff gather and share information and have a clear picture of the child or young person's circumstances, risks and needs.
- Develop or adapt and implement clear referral pathways to local services that can support children and young people affected by domestic violence and abuse.
- Ensure staff know how to refer children and young people to child protection services. They should also know how to contact safeguarding leads, senior clinicians or managers to discuss whether or not a referral would be appropriate.
- Ensure staff know about the services, policies and procedures of all relevant local agencies for children and young people in relation to domestic violence and abuse.
- Involve children and young people in developing and evaluating local policies and services dealing with domestic violence and abuse.
- Monitor these policies and services with regard to children's and young people's needs.

Recommendation 11: Provide people who experience domestic violence and abuse and have a mental health condition with evidence-based treatment for that condition

Those responsible for safeguarding children, and commissioners and providers of specialist services for children and young people affected by domestic violence and abuse (see Who should take action?) should:

- Address the emotional, psychological and physical harms arising from a child or young person being affected by domestic violence and abuse, as well as

their safety. This includes the wider educational, behavioural and social effects.

- Provide a coordinated package of care and support that takes individual preferences and needs into account.
- Ensure the support matches the child's developmental stage (for example, infant, pre-adolescent or adolescent). Interventions should be timely and should continue over a long enough period to achieve lasting effects. Recognise that long-term interventions are more effective.
- Provide interventions that aim to strengthen the relationship between the child or young person and their non-abusive parent or carer. This may involve individual or group sessions, or both. The sessions should include advocacy, therapy and other support that addresses the impact of domestic violence and abuse on parenting. Sessions should be delivered to children and their non-abusive parent or carer in parallel, or together.
- Provide support and services for children and young people experiencing domestic violence and abuse in their own intimate relationships.

4.3.3 Current UK practice

Referral to specialist services

While published studies were provided on the efficacy of referral to specialist services no published studies on current practice were highlighted for this suggested area for quality improvement; this is therefore based on stakeholder's knowledge and experience.

Children and young people

A refuge and NSPCC report identified that there are currently significant gaps in services that address the need of children and young people living with domestic violence in London. There was also a need for improved equality of access as well as opportunities for children and young people to express their views[8].

[8] Radford, L et al (2011). Meeting the needs of children living with domestic violence in London.

4.4 Training

4.4.1 Summary of suggestions

Training

Stakeholders felt that in order to appropriately identify and refer service users for specialist domestic violence services all staff in health and social care require training in domestic violence and abuse. This includes but is not limited to initial awareness and skills development, as well as the need for continuing training. As part of implementing this services should also have at least one named domestic violence lead that other staff can access for support.

4.4.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Training	**Ensure trained staff ask people about domestic violence and abuse** NICE PH50 Recommendation 6 **Provide specific training for health and social care professionals in how to respond to domestic violence and abuse** NICE PH50 Recommendation 15 **GP Practices and other agencies should include training on, and a referral pathway for, domestic violence and abuse** NICE PH50 Recommendation 16 **Pre-qualifying training and continuing professional development for health and social care professionals should include domestic violence and abuse** NICE PH50 Recommendation 17

Training

NICE PH50 - Recommendation 6

Ensure trained staff ask people about domestic violence and abuse

Health and social care service managers and professionals should:

- Ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse. The enquiry should be made in private on a one-to-one basis in an environment where the person feels safe, and in a kind, sensitive manner.

- Ensure people who may be experiencing domestic violence and abuse can be seen on their own (a person may have multiple abusers and friends or family members may be colluding in the abuse).

- Ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.

- Ensure staff know, or have access to, information about the services, policies and procedures of all relevant local agencies for people who experience or perpetrate domestic violence and abuse.

- Ensure all services have formal referral pathways in place for domestic violence and abuse. These should support: people who disclose that they have been subjected to it; the perpetrators; and children who have been affected by it

NICE PH50 - Recommendation 15

Provide specific training for health and social care professionals in how to respond to domestic violence and abuse

Organisations responsible for training and registration standards and providers of health and social care training should provide different levels of training for different groups of professionals, as follows.

- Training to provide a universal response should give staff a basic understanding of the dynamics of domestic violence and abuse and its links to mental health and alcohol and drug misuse, along with their legal duties. In addition, it should cover the concept of shame that is associated with 'honour'-based violence and an awareness of diversity and equality issues. It should also ensure staff know what to do next:

- Level 1 Staff should be trained to respond to a disclosure of domestic violence and abuse sensitively and in a way that ensures people's safety. They should also be able to direct people to specialist services. This level of training is for: physiotherapists, speech therapists, dentists, youth workers, care assistants, receptionists, interpreters and non-specialist voluntary and community sector workers.

