Linking
Abuse and
Recovery through
Advocacy
(for
Victims and
Perpetrators)

A resource to help mental health professionals identify and respond to Domestic Violence and Abuse (DVA)

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Introduction

Domestic violence and abuse (DVA) is a major public mental health concern. People presenting to mental health services are particularly likely to have experienced DVA at some point in their lives; some UK surveys have estimated prevalence at 69% among women and 49% among men with severe mental illness in contact with services. Indeed, up to 1 in 4 women and 1 in 10 men in contact with mental health services may be experiencing or have recently experienced DVA when you see them.

However, many mental health service users are not asked about their experiences of DVA. In some cases, mental health service users' disclosures of DVA are not believed, even though false allegations of DVA are rare, and the reliability of mental health service users' accounts of abuse is both high and very rarely affected by psychiatric symptomatology. As a result, only 10-30% of DVA cases are known to services. Domestic Homicide Reviews highlight suboptimal identification, care and information sharing for victims and perpetrators in contact with mental health services prior to the homicide.

We have therefore created this information resource to help mental health services to identify and respond appropriately to those affected by DVA; a follow-on project from our successful intervention within mental health services (**LARA**). The content has been informed by the most recent evidence, NICE clinical guidelines, Domestic Homicide Reviews, Serious Incidents, and Serious Case Reviews. It has also been informed by expert feedback, including from frontline clinicians and people with lived experience via **Woman's Trust**, for which we are extremely grateful.

We hope that this resource equips you with the necessary knowledge and understanding for you to work collaboratively with your service users, so that you can empower them to seek the appropriate support that they need and so you can provide the best possible care – whether they are experiencing DVA, or whether they have perpetrated it. This resource contains information about how to identify and respond to historical as well as current DVA, emphasises the importance of taking a whole family approach to your practice and always discussing these complex cases with your multi-disciplinary team. However, it cannot replace DVA training which should be available at all Trusts.

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Background & Prevalence

What is DVA?

Domestic violence and abuse (DVA) is any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality (1)

DVA can mean that an adult partner, ex-partner or relative abuses their power to control how another adult behaves, thinks and feels through a pattern of:

- **Controlling behaviour** such as isolating a partner/ex-partner/family member from sources of support, exploiting them for personal gain, or regulating their everyday behaviour. These acts make a person subordinate and/or dependent on an abuser by isolating them from sources of support or escape.
- **Coercive behaviour** such as assaults, threats, humiliation or intimidation used to harm, punish or frighten the person experiencing them. These actions can be used to set certain requirements or expectations that a person must meet to avoid escalation of harm.

What about when a relationship ends?

Even when a relationship ends, there is an ongoing risk of further abuse: 9% female homicide victims in the UK are killed by an ex-partner (6).

Specific acts of DVA include:

- **Physical violence** such as hitting, kicking, or choking.
- **Psychological abuse** such as threatening violence, destruction of property, gaslighting,[1] or manipulating children against a non-offending parent.
- **Sexual abuse** such as rape or coercion to perform sexual acts.
- **Economic abuse** such as withholding money or food, monitoring expenses, or forcing a partner/family member to take out a loan.
- **Emotional abuse** such as insults, criticisms, isolating someone from family or friends, and/or undermining someone's independence.

Harassment, stalking, and Honour-Based Violence

Harassment, stalking and **honour-based violence** are other illegal forms of abuse that may be perpetrated by partners/ex-partners/family members. **Harassment** includes repeated attempts to impose unwanted communications or contact upon a person in a manner that causes alarm or distress; **stalking** specifically includes any spying, physical pursuit, or persistent and threatening text messages, e-mails, and phone calls that result in alarm or distress (2); and **honour-based violence** refers to any violence or abuse committed to protect or defend the "honour" of a family/community (3).

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1. Gaslighting is a powerful form of manipulation in which the abuser causes their victim to question their perception of reality, for example by insisting that their memory of events is false because they are "crazy" or "sensitive". It is important to remember that even actions that appear minor can have a serious negative impact on someone who is being abused. Control and manipulation can be more powerful than shouting and/or physical abuse.

Technology-based abuse

Technology-based abuse is increasingly prevalent (4). A perpetrator can use various devices to control and coerce their partner/ex-partner/family member, e.g. by monitoring emails, social media, mobile phones, GPS tracking, smart watches, or smart homes[2] and cars. Perpetrators may gain control of technology by asserting that they are more technologically competent than their partner/ex-partner/family member. Ex-partners may also use technology for revenge pornography – sharing sexual videos or images without a person's consent is a powerful means of abuse, and is a criminal offence in the UK (5).

How prevalent is DVA?

DVA is endemic across the UK. The Crime Survey for England and Wales (year ending 2018) indicates that:

- **26% women** experienced DVA during adulthood; 8% experienced DVA in the past year (7).
- **14% men** experienced DVA during adulthood; 4% experienced DVA in the past year (7).
- **293 women and 107 men were killed** in one year by a family member or current/former partner (7); nearly one woman per day.

Remember that DVA is generally under-reported and these data may therefore underestimate the scale of DVA in the UK, and that DVA is more prevalent for mental health service users.

DVA, gender, and sexuality

Women[3] experience higher rates of all types of DVA than men (7), particularly the more severe repeated type of abuse.

Crime Survey data from England and Wales indicates that:

- **Prevalence:** 82% of all domestic violent crimes are committed against women (8).
- **Severity:** 91% of injurious domestic violent crimes are committed against women (8).
- **Frequency:** Of people who experience more than 10 incidents of DVA per year, 83% are women (8).
- **Death:** 50% of female homicide victims are killed by a current or former intimate partner, compared to 3% of male homicide victims (9).

Women are significantly more likely to have experienced DVA in the past year if they are: young; bisexual; Black, Asian, and Minority Ethnic (BAME); socio-economically deprived; or have a disability/long-term illness (10). Older women may also be at risk of DVA (11): 28% women over 60 have experienced violence or abuse in the past year (12), and they experience emotional and economic abuse and controlling behaviour at the same rates as women of other ages (13).

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2. A home that is equipped with lighting, heating, and electronic devices which can be controlled remotely.
3. All statistics cited in the bullets below this statement are based on data from the Crime Survey for England and Wales, in which the sex of the participant is identified by the interviewer.

While it is important to understand who might be especially vulnerable to DVA, people from all backgrounds and social classes experience DVA. Try to be reflective about any assumptions you might be making about your service user and their experience of DVA.

LGBTQ+ individuals experience violence and abuse at higher rates than the general population (14, 15):

- **Prevalence:** 25-46% gender non-binary individuals experience DVA (16) and 39-67% transgender individuals experience violent DVA (17).
- **Impact:** Experience of violence and abuse is significantly associated with the high rates of suicidality in LGBTQ+ youth (18).

False allegations are rare

Many DVA incidents go unreported, and false accusations of DVA are extremely rare (see figure 1 below) . The reliability of allegations of abuse amongst mental health service users is high, and is unaffected by the severity of psychological symptoms (21). This applies to all types of DVA - you should take any disclosure of psychological or emotional abuse seriously. Being disbelieved can be both distressing and damaging, especially for people who have been told by their abuser that no one will believe them because they are "mad".

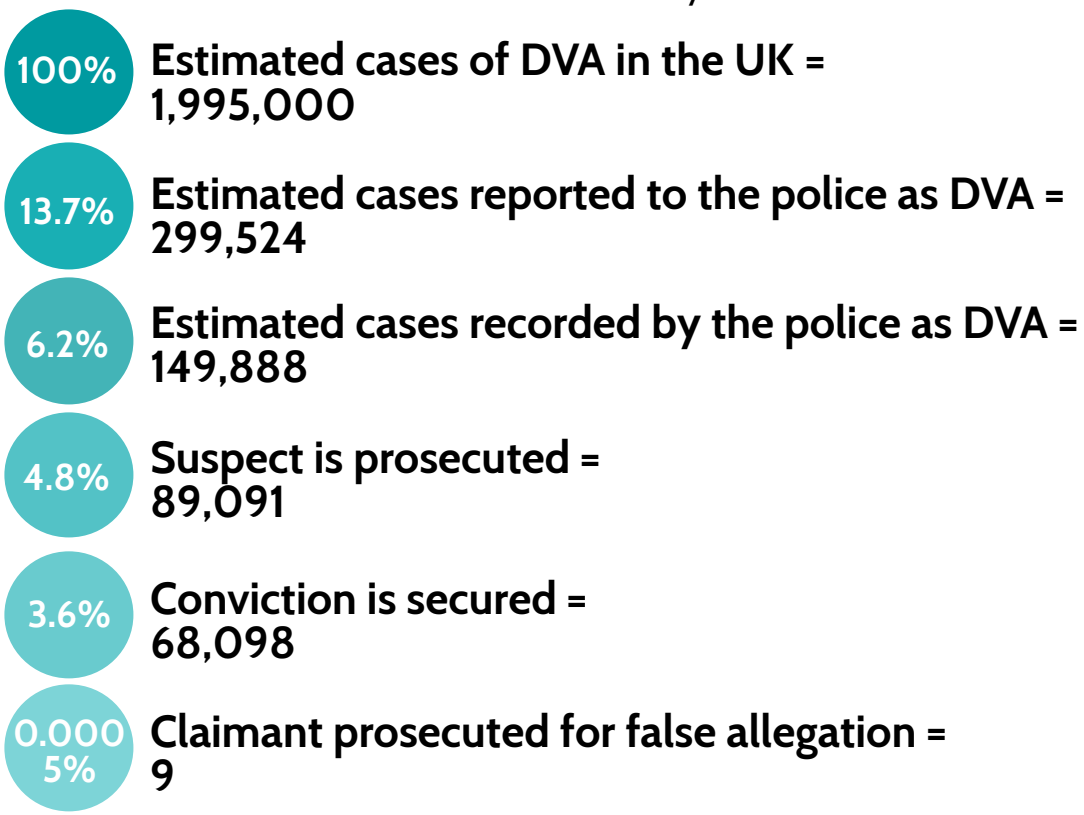


Figure 1. False allegations of DVA[4]

4. This diagram was calculated using the most up-to-date annual estimates, where a "case" indicates a single victim-perpetrator dyad (6,20). However, the data on DVA reported to the police and recorded by the police (points 2 and 3) was originally reported for individual incidents rather than individual cases; for consistency, we have therefore divided the original statistics by 4, assuming that each victimised person experiences an average of 4 incidents per year (8).

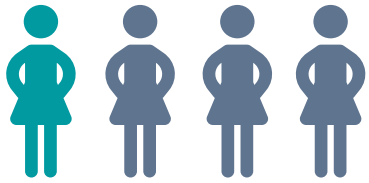
Prevalence of experiences of DVA among mental health service users

Experiences of DVA are more common among mental health service users compared with the general population (22), yet are under-detected. Estimates suggest only around a third of cases of DVA are known to services (23); this is mirrored by research into child abuse that indicates only 28% of cases of child abuse are identified (24) . Moreover, **mental health service users (both men and women) are more likely to be victims than perpetrators of DVA** (25).

A survey (conducted between 2011 and 2013) of mental health service users from South London and Maudsley (SLAM) and Camden and Islington (Candi) NHS Foundation Trusts found (22):

- **27% of women** had experienced DVA ***in the past year*** and had three times the odds of past year DVA compared with women in the general population.
- **13% of men** had experienced DVA ***in the past year*** and had twice the odds of past year DVA compared to men in the general population.
- **69% of women** had ever experienced DVA and had four times the odds of lifetime DVA compared with women in the general population.
- **49% of men** had ever experienced DVA and had four times the odds of lifetime DVA compared with men in the general population.

This indicates that **up to 1 in 4 women and 1 in 10 men in contact with mental health services may be experiencing or have recently experienced DVA when you see them (and are therefore still at risk).** You should be mindful that many people may not be aware that they are experiencing abuse, and that the abuse often continues even after a relationship has ended (10). Abusive partners/ex-partners/family members may appear loving and overly attentive; coercive and controlling behaviour may therefore be difficult to detect.



1 in 4 women in contact with mental health services may be experiencing DVA.