- Level 2 Staff should be trained to ask about domestic violence and abuse in a way that makes it easier for people to disclose it. This involves an understanding of the epidemiology of domestic violence and abuse, how it affects people's lives and the role of professionals in intervening safely. Staff should also be able to respond with empathy and understanding, assess someone's immediate safety and offer referral to specialist services. Typically this level of training is for: nurses, accident and emergency doctors, adult social care staff, ambulance staff, children's centre staff, children and family social care staff, GPs, mental health professionals, midwives, health visitors, paediatricians, health and social care professionals in education (including school nurses), prison staff and alcohol and drug misuse workers. In some cases, it will also be relevant for youth workers.

- Training to provide a specialist response should equip staff with a more detailed understanding of domestic violence and abuse and more specialist skills:

  - Level 3 Staff should be trained to provide an initial response that includes risk identification and assessment, safety planning and continued liaison with specialist support services. Typically this is for: child safeguarding social workers, safeguarding nurses, midwives and health visitors with additional domestic violence and abuse training, multi-agency risk assessment conference representatives and adult safeguarding staff.

  - Level 4 Staff should be trained to give expert advice and support to people experiencing domestic violence and abuse. This is for specialists in domestic violence and abuse. For example, domestic violence advocates or support workers, independent domestic violence advisers or independent sexual violence advisers, refuge staff, domestic violence and abuse and sexual violence counsellors and therapists, and children's workers.

- Other training to raise awareness of, and address misconceptions about, domestic violence and abuse issues and the skills, specialist services and training needed to provide people with effective support. This is for: commissioners, managers and others in strategic roles within health and social care services.

Organisations responsible for training and registration standards and providers of health and social care training should ensure:

- The higher levels of training include increasing amounts of face-to-face interaction, although level 1 training can be delivered mostly online or by distance learning.

- Face-to-face training covers the practicalities of enabling someone to disclose that they are affected by domestic violence and abuse and how to respond.

NICE PH50 - Recommendation 16

- NHS England, commissioners and GPs should commission integrated training and referral pathways for domestic violence and abuse. This should include education for clinicians and administrative staff in GP practices on how to make it easier for people to disclose domestic violence and abuse. It should also include education for clinicians on how to provide immediate support after a disclosure and how to make referrals to specialist agencies.

- Managers of specialist domestic violence and abuse services, clinical commissioning groups and public health departments should work in partnership with voluntary and community agencies to develop training and referral pathways for domestic violence and abuse.

NICE PH50 - Recommendation 17

Organisations responsible for training and registration standards and providers of health and social care training (see Who should take action?) should:

- Ensure training about domestic violence and abuse is part of the undergraduate or pre-qualifying curriculum, and part of the continuing professional development, for health and social care professionals who come into contact with service users. It should be delivered in partnership with local specialist domestic violence and abuse services and include face-to-face contact, even if it is mainly delivered online.

- Implement a rolling training programme that recognises the turnover of staff and the need for follow-up. The training strategy should:

    - be clear about the level of competency needed for each role (see recommendation 15)

    - refer to existing accredited materials from specialist organisations working in domestic violence and abuse, if they are suitable

    - ensure the content on domestic violence and abuse is linked to child welfare, safeguarding and adult protection services, and vice versa

    - follow the recommended content for each level (see recommendation 15).

4.4.3 Current UK practice

Training

The home office review, Domestic Homicide Reviews, identified that there have been cases where victims of domestic violence and abuse have made disclosures, but that these had not been followed up or referred to the appropriates agencies, with

the review stating that the healthcare professional had not known what to do when a patient discloses domestic violence[9].

[9] Home Office. Domestic Homicide Reviews: Common themes identified as lessons to be learned.

4.5 Additional areas

4.5.1 Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either outside the remit of the quality standard referral and the development source (NICE guidance) or require further discussion by the Committee to establish potential for statement development.

There will be an opportunity for the QSAC to discuss these areas at the end of the session on 05 February 2015.

Disabilities

A stakeholder highlighted that services need to meet the needs or service users with disabilities, as service users with disabilities may be more likely to experience domestic violence and abuse. While this is covered in the source guidance, Domestic violence and abuse (2014) NICE guideline PH50, it may be preferable to address this within the equality and diversity considerations of the quality standard.

Female Genital Mutilation (FGM)

A stakeholder felt that healthcare professionals needed to be aware of the increased association between domestic violence and female genital mutilation (FGM). FGM is not within the scope of the source guidance, Domestic violence and abuse (2014) NICE guideline PH50, however reference is made in Antenatal Care (2008) NICE guideline CG62 and Pregnancy and complex social factors (2010) NICE guideline CG110, though these pathways focus on pregnancy rather than a general referral for FGM. FGM is covered in NICE accredited guidance Female Genital Mutilation and its Management (2009), RCOG green-top guideline 53, if this area was put forward for prioritisation.