Impacts of DVA

- **All types of DVA, including psychological DVA, has the potential to damage an individual's health (26-28).**
- Physical impacts of DVA can include **death** (9, 29); **physical injuries, chronic illnesses** (e.g. headaches), **gynaecological problems** (30-35).
- Experiencing DVA is associated with all mental disorders, including **severe mental illness**, and with **substance use, suicidal ideation**, and **suicide attempts** (27, 36-43). These in turn impact on other aspects of a person's life, such as their ability to parent and to work.
- Pregnancy often represents a turning point in abusive relationships: either where the abuse starts or where it escalates (44).
- DVA in pregnancy can also incur a variety of complications, both for mother (e.g. **perinatal mental health problems, miscarriage, placental separation, ruptured uterus, maternal death**) (45-47) and baby (e.g. **pre-term birth, low birth weight, infant requiring intensive care, infant behavioural problems, infant developmental delay**) (48-51).

It is important that you are aware of any children who may be harmed by DVA – whether they are the children of a service user affected by/perpetrating DVA, or whether they are present in a household in which DVA is occurring. Children in families affected by DVA are at increased risk of harm, including risk of mental health problems.

Service users with experience of DVA

Preparing to ask

Before implementing routine enquiry in your team, create a safe and disclosing environment for people experiencing DVA (52). For a printable flowchart detailing key steps and considerations throughout the process of identifying and responding to people with experience of DVA, please refer to page 36.

1. Display information about DVA in the team base

In any mental health setting, people should be able to find information about local or national DVA services, so ask yourself:

- Do you have posters and leaflets providing information about DVA services and sources of help (including helpline numbers) displayed in waiting areas, toilets and/or your consulting room? If not discuss with your team leader so they can be obtained and displayed.
- Is information on sources of support available in a range of formats and locally used languages?

People should not be asked to take away leaflets, cards, or other written information if it may be unsafe to do so. **Make sure that posters and information about experiencing DVA are also accessible to staff. For more information on how to make provisions for staff who have experienced or perpetrated DVA, please refer to page 35 at the end of this resource.**

2. Ensure privacy

It should be part of routine practice to see service users without partners/family members for at least a portion of the consultation. Enquiring about DVA in the presence of a partner or family member may put a person experiencing DVA in danger; this includes any children who may be of comprehending age. If you are finding it difficult to see service users alone, you may find it useful to tell all your service users and the person or people accompanying them that this is just part of routine practice:

> *"It is routine practice for us to see our service users on their own for a portion of the consultation."*

If private enquiry is not possible (e.g. during a home visit) then remember to document that DVA has not yet been assessed.

3. Choose an appropriate interpreter if necessary

If an interpreter is needed, make sure to use an independent professional and arrange for someone who is the same gender whenever possible. Interpretation should not be provided by a friend or relative of your service user, or by someone from your service user's local community – this may affect both your service user's ability to disclose and your duty to provide confidential care. If an interpreter could not be accessed in time for a meeting, you may find it useful to use readily available translation services such as Language Line.

4. Be clear about the limits of confidentiality

Before you ask your service users about DVA, you should explain the limits of confidentiality, and ensure that your service user understands these limits. Your goal is to work collaboratively with your service user, and to see how you can empower and support them in the way they want to be supported. Be clear that you will try to obtain your service user's consent before you share any information and that you are working to prioritise your service user's safety.

Why some service users will not disclose experiences of DVA

Research shows that mental health service users want to be asked about DVA (53).

"I think sometimes if you're not asked it can be like a secret that you don't talk about" (CMHT Service User) (54).

However, mental health service users face several barriers to disclosing DVA; our research at SLAM (55, 56) has revealed several common concerns among service users experiencing DVA (see figure 2):

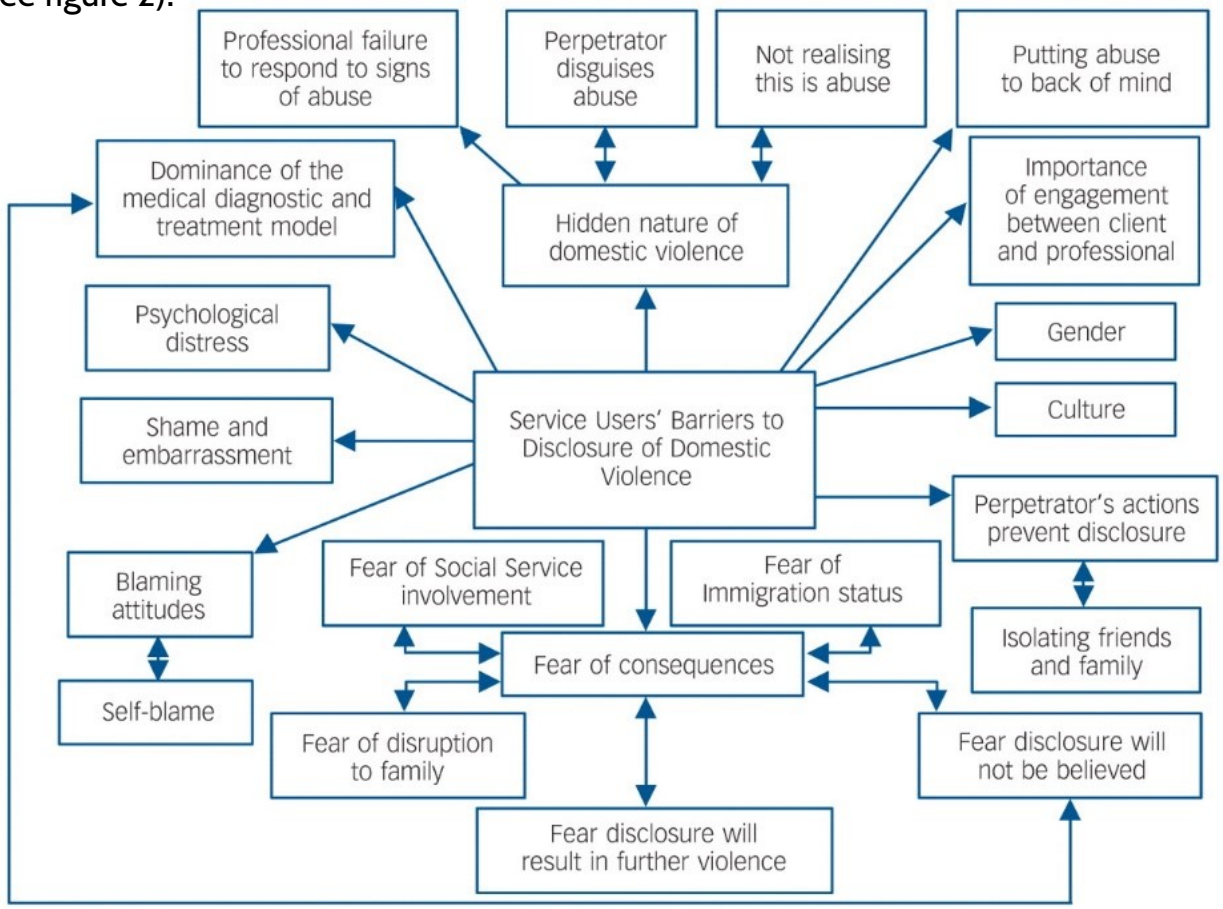


Figure 2. Barriers to disclosure of DVA in mental health services.[5]