Identifying child abuse

A stakeholder highlighted that healthcare professionals should identify, and where necessary, refer children and young people who have suffered from child abuse. While the source guidance, Domestic violence and abuse (2014) NICE guideline PH50, covers children and young people who have been affected by domestic violence and abuse, this does not refer to children and young people who have themselves experienced abuse. This will be covered in a referred quality standard on child abuse and neglect.

Interpreters

Stakeholders stated that service users who experience domestic abuse who require an interpreter should be offered a professional interpreter as opposed to family or friends as this can place a service user at further risk. While this is covered in the source guidance, Domestic violence and abuse (2014) NICE guideline PH50, it may

be preferable to address this within the equality and diversity considerations of the quality standard.

Legislation

A stakeholder highlighted that legislation should be widened to include a younger age in respect to domestic violence and abuse, as some young people are exposed to these types of relationships under the age of 16. This area of quality improvement aims to inform national policy and therefore is not within the scope of quality standards.

Recording domestic violence

A stakeholder stated that services need to have systems in place to record domestic violence and abuse, to enable the reporting of levels of domestic violence and abuse. This is not covered in the source guidance, Domestic violence and abuse (2014) NICE guideline PH50.

Social media

A stakeholder highlighted the role that social media can play in domestic abuse. This is not covered in the source guidance, Domestic violence and abuse (2014) NICE guideline PH50.

Appendix 1: Suggestions from stakeholder engagement exercise

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Section 4.1: Integrated care					
001	Royal College of Obstetricians and Gynaecologists	Multiagency approach for women with significant drug and alcohol problems	Substance use (by the perpetrator, the victim or both) is involved in as many as 92% of reported episodes of domestic violence. Studies report rates of alcoholism of 67% and 93% among wife batterers. Among male alcoholics in treatment, 20 to 33% reported having assaulted their wives at least once in the year prior to the survey, their wives reporting even higher rate.	Violence is a risk factor for and an outcome of alcohol and substance abuse.	Lewis G, editor. Saving Mothers' Lives: Reviewing Maternal Deaths to Make Motherhood Safer 2003–2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. London: Confidential Enquiry into Maternal and Child Health; 2007 American Medical Association Diagnostic and Treatment Guidelines on Domestic Violence. Arch Fam Med. 1992;1(1):39-47
002	SCM1	Key area for quality improvement 1 Develop an integrated commissioning strategy	There is evidence that a co-ordinated integrated strategy can save lives and reduce harm.	Commissioning strategies for domestic violence services are still patchy and inconsistent with considerable variance across local authority areas especially with respect to joint commissioning. The potential for cost-savings is considerable as is the potential for saving lives. Moreover, as Health improves its responses, there is a knock-on effect for local specialist providers	See NICE, London Domestic Violence Strategy outcomes; MARAC and IDVA evaluations; Duluth.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				who are currently struggling to survive let alone deal with an increase in referrals.	
003	SCM2	Integrated commissioning strategy for DVA services across health care, social care and the specialist DVA sector generating integrated care pathways	A pre-requisite for an effective multi-sector response to DVA. . Clear NICE recommendation.	It's not happening in most areas.	NICE DVA guidelines (recommendations 3&4)
004	SCM2	Provide specialist advocacy and support services as part of integrated care pathways	Without these services, frontline health and social care professionals cannot engage appropriately and safely with survivors of DVA	Patchy provision nationally and becoming patchier because of local authority cuts	NICE DVA guidelines (recommendation 12)
005	Standing Together Against Domestic Violence	Domestic violence and abuse (DVA) is given clinical priority and incorporated within JSNA's and Health and Wellbeing Boards	Sir George Alberti recognised in his report on the role of the NHS for responding to violence against women and girls (VAWG) that DVA is not given proportional priority given how prevalent it is in our society. The Crime Survey of England and Wales (CSEW) consistently reports that 7% of women and 5% of men will experience DVA in a given year, which is more than the number of women who will experience stroke (2%), heart attacks (4%) and diabetes (4%).	There is a need to embed DVA within services' strategic and operational plans, which will then influence policies & procedures, learning & development, service provision and partnership working.	The report of the Taskforce on the Health Aspects of Violence Against Women and Children (2010) Responding to violence against women and children: the role of the NHS. For guidance on how to incorporate domestic violence into JSNA's, see Better health for women – how to incorporate women's health needs into