Fear disclosure will not be believed: *"You're living in fear until people believe you. You're left feeling dirty and like you've been let down again by the system, 'cause there is a lack of support and lack of people believing you." (CMHT Service User) (55)*

Fear of Social Service Involvement: *"You're a bit scared to tell anyone in case you lose... I lost two children." (CMHT Service User) (55)*

Not realising this is abuse: *"If you haven't got a straight thing in your mind 'no this is wrong and this shouldn't be happening' and 'no you're not going to allow that man to do that to you', that's what I lacked... I suppose you just think it's normal sometimes." (CMHT Service User) (55)*

Dominance of the medical diagnostic and treatment model: *"[The treatment] was more for my anxiety and depression rather than the kind of root cause of it which I feel is the thing that I really need to sort of talk about and sort out really." (CMHT Service User) (57)*

Blaming attitudes: *"They [professionals] just blame it on me...'nothing happened to her, it's all in her mind' but I was badly beaten." (CMHT Service User) (54)*

5. From Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G., & Howard, L. Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study.

You should also be sensitive to the fact that many people presenting to services will face specific barriers to disclosing, including BAME women (73) and LGBTQ+ people (58). Being sensitive to the particular barriers and needs of your service users will help you in your DVA enquiry. Remember that not receiving a disclosure does not necessarily mean that your service user has not experienced DVA.

Consider whether there are any specific factors through which the perpetrator may have used against your service user to threaten, frighten, or confuse them about what might happen if they disclose. For example:

- **Mental health issues** *e.g. Perpetrator says they are mad and a disclosure will not be believed.*
- **Substance use issues** *e.g. Perpetrator causes/perpetuates substance use problems that render the other person incapacitated.*
- **Insecure immigration status** *e.g. Perpetrator threatens they will be deported if they disclose DVA.*
- **Religion/sexuality** *e.g. Perpetrator threatens to tell rest of the family that the person experiencing DVA is a "slut"/ "gay".*

Why mental health professionals might find it difficult to ask about DVA

Our research also explored barriers to professionals' asking about DVA in mental health services, again identifying several common themes (see figure 3):

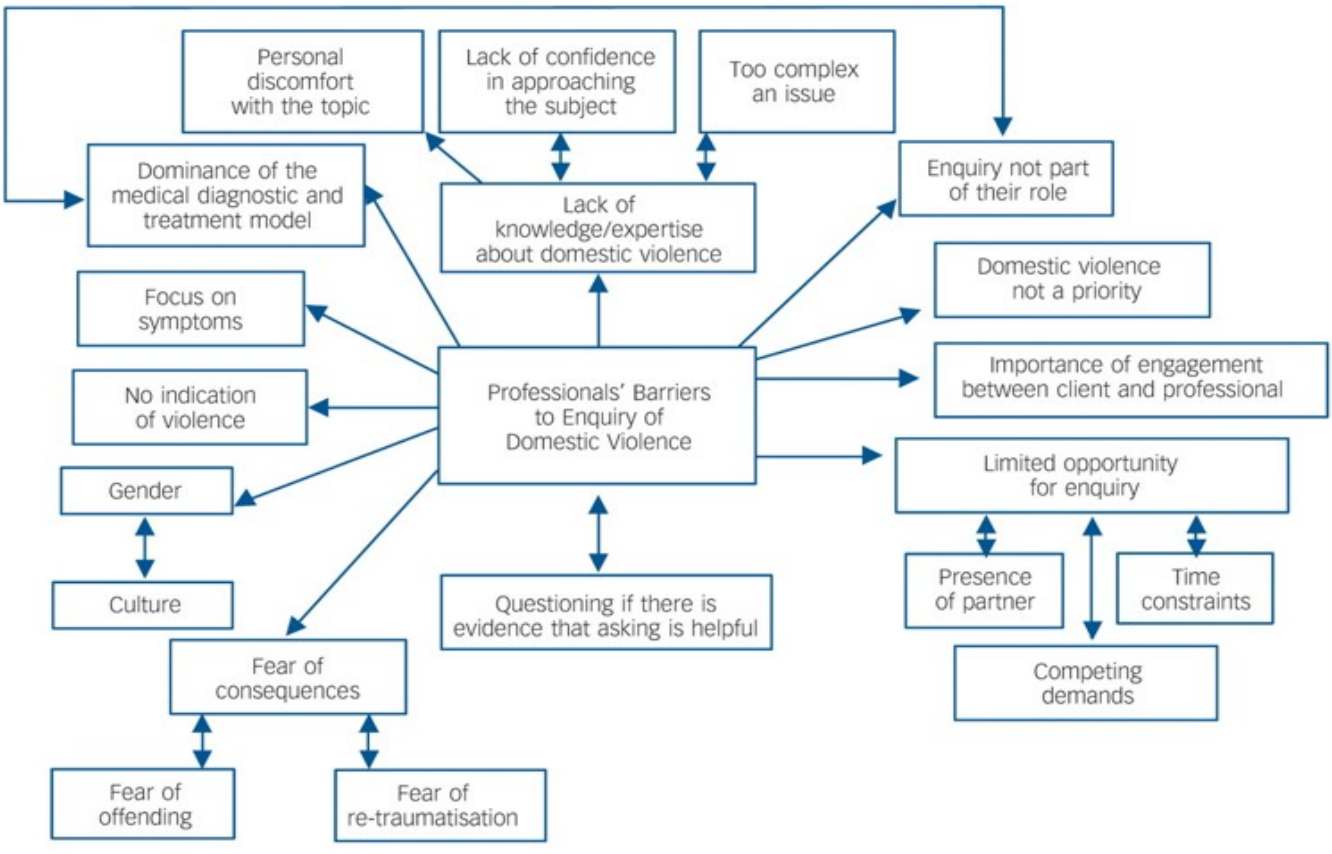


Figure 3. Barriers to professionals' enquiry into DVA in mental health services.[6]

Remember that perpetrators can be family members – be alert to signs of abusive behaviours from parents, children, and grandchildren.

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6. From Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G., & Howard, L. Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. Copyright © 2011 by Cambridge University Press. Reprinted by permission from Cambridge University Press.

You feel frustrated when service users remain in abusive relationships (57)

It is difficult to watch someone remain in an abusive relationship, but it is important to remember that your service user may understand the risks of their situation better than you do. Leaving a relationship may not always be the safest option, and many people experiencing abuse want to maintain a relationship with their perpetrator; for example, if it is their own child, or a long-term partner. Your job is to empower the victim by providing choices, ensuring safeguarding issues have been addressed, and to continue to support **and work with the victim even if the relationship continues.**

You feel under-confident about conducting the enquiry (55)

Some professionals feel under-confident or uncomfortable about conducting DVA enquiry. Some measures (57) that can improve you and your team's confidence include:

- Establishing who your local DVA service providers are and creating a relationship between them and your team.
- Conducting regular supervision and team meetings to discuss difficult DVA cases and foster a supportive working environment.

You fear that service users will find it traumatising (57)

Qualitative research indicates that mental health service users find it acceptable to be asked about experience of DVA (53); although service users may become distressed when talking about their experience, a properly handled disclosure can bring relief. The guidance in this resource will help you conduct a DVA enquiry as respectfully and sensitively as possible. **Make sure to document any disclosure of DVA, so that the service user will not have to make an "initial disclosure" too many times. If there is ongoing risk, remember to document this in your system's alerts.**

You are sure this service user isn't experiencing DVA ("there are no signs")

People experiencing DVA come from all social groups (10). They can be of any gender, age, ethnicity, diagnosis, social class, and sexuality. It is important to be wary of any assumptions that you might be making about potential cases of abuse, and to afford everyone the same opportunity to disclose. For example, some people may need an appropriate interpreter to communicate with you effectively, while others may require more time to build a trusting non-judgemental relationship with you. **NICE recommends that all mental health service users be asked about DVA** (52).

You do not consider DVA as a reason for the following behaviours:

Service user:

- Attending late or frequently missing appointments/"non-engagement".
- Frequent visits with complaints or symptoms that have vague or implausible explanations.
- Inconsistent explanations for injuries, or the person seems evasive or embarrassed.
- Seeming anxious, fearful or passive (particularly in the presence of others).
- Self-harming behaviours.
- Covering the body to hide marks (long sleeves, trousers or scarves).
- Not wanting to receive letters or be contacted at home (post, telephone, email).

Partner or family member:

- Cancels appointments on behalf of the service user.
- Always attends with the service user and never leaves their side.
- Seems to bully or be aggressive or **conversely, over-protective.**
- Is sexually jealous or possessive of the service user.
- Is critical, judgmental or insulting about the service user
- Frequently talks on behalf of the service user and does not consult them.

Asking about experiencing current DVA

Asking even a single question about DVA means that people experiencing DVA can:

- Know that you are willing to listen, so they are not on their own.
- Find out that you understand that DVA affects mental health.
- Discuss with you how to improve their safety.
- Find out about sources of help.

When you're asking service users about DVA, it may be helpful to start with a general phrase such as: *People's mental health is affected by how things are at home and how people treat them. How are things with your partner/ex-partner/family?*

- *Am I ready to ask?*
- *Is it safe to ask?*
- *Do I know what to do if I receive a disclosure?*
- *Do I feel adequately trained?*
- *Do I know how to refer my service user for further specific DVA support?*

Your service user may not realise or acknowledge that what they are experiencing is DVA, and your goal is to develop a dialogue about how your service user interacts with those closest to them. Asking specific questions can be easier to understand. You could start by asking an open question, for example:

- *I know that 1 in 4 women/1 in 7 men experience abuse from someone close to them, so I ask everyone if this has ever happened to them. Has anyone close to you ever hurt or frightened you?*
- *How are things with your partner/ex-partner/family?*
- *Are you afraid of anyone close to you?*
- *What happens when you and your partner/expartner/family member argue? What sort of things do you argue about?*
- *Who makes the rules in your household? What happens when you do not obey them?*
- *Does anyone consistently put you down or belittle you?*
- *Do you ever change your behaviour because you're worried about how someone at home might react?*
- *Many people who have these symptoms have been experiencing difficulties in close relationships. Has anyone hurt or upset you?*

If DVA is disclosed, try and establish the **extent, impact** and **pattern** of the abuse. You could ask:

- *What is the worst that has happened? How did this affect you?*
- *Has the abuse ever resulted in hospitalisation or attendance at an Accident and Emergency department?*
- *Have the police ever been called? Who called them? What happened?*
- *Has anyone ever taken an injunction out against the perpetrator?*
- *Does the perpetrator have a history of convictions/prison for violence (or threats of violence) to partners/family members?*
- *How frequent is the violence or abuse?*

Remember, however, that an absence of a criminal record does not mean that the perpetrator does not pose a risk of harm to their partners, ex-partners, and family members.

If you suspect DVA (or have a disclosure), your service users may find it helpful to read other people's accounts of their abuse. There are several such testimonies on the SafeLives website which you can access and print if required, and resources available in the Women's Aid Survivor's Handbook may also be useful for your service user to identify and process their own experiences.

Your aim is to have a supportive conversation rather than to force a disclosure. However, informing your service users about the nature and prevalence of DVA, and adopting a non-judgmental approach may help them disclose, either at the time or in the future. It is important that your service users do not feel that you blame or hold them responsible for their abuse.