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Joint Strategic Needs Assessments and Joint and Wellbeing Strategies (Women's Health & Equality Consortium 2013) http://www.whec.org.uk/wordpress/
006	Standing Together Against Domestic Violence	Services take part in local Multi Agency Risk Assessment Conferences (MARACs) and appoint a MARAC representative for their organisation or department	The aim of the MARAC is to prevent serious injury and homicide. Death is the worst possible health outcome for someone experiencing DVA and disproportionately affects women. On average, 2 women a week or 112 women a year are killed by a violent partner. A further aim of the MARAC meeting is to share information between core agencies in a local area, which contributes towards a risk reduction plan for victims.	Children Services are usually represented at the MARAC however Health tends to be underrepresented. Health professionals hold crucial information about victims and abusers that other agencies are unlikely to hold. As we know that victims are most likely to access health, we are missing a key piece of the puzzle without their input. It is important to consider the involvement of both primary and secondary tiers of health services.	Standing Together employs five MARAC Coordinators, representing five London Boroughs. Feedback from the MARAC team regarding the health services they would like see represented on the panel include: A&E Maternity services GPs (Lead Safeguarding GP) Sexual health Health visitors School nurses
Section 4.2: Identification					
007	Public Health England	Key area for quality improvement 3 Ensure antenatal, postnatal, reproductive care, sexual health,	Patients in these health and social care services are at higher risk of experiencing domestic abuse, based on NICE guidance recommendation 6. Also, children	Universal screening for domestic abuse has been implemented successfully in certain high risk health and social care settings across the UK, but there is significant room for identification and early intervention by	NICE Guidance 50 www.theacestudy.org

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		alcohol or drug misuse, metal health, children's and vulnerable adults services users are asked whether they have experienced domestic violence and abuse or adverse childhood experiences.	who witness domestic abuse are at increased risk of other adversities and they must be considered collectively. If as a child one witness's domestic abuse, they are 66% more like to suffer other adverse childhood experiences.	implementing universal screening more broadly across these high risk settings. Screening for adverse childhood experiences is successfully being done in specific parts of the country, within targeted services where the risk is much higher. For example: 65% of people in contact with substance misuse services have 4+ childhood adversities	
008	Respect	Key area for quality improvement 1 Ask men as well as women about domestic violence	For male victims, as for female victims, asking about domestic violence reduces stigma and gives 'permission' to survivors to disclose. It also identifies perpetrators which is key given Hester's research showed perpetrators are most likely to seek help from their GP.	Domestic violence won't end unless perpetrators stop. The financial and health costs of not engaging with perpetrators are huge.	PROVIDE research, University of Bristol, 2014: http://www.bris.ac.uk/social-community-medicine/projects/provide/ Domestic Violence Perpetrators: Identifying Needs to Inform Early Intervention, Hester (2006): http://www.nr-foundation.org.uk/wp-content/uploads/2011/07/DomesticViolence_Report.pdf
009	Royal College of Obstetricians and Gynaecologist	Healthcare workers should ask maternity patients whether they have experienced domestic violence and	Maternity patients are at particular risk of domestic violence and abuse (NICE public health guidance 50, recommendation 6. February 2014).	This has been highlighted as being crucially important in several key documents including: NICE public health guidance 50 (February	*Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006–2008. The Eighth Report*

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	s	abuse. This should be a routine part of good clinical practice, even when there are no indicators of such violence and abuse	Sequential reports on the Confidential Enquiries into Maternal Deaths in the United Kingdom, have highlighted the issue of domestic abuse, and even murder, in pregnancy or after delivery. Pregnant women who experience domestic violence and abuse are at increased risk of adverse pregnancy outcomes in addition to risks to themselves (Shah & Shah, 2010)	2014) RCOG Standards for Maternity Care (June 2008) – standard 7 Department of Health. Responding to Domestic Abuse. A Handbook for Health Professionals. London: department of Health, 2006	*of the Confidential Enquiries into Maternal Deaths in the United Kingdom. BJOG, 2011: 118: Annex 12.1 Domestic abuse. 146-148* *Mezey GC, Bewley S. Domestic violence and pregnancy. BJOG 1997; 104: 528-531* *Shah PS, Shah J. maternal exposure to domestic violence and pregnancy and birth outcomes: a systematic review and meta-analyses. J Women's Health 2010; 19: 2017-2013*
010	SCM1	Key area for quality improvement 2 Ask about domestic violence and ensure formal referral pathways are in place	Asking about domestic violence reduces stigma and gives 'permission' to survivors to disclose. Knowing what to do with a positive disclosure is equally important!	Practice varies considerably including some dangerous practice (eg screening in front of perpetrators). Survivor testimony repeatedly emphasises that this is an area for considerable improvement	See NICE evidence base and 'A Bitter Pill' (survivor focus groups undertaken for the Alberti Review)
011	Standing Together Against Domestic Violence	Services choose a type of DVA enquiry (routine or selective) and embed the question within existing clinical and social care assessments	Asking patients and service users about DVA provides an opportunity to detect DVA, possibly at an earlier stage. It is equally important that	The health sector may be a victim's first and only point of contact with a professional and research shows that abused women are more likely to be in contact with health services (their GP in particular) than any other agency .	For evidence of DVA victims increased access to health services, see: Ramsay J, Rivas C, Feder G (2005) Interventions to reduce violence and