> *"You really feel it's you. The more they hit you... you convince yourself that it's you... I convinced myself 'well look, this is the third violent relationship I've had, it can't be them it must be me, it must be something I'm doing wrong'." (CMHT Service User) (55)*

Asking specific questions after the more open questions above are often the only way to elicit disclosure. It is therefore important to ask about specific behaviours. For example, you could ask whether a partner, former partner, or a family member has ever:

- *Forced you to have sex when you didn't want to?* (Sexual abuse)
- *Insulted you, called you names or sworn at you?* (Psychological abuse)
- *Forced you to take out a loan?* (Economic abuse)
- *Monitored your spending or implied that you need to seek their*
- *approval before spending money?* (Controlling behaviour)
- *Monitored your emails, texts, or whereabouts?* (Technology-based abuse)
- *Used your gender identity or sexuality as a basis for threats, intimidation or harm?* (LGBTQ+)
- *Used your immigration status or religion as a basis for threats, intimidation or harm?* (Cultural-based abuse)
- *Sent you emails or texts that you found intimidating or threatening?* (Stalking)

Using language effectively

Some people (male service users in particular) may not be willing to admit they are "afraid" of anyone, and it may be more sensible to ask a general question about whether they modify their behaviour to avoid a negative reaction from someone at home. If your service user speaks a different language to you, you should arrange for an appropriate interpreter. If your service user is from a different cultural background, think about how you can provide more culturally appropriate, individualised care in the context of DVA.

For a detailed list of more potential questions to use, please see **appendix 2**. Different practitioners are more comfortable with different questions.

If your service user does not disclose DVA, this does not mean that they are not experiencing it. Make sure that you enquire repeatedly over time using a variety of different questions, as a matter of routine practice.

> *"Some people might not be able to talk about it but if [the professional] is asking them, asking them in a nice way, in a gentle way... making sure that there is good contact between them then one day they will open and say 'look this is happening to me.'" (CMHT Service User) (54)*

Abuse often continues after a relationship has ended; it is important that you also ask all service users about abusive experiences with former as well as current partners and family members in your enquiry about DVA.

Asking about experiences of historical DVA

Your service user may not be experiencing DVA currently but may have done so in the past. Historical experiences of DVA may be an important factor in your service user's mental health problems and in their treatment. **Remember: DVA can affect people regardless of gender, age, ethnicity, diagnosis, social class, and sexuality.**

You can adapt the example questions provided on the previous page to enquire about less recent experiences of DVA. For example:

- *I know many service users coming to our team have experienced domestic violence and abuse. This does not just affect physical but emotional and mental health.*
- *I know that 1 in 4 women/1 in 7 men experience domestic violence and abuse at some time in their lives, so I ask everyone if this has ever happened to them. Has anyone close to you ever hurt or frightened you?*

Or you could ask about more specific behaviours, as before:

- *Has a partner/family member ever stopped you from seeing friends or family?*
- *Has a partner/family member ever hit/choked you?*
- *Has a partner/family member ever monitored your whereabouts or your texts/emails/social media profile?*

What is historical DVA?

If a service user discloses historical DVA, seek to clarify whether the abuser is still in contact with them and whether this poses any risk of harm. If you identify no current risks, you may not need to help your service user with safety plans and/or safeguarding referrals. . With these exceptions, your immediate response, psychological management, and offer therapeutic interventions should follow the guidance provided in this resource.

Responding to people with experience of DVA

Key principles for your team

"The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections. Recovery can take place only within the context of relationships; it cannot occur in isolation... The first principle of recovery is the empowerment of the survivor. [They] must be the author and arbiter of [their] own recovery. Others may offer advice, support, assistance, affection, and care, but not cure." (59)

1. Make safety a priority

Safety should always be your first priority. What seems an appropriate response at one time could be dangerous at another. Service users who are at ongoing risk of harm have different support needs than service users whose safety is assured. For more information about how to support the safety of service users who are still at risk of DVA, please refer to the **risk assessment** and **information sharing** sections of this resource. **Full recovery can only be completed when they are safe**. However, professional support should never be withheld until a service user is 'safe' or has left a relationship. It is your role to explore options with the service user and to provide support even if they stay with their partner/family member.Focus on increasing your service user's choices, which in turn will support them to increase their safety, and remember that women are at increased risk at or just before the point of separation (10).

2. Respect and endorse the person's strength

People experiencing DVA use an impressive range of strategies to cope with the abuse which they may not even be aware of. These might involve escape plans (to get away from abuse), protection plans (trying to minimise risk of injury) and psychological strategies (such as dissociation, hypervigilance, alcohol consumption, apparent passivity, or switching off). The person experiencing DVA will likely be doing everything they can to protect both themselves and their children, and you can reassure them that their behaviours are normal and rational responses to an abnormal environment.

Be wary of making snap judgments about a person's coping strategies or of pointing them out to your service user. Empowerment and recovery may be achieved by focusing on past successes and solutions, although even with your help, it may take time for your service user to be able to identify what these are.

3. Understand the person in the context of DVA

It is important that you believe and validate any service user who discloses to you that they are experiencing DVA, rather than:

- Acting as if they are contributing to or causing abusive behaviours
- Pathologising the impact of DVA *i.e. viewing their coping strategies (e.g. alcohol use) or symptoms (e.g. hallucinations) in isolation from the abuse*.
- Focusing on how to manage symptoms rather than being concerned with what underpins them.

"It would either be 'well here's an antidepressant to help you get through'.... 'here's a tablet to help you sleep. Try eating better', you know, there was never any talking about it." (CMHT Service User) (55)

4. Empower rather than advise

Whenever possible, you should support your service user to set goals and explore their options. Good practice empowers the service user to take control as the agent of their own situation and does not dictate their choices, even if they are at risk (within safeguarding limits).

5. Document enquiry and disclosure

Writing down what your service user told you about DVA is an important aspect of treatment (60), in that:

- It shows that you listened and take DVA seriously.
- Your records can protect people who have experienced DVA by helping them access legal and welfare support.
- Your notes may play a crucial role in helping a service user's safety. Many housing agencies will accept an application to be re-housed if the person who has experienced DVA can produce evidence from a health professional, and Home Office representatives will often respect a health professional's records when making decisions about someone's immigration status.
- Your team will be able to monitor and assess the degree of risk to inform their clinical decisions.

Make sure that you:

- Keep records secure.
- Always make records in an interview with the person experiencing DVA alone.
- Include names (of victims and perpetrators), date of birth, ethnicity, children and/or pregnancy.