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			professionals then know how to handle the disclosure and about the specialist services available so to provide appropriate, effective and safe interventions. Benefits to patients include being offered access to appropriate support in a timely way, increased safety, reduced risk and improved quality of life.	Research also shows that women who experience DVA present more frequently to health services. They are admitted to hospital more often than their non-abused counterparts and are issued with more prescriptions. There is evidence of a linear relationship between severity of DVA and the use of health services.	promote the physical and psychological wellbeing of women who experience partner violence: A systematic review of controlled evaluations Barts and The London. Yeung et al (2012). Responding to Domestic Violence in General Practice: A qualitative study on perceptions and experiences. International Journal of Family Medicine Article
Section 4.3: Specialist services					
012	Public Health England	Key area for quality improvement 5 Identify children affected by domestic violence and abuse and childhood adversity and refer appropriately.	Children who witness domestic violence and abuse, and other childhood adversities, are not only at high risk of abuse and injury themselves, but are at risk of long-term negative effects to their health and wellbeing and becoming victims or perpetrators of domestic abuse themselves. There is good evidence to suggest that early intervention can reduce these negative long-term effects to health and wellbeing.	Local safeguarding boards, schools, health visitors and other service providers can ensure that children are identified and referred to supportive services to intervene early to prevent long term negative health effects.	NICE Guidance 50

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
013	Public Health England	Additional developmental areas of emergent practice Consider how to embed and implement action on childhood experiences within the guidance.	Significant epidemiological evidence shows the impact of childhood adversity, including domestic abuse, on poor health and social care outcomes.		www.theacestudy.org Bellis et al (2014). Bellis et al (2013).
014	SCM1	Key area for quality improvement 4 Provide children and young people at risk with specialist services	Children and young people affected by domestic violence need help in making sense of their experiences. Like their mothers, children especially benefit from group work interventions as this helps to lessen the stigma and shame.	Provision outside of CAHMS is almost non-existent for most of the UK	See NICE evidence and evaluation of children's community group work programme.
015	SCM3	Key area for quality improvement 2	Joint commissioning of interventions that aim to strengthen the relationship between children who have experienced domestic violence and their non-abusive parent or carer.	There is a large body of evidence identifying the long and short-term effects of domestic violence on children (Stanley 2011). The availability of these interventions in the UK is limited (Radford et al 2011). There is good evidence for the effectiveness of these interventions (see British Columbia Centre of Excellence for Women's Health (2013) Review of Interventions to Identify, Prevent, Reduce and Respond to Domestic Violence, which informed NICE DV Guidance)	NICE DVA Guidelines Recommendation 11
016	Public Health England	Key area for quality improvement 4 Ensure clear referral	When health and social care professionals have a clear pathway to refer people	Local authorities, clinical commissioning groups, NHS trust and general practices have various specialist services available for	Feder, Gene, et al. "Identification and Referral to Improve Safety (IRIS) of

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		pathways to specialist domestic violence and abuse agencies exist in health and social care services exist	experiencing domestic abuse to specialist services, the identification of people experiencing domestic abuse increases. Based on NICE guidance recommendation 5, 6	those experiencing domestic abuse, but do not always have clear communication between services and a clear pathway for referral. Improving clear referral pathways can ensure that people experiencing receive the services they need.	women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial." *The Lancet* 378.9805 (2011): 1788-1795.
017	Respect	Key area for quality improvement 2 Ensure formal referral pathways are in place for perpetrators as well as victims	GPs and other healthcare professionals struggle to refer perpetrators to effective interventions. They sometimes refer them to inappropriate services like couples counselling or anger management. Not only is this not helpful, it can actually raise the risk and lead to further harm.	There are services available for perpetrators but GPs and others often don't know about them. Domestic Violence Perpetrator Programmes, accredited by Respect, which meet national standards http://respect.uk.net/wp-content/themes/respect/assets/files/accreditation-standard.pdf The findings of a 6 year ESRC funded study into Respect accredited DVPPs, the Mirabal Project, will be published in January. Early indications are very positive. The government funded national helplines are a good start as a referral route, even if locally nothing else exists or is known about. The PROVIDE research discovered that giving men a card with the Respect Phoneline (for perpetrators) details on one side and the Men's Advice Line (for male victims) on the other was a useful first step.	The Mirabal Project research, University of Durham, London Met and London School of Hygiene and Tropical Medicine: https://www.dur.ac.uk/criva/projectmirabal/ PROVIDE research, as above http://respectphoneline.org.uk/ http://mensadviceline.org.uk/