Records must include:

- Questions and answers in your service user's words.
- Symptoms or injuries observed.
- Any information on frequency/severity of abuse.
- A clear statement of who experienced DVA and who was the perpetrator including **names of the people involved,** as people may experience/perpetrate DVA from/towards multiple individuals.
- A record of your action *e.g. information provided, referral to your local DVA agency.*

Records would ideally also include:

- Your service user's response to questions (use your service user's own words when possible).
- Descriptions of types or nature of abuse, including specific incidents wherever possible. This includes all types of DVA, including incidents of emotional, psychological, and technology-based abuse.
- Any effects of the abuse *e.g. suicide attempt or onset or exacerbation of psychiatric symptoms* (a good question to find out may be 'how have things changed since the DVA started?')
- Dates and times of incidents, if known.
- Description of your service user's current psychological state, without interpretation/judgments/assumptions.

Remember to document previous and current risks in your system's alerts.

Initial support

What you say in response to a disclosure can have a profound impact on a person experiencing DVA. Your service user may have told no one else about their experiences and may fear – or have been told by their abuser - that they will not be believed, including because of their mental health problems (55, 56). Being able to talk to you can help to lift the self-blame and isolation. People who have been supported through their experience of DVA by mental health professionals report that they value external validation and acknowledgement of their experience, whether or not they want any other action to be taken.

Key features of your conversation could include **reassurance** that the abuse is not their fault, **willingness to offer another appointment**, and the **offer of information about DVA** and what support options are available. While your service user's safety in their own home is a priority and a health issue, they are the expert on what they need and what should happen next. **However, you can inform people experiencing DVA that help is available, and that you can provide appropriate psychiatric support/refer them to a local DVA support service.**

In your initial response, we recommend you offer at least one key message, such as:

- *I am willing to listen and glad that you told me.*
- *DVA affects mental health and it is important to talk about it.*
- *You are not alone; 1 in 4 women/1 in 7 men experience DVA at some point in their lives.*
- *Your safety is my priority.*
- *The abuser is responsible for his/her actions; the abuse is not your fault.*
- *There is help available that I can provide/help you access.*

It may be enough simply to ask:

- *What do you need?*
- *Would you like some support?*

Listen to your service user – your job is to validate and empower, not to judge or insist on a particular course of action.

The LIVES model of responding to DVA

Traumatic experiences may mean service users have difficulties in trusting other people; extra encouragement and support may be needed within the therapeutic relationship. Mobilise support for your service user by providing them with short-term coping strategies and safety plans to manage their emotions and their situation, and long-term referrals and treatment to manage their symptoms. Use the WHO's "LIVES" model (61) to provide immediate psychological management:

- **Listen** to your service user with empathy, and without judgement.
- **Inquire** about needs and concerns.
- **Validate** your service user. Show that you understand and believe them, and that they are not to blame.
- **Enhance safety**, discuss making a *safety plan* (appendix 1).
- **Support** your service user by connecting them to information, services and support.

Safety planning and support

While your service user is at risk of further violence or abuse, explain the purpose of developing a safety plan – even if your service user doesn't want to leave their relationship, a safety plan can be useful in times of crisis. A template for making a safety plan is provided in appendix 1. If your service user agrees, this work can be done in more depth with an expert DVA adviser from your local DVA service.

Whether or not your service user wants to develop a safety plan, psychoeducation about DVA, mental health, and the effects of trauma is also important as it may help them to understand their situation and their responses to it. Doing so can empower them to understand and take ownership of their experience, so that they are better equipped to assess the next steps that are right for them.

Assess risk and safety

If your service user is still being abused, it is imperative that you make ongoing enquiry about their safety and the risks they face – you should work collaboratively to support them to protect themselves and any children involved, while ensuring use of safeguarding adults and children procedures where appropriate.

If someone is experiencing DVA, you should ask:

- *Is it safe for you to go home?*
- *What are you afraid might happen?*
- *What has [the abuser] threatened?*
- *What about threats to the children?*

You can obtain more information about the extent and pattern of abuse by reviewing case notes, discussing the case with your team, and through using the Domestic Violence Disclosure Scheme (DVDS). The DVDS, also known as "Clare's Law", is a means of obtaining a potential perpetrator's criminal DVA history. In order to access this information, your service user would need to make contact with local Police, either by calling 101, or by going into a local Police station. They will likely need to verify their identity in person. If you would like further advice on supporting your service user through this process, contact your local DVA agency. In cases of high risk, you might also consider discussing the case with your line-manager, or referring your service user to a Multi-Agency Risk Assessment Conference (MARAC).

Provide information and resources

Make sure to familiarise yourself with local safeguarding procedures and DVA agencies and how to contact your local independent domestic violence advisor (IDVA). Close links between mental health professionals and DVA advocates can be beneficial for mental health service users (62) and advocacy services provided by shelters can both improve both quality of life and reduce violence by providing access to emergency housing, informal counselling and advice (63,64). Be ready to offer information about and make referrals to DVA agencies that could provide support to your service user if they would like this support, and if they do not want outside support, be ready to offer appropriate responses and support within the Multi-Disciplinary Team (MDT).

The DVA agency working with your Trust is:

What are Multi-Agency Risk Assessment Conferences (MARACs)?

A MARAC is a confidential information-sharing meeting for the highest risk DVA cases. MARACs are attended by representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors. High-risk cases of DVA need to be referred to a local MARAC – you can refer both perpetrators and people experiencing DVA. Referrals do not require the consent of the service user but involvement of the person experiencing DVA in the decision is good practice, especially as they can provide the most accurate assessment of risk throughout the process. A case should be referred to a MARAC if any of the following criteria are met:

1. **Professional judgement of high risk of serious harm.** If you have significant concerns about the safety of a service user, you should contact your local MARAC representative. This judgement would be based on professional experience and/or the service user's perception of risk – if the service user is extremely fearful of their situation, then you should refer them to a MARAC even if they don't meet the remaining criteria for a MARAC referral.
2. A score of 14 or more on the DASH checklist (appendix 3). If using the DASH checklist to assess risk, 14 or more "yes" answers indicates that you should seek a MARAC referral. However, if *under* 14 items on the DASH checklist are met, **you should still use your professional judgement to consider whether a referral might be appropriate – you can discuss this with your Trust MARAC representative, and your local DVA agency.**
3. **Potential escalation.** Increased frequency of DVA incidents can indicate significant increased risk of escalation and harm. It is common practice for service to refer people experiencing DVA to MARACs if there have been 3 DVA incidents in the past 12 months.
4. **Repeat MARACs.** If a service user experiences any further instance of DVA within 12 months of the last referral to MARAC, then they should be referred to a repeat MARAC.