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				Please note that GPs and other health professionals can call these lines as well as passing the numbers on to patients.	
018	Respect	I would also like you to draw your attention to the national service standards for domestic violence perpetrator programmes (DVPPs), supported by the Home Office amongst others. The Respect Accreditation Standard, 2012: http://respect.uk.net/wp-content/themes/respect/assets/files/accrediation-standard.pdf We would welcome its inclusion in the "Key policy documents, reports and national audits" section of the NICE quality standard document. I'd appreciate it if you could confirm that this is possible.			
019	Royal College of Nursing	Generally the new guidelines, with	We feel there is a lack of appropriate and timely refuge		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		associated enhanced training for Clinical Staff have been welcomed, however there are still concerns for Health & Social Care Staff	services, especially for men and diverse groups who experience DA and Violence.		
020	Royal College of Nursing	There is the need for timely access to transition services.			
021	SCM1	Key area for quality improvement 3 Support people with mental health conditions	The co-existence of domestic violence with both mental health issues and substance use is very high. If professionals cannot respond appropriately to these three issues, some of the most vulnerable victims get 'lost'.	Support for victim-survivors who have mental health issues (and / or substance use issues) as a consequence of abuse is often very poor (and consequently costly).	See NICE evidence base.
022	Standing Together Against Domestic Violence	Services can offer victims, children and abusers the option of specialist DVA support A recommendation is that health and social care services work in partnership with specialist DVA services to establish referral pathways. This includes the IRIS model for GP practices.	As somebody with a heart condition would be referred by their GP to a cardiologist, so should people who are experiencing DVA to a specialist domestic abuse practitioner. It is especially important that victims who are high risk of serious injury and/or homicide are provided with access to specialist support so that risk reduction and safety plans can be put in place. And it's important to provide victims who are at the lower end of the risk	Research shows that DVA is rarely a one off incident but rather a pattern of repeated abusive behaviours that tends to increase in severity and frequency over time. DVA can result in a range of negative impacts including physical injury and chronic health problems such gynaecological disorders, chronic pain, neurological symptoms, gastro-intestinal disorders, and self-reported heart disease. The most prevalent effect is on mental health, including post-traumatic stress disorder, depression, anxiety, suicidal thoughts, and substance misuse.	For evidence of the effectiveness of specialist domestic violence services, see: Howarth, E et al (2009). ''Safety in Numbers: a multi-site evaluation of independent domestic violence advisor services'' For evidence of negative impacts caused by DVA: Ulrich, Y et al (2003).

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			scale with support and advice to prevent their situation from escalating and to minimise the negative impacts that DVA has on one's health and wellbeing.	It is well established through research and findings from Serious Case Reviews and Domestic Homicide Reviews that victims are disclosing to health professionals and are presenting to their GP's with signs and symptoms of DVA. If GP's do not have the awareness or knowledge of DVA, it is unlikely that they will accurately detect DVA, know how to safely handle disclosures and manage the risks. This can result in patients receiving inappropriate care and may prevent them from accessing lifesaving support. The earlier detection and an offer of a DVA intervention can help prevent patients from reaching a critical risk level and developing long term, chronic medical conditions.	Medical Care Utilization Patterns in Women with Diagnosed Domestic Violence. American Journal of Preventative Medicine. 2003;24(1). Coid, J et al (2003). Abusive experiences and psychiatric morbidity in women primary care attenders. British Journal Psychiatry 2003: 183; 332-39 An example of good practice is at St Mary's Hospital in Westminster where there is a co-located Independent Domestic Violence Advocate (IDVA) based in A&E. The maternity service at St Mary's and Queen Charlotte's Hospitals also has a co-located IDVA in recognition that pregnancy is a high risk time where DVA increases by 30%.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Both IDVA's are employed and managed by ADVANCE Advocacy Service and Standing Together provides coordination and project management support.
Section 4.4: Training					
023	Public Health England	Key area for quality improvement 1: Ensure health and social care professionals receive pre-qualification training on domestic violence and abuse that incorporates adverse childhood experiences.	Health and social care professionals need knowledge of the prevalence of violence and abuse and health impacts of domestic abuse, including short term, long term and intergenerational effects, to learn how to identify people experiencing domestic abuse and respond appropriately. Also, health and social care professionals need knowledge on how to respond to and support children and young people who witness domestic abuse.	There is evidence suggesting a general lack of knowledge of domestic abuse as a health care issue or lack of confidence in responding to patients experiencing domestic abuse. There is also evidence suggesting a lack of health care professionals having the confidence to ask questions or routinely ask questions about any type of abuse, including domestic abuse. When health and social care professional receive knowledge and skills on identification and response, they can be involved in responding early and potentially reducing the long-term health effects of ongoing domestic abuse. Also, when professionals understand the long term impact of domestic abuse on the child and the parent, more targeted and appropriate interventions can be put in place.	Royal College of Nursing (2000) Domestic violence: Guidance for nurses Bacchus L, et al. (2012) Health sector responses to domestic violence in Europe: a comparison of promising intervention models in maternity and primary care settings. London School of Hygiene and Tropical Medicine: London. Royal College of General Practitioners (2012) Responding to domestic abuse: Guidance for general practices. The ACE Study

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					www.theacestudy.org Whitfield et al (2003), Violent Childhood Experience and the Risk of Intimate Partner Violence in Adults.
024	Public Health England	Key area for quality improvement 2 Ensure health and social care professionals receive ongoing training on domestic violence and abuse	Health and social care professionals need knowledge on the prevalence and health impacts of domestic abuse, including short term, long term and intergenerational effects, to learn how to identify and support people experiencing domestic abuse and respond appropriately. Health and social care professionals should remain up-to-date with the latest evidence, guidance and advice.	See above	See above.
025	SCM1	Key area for quality improvement 5 Training and a referral pathway for GP practices and other agencies	GPs are the health professional to which both victims and perpetrators are most likely to disclose.	In most instances, GPs have not accessed training and have a poor understanding of available services. Inappropriate referrals (such as anger management) are still widespread.	A large number of Domestic Homicide Reviews; practice experience from working with local domestic violence partnerships and survivor consultations (eg *A Bitter Pill*, DH, 2009)
026	SCM2	DVA training for all NHS and social care staff	Another pre-requisite for an effective response to DVA within	Not implemented in any area yet.	NICE DVA guidelines (recommendation 15)

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			health and social care		
027	SCM3	Key area for quality improvement 1	Delivery of training for staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services to enable them to ask service users whether they have experienced domestic violence and abuse. Such enquiries to be made in private on a one-to-one basis in an environment where the person feels safe, and in a kind, sensitive manner.	Identification of domestic violence is the necessary first step in intervention and there is evidence that victims want practitioners to ask them about DV.	NICE DVA Guidelines Recommendation 6
028	SCM3	Key area for quality improvement 3	Mental health professionals to receive training in how to address domestic violence and abuse. Mental health treatment programmes to include an ongoing assessment of the risk of further domestic violence and abuse, collaborative safety planning and the offer of a referral to specialist domestic violence and abuse support services.	There is high prevalence and increased likelihood of being a victim of domestic violence among those with mental health disorders (Trevillion et al 2012). Currently, mental health services rarely take account of this in planning and delivering interventions (Howard et al 2009).	NICE DVA Guidelines Recommendation 13
029	Standing Together Against	DVA training is provided to all staff and includes awareness and skills	DVA is often experienced as a range of abusive behaviours including physical, emotional,	Findings from serious case reviews and domestic homicide reviews (DHR's) show that victims are making disclosures and are	For evidence that separation is a high risk time, see: Lees, S. (2000).

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	Domestic Violence	development What is the role of Health Education England for developing DVA training?	financial and sexual types of abuse that are used over a period of time that can last months into years. Often the abuse is non-physical but rather emotional and psychological, such as verbal aggression, threats, intimidation, coercive control, stalking and harassment. DVA limits a person's freedoms and choices because the abuser often exerts power and control over the victim. It is crucial that professionals have a good level of understanding and awareness about DVA so not to victim blame or give unsafe advice, such as to leave the abuser when in fact separation is a high risk time where many victims continue to experience post-separation violence and where 75% of homicides occur during the first 6 months post separation. Training will provide professionals with an understanding of the dynamics, impacts, risks and specialist services available. It will also provide them with the skills to know how to ask about abuse and	presenting with signs and symptoms of DVA to health professionals such as their GP. Without training, it is unlikely that professionals will accurately detect DVA, know how to safely handle disclosures and manage the risks. DHR reviews show a common theme emerging for health where there is a need for providing training and improving information sharing. The Home Office reviewed 54 completed DHR's (quality assured by the Home Office Quality Assurance Panel) and published a report that highlighted common themes arising and made recommendations for actions that can be taken locally by agencies to prevent further homicides. The report mentions cases where disclosures of DVA were not followed up or where GP's were aware about the DVA but did not know what to do with the information.	"Marital rape and marital murder". In Hanmer, J and Itzin, C.(eds). Home Truths about Domestic Violence: Feminist Influences on Policyand Practice: A Reader. (London, Routledge). For the Home Office's report on DHR's, see Home Office, 2013. Domestic Violence Homicide Reviews: Common Themes Identified as Lessons to be Learned. Standing Together are in the process of writing up a case analysis of the 50 DHRs chaired by associates of the charity. Similar themes for health and in particular mental health are emerging. The final report is due later in the year. Contact j.levell@standingtogether.org.uk for a copy of this report.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			how to support families in a safe way.		
030	Standing Together Against Domestic Violence	Services have at least one named DV lead that staff can access	To provide staff with a go to person who has in depth knowledge and can offer practical and debrief support to staff.	Supports professionals development of staff team and recognises DVA as a clinical priority	
Section 4.5: Additional areas					
031	Royal College of Obstetricians and Gynaecologists	Services should meet the needs of women with disabilities	Specially designed services are needed to improve pregnancy outcomes for disabled women who suffer domestic abuse.	Disabled women, including those with children, often experience significantly more abuse than non-disabled women and are, therefore, likely to have an increased need for services	Hague G, Thiara R, Mullender A and Magowan P. 2008. Making the links: disabled women and domestic violence. Bristol: Women's Aid Improving safety, Reducing harm: Children, young people and domestic violence; Dept of Health (November 2009)
032	Royal College of Obstetricians and Gynaecologists	Health professionals should be aware of the increased association between domestic abuse and female genital mutilation (FGM)	FGM is often practiced within cultural systems which uphold male aggression, beating, punishment and abuse of women as acceptable.	The practice of FGM is against the law in the UK and in breach of women's civil rights. Health care providers should be aware and should act upon the association with domestic abuse which may be enshrined in cultural attitudes towards women	http://www.hawaii.edu/hivandaids/Domestic%20Violence%20Against%20Women%20and%20Girls.pdf Female Genital Mutilation Act 2003 (Commencement) Order 2004
033	Royal College of	Healthcare workers should identify and,	The RCOG Standards for maternity care (June 2008) stated	This has been highlighted as being crucially important in several key documents	National Collaborating Centre for Primary Care.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	Obstetricians and Gynaecologists	where necessary, refer children and young people affected by domestic violence and abuse	that healthcare professionals should be alert to risk factors and signs and symptoms of child abuse. If there is a raised concern, healthcare professionals should follow local and statutory child protection policies	including: NICE public health guidance 50 (February 2014) RCOG Standards for Maternity Care (June 2008) – standard 7.7	Postnatal Care: Routine Postnatal Care of Women and their Babies. London: NICE; 2006 Lewis G, editor. Saving Mothers' Lives: Reviewing Maternal Deaths to Make Motherhood Safer 2003–2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. London: Confidential Enquiry into Maternal and Child Health; 2007
034	Royal College of Obstetricians and Gynaecologists	Staff in direct contact with people affected by domestic violence and abuse should ensure that professional interpreters are used and that family members or friends are not used.	To ensure that the patient's views are conveyed correctly and accurately To ensure that patients at risk of Domestic Violence are identified To ensure that women and children are able to disclose violence and abuse confidentially and confidently	This has been highlighted as being crucially important in several key documents including: NICE public health guidance 50 (February 2014) RCOG Standards for Maternity Care (June 2008) – standard 7.3 The most recent (8th) report on the Confidential Enquiries into Maternal Deaths in the United Kingdom (March 2011)	Department of Health; Department for Education and Skills. National Service Framework for Children, Young People and Maternity Services. London: The Stationery Office; 2004 Task Force on the Health Aspects of Violence Against Women and Children – the Role of the NHS. London: Department of Health, March 2010

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
035	Standing Together Against Domestic Violence	In instances where there is a language barrier and DVA is suspected or detected, services offer an interpreter	Using friends or family may not be safe and can increase the risk. Victims are unlikely to disclose in these instances.	Access to and use of interpreters is not consistent across health services.	
036	Royal College of Nursing	Legislation should be widened to include a younger age in respect of DA and Violence given that young people are exposed to sexualisation and relationships under the age of 16. These young people are developmentally not able to understand what is acceptable in terms of relationship boundaries and are at high risk of DA and Violence.			
037	Standing Together Against Domestic Violence	Monitoring and evaluation – Services have IT systems in place that can record DVA and can be used for reporting on levels of DVA.	It is important to record DVA within a patient's file and history or chronology so to get an accurate picture of needs and risks and so that appropriate care and support is provided. This will also enable services to participate in local strategic and operational DVA partnerships by contributing data that will help	DVA is a highly prevalent problem in society with significant impacts on health and wellbeing but yet it remains almost invisible in primary care. Only around 15% of women with a history of DVA have any reference of this in their medical records in primary care.	For evidence of DVA documentation in medical records, see: The Health Foundation (2011) Improvement in practice: The IRIS case study Implementing a successful primary care domestic violence service: early experiences

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			inform and plan for services that are based upon need.		
038	Royal College of Nursing	Increased knowledge and awareness of social media and internet abuse is also required.			
None					
039	Respect	Respect have seen and would like to support the comments made by specialist committee member Davina James-Hanman			
040	SCM4	Has no comments to make.			