Each Mental Health Trust will have a MARAC lead who attends local MARAC meetings, and who you can contact to discuss the possibility of a referral.

For further resources on MARACs for everyone working with people experiencing domestic abuse, please refer to the SafeLives website.

For more information on risk assessment, safeguarding, and information sharing, or to help your service user to construct a safety plan (appendix 1), refer to the appropriate sections in this resource. Remember to also discuss with your line manager.

Provide appropriate therapeutic interventions

The World Psychiatric Association advises that therapeutic interventions for mental health service users with experience of DVA should address their experience of trauma (65). Plans should be developed on an individual basis dependent on the needs of your service user. Appropriate therapies my include (65): trauma-focused and non-trauma focused CBT, EMDR, and parent-child interventions.

NB: Couples therapy is usually **NOT** appropriate for service users experiencing DVA and the partners should be seen individually, assessed and supported individually in addition to couple sessions if couple therapy is assessed to be appropriate. The dynamics of any controlling coercive behaviour usually mean that couple therapy is not possible.

What you should do

- Continually assess risk and safety.
- Develop individual intervention and safety plans with your service user.
- Maintain a relationship with the service user.
- Provide appropriate therapeutic interventions.
- Provide information about relevant services and sources of support.

What you should not do

- Ask about DVA in front of anyone else.
- Approach the abuser without the express consent of your service user, because it may endanger them.
- Approach your service user's family without their consent, because this may endanger them e.g. if there is a risk of honour-based violence.
- Approach the abuser's family without the express consent of the service user.

Culturally-appropriate, individualised care

It is essential that you are sensitive to a person's particular background and experiences when supporting them through experience of DVA. As re-iterated throughout this document, DVA can affect anyone irrespective of any **gender, age, ethnicity, diagnosis, social class, and sexuality**.

A service user's cultural and personal background may impact on how they understand and express their experience of DVA, as well as their expectations of mental health care. A person's background may also mean they experience particular barriers to support, including because of language/literacy skills, cultural traditions and gender roles, or experiences of prejudice and discrimination that contribute to mistrust of services and/or people.

If there are language barriers, use independent and professionally trained interpreters.

- Never use a service user's partner, child, family member or 'friend'.
- Try to get an interpreter of the same gender as your service user wherever possible.
- Ask your interpreter to sign a confidentiality agreement.
- An advocate from a specialist organisation might be an alternative.
- Agree the agenda with the interpreter and that s/he will not 'edit' what your service user says.
- Be alert to any tensions between the interpreter and service user.
- Look at your service user and speak directly to her not the interpreter.
- Have information available in an appropriate language.

You may find it useful to consult a service such as language line.

Reflect on your service users' background and experience

- Identify any additional stressors your service user is experiencing *e.g. financial, housing, legal, social services*
- Explore your service user's understanding of their experience of DVA *e.g. if they perceive divorce or separation as bad or dishonourable*
- Ensure that your service user's wishes are respected *e.g. if they want to speak to a practitioner of the same sex, or if they want to be referred to specific services*
- Recognise the importance of religious/cultural beliefs in your service user's understanding of their experience and their recovery process.

Ask questions using universal terms

- How do you describe what you are feeling?
- When do you think you started feeling like this?
- How does this problem affect you?
- What or who makes things worse?
- What worries you most?
- What would be of most help to you?
- What kind of treatment do you think you should receive?
- What kind of support would you like?

> *"When I come in here I see people that look like me. I see people that think like me. And even if they don't look like me and think like me, I know that they know me."(66)*[7]

You must be able to understand your service user in the context of their experiences and expectations before you can help to support them effectively, in the way that they want to be supported. In your practice you must:

- **Listen to your service user's perspective.**
- **Never accept culture as an excuse for DVA. Everyone deserves the right to be safe in their own home.**

For information about support services for people from ethnic and religious minorities, please refer to appendix 8.

> *"Multicultural sensitivity is not an excuse for moral blindness." (67)*

7. Reprinted by permission from Springer Nature: Journal of Internal Medicine. The Interconnections Project: Development and Evaluation of a Community-Based Depression Program for African American Violence Survivors. Nicolaidis, C., Wahab, S., Trimble, J., Mejia, A., Mitchell, S.R., Raymaker, D., Thomas, M.J., Timmons, V., Waters, A.S. ©2013

What about children?

Children and DVA

Living with and witnessing DVA is recognised as a source of "significant harm" for children in the Adoption and Children Act 2002 (68), and abused parents are often fearful of making a disclosure in case this results in their children being removed (55). Services should always strive to help children to stay with their victimised parent, not the abuser.

- **Children are in the same or next room for 90% of DVA incidents occurring in households with children** (69). DVA
- is the most commonly cited factor in situations where children are at risk of serious harm in the UK (70,71) and is cited as a risk factor in over half of Serious Case Reviews concerning children (72,73).
- By the time they reach 18, almost 1 in 4 children in the UK have been exposed to DVA in their home (74).
- Even if children are not the direct target of violence, witnessing/hearing abuse can produce significant mental health difficulties (75) and self-harming behaviours (76).

Children may also experience harms through:

- Becoming an informal carer for the person experiencing DVA.
- Loss of contact with family members or friends (either because a family member was previously a perpetrator, or because the perpetrator is isolating them from other family members).
- Disruption from moving houses/schools.

Remember that DVA has the potential to affect any children who have contact with the perpetrator. In the home, this might be the perpetrator's biological children, children of the person experiencing DVA, or any siblings or younger relatives living in the house. Outside of the home, consider whether the perpetrator may regularly come into contact with any children – for example, at work.

Childhood abuse is associated with significant increased health risks in adulthood such as:

- Mental health problems (77-79);
- Physical health conditions (78-80);
- DVA victimisation (81, 82); and
- DVA perpetration (83).

Witnessing DVA is the strongest risk factor for adult violence perpetration out of several types of child maltreatment (84).

Responding to children in the context of DVA

Mental health professionals regularly come into contact with children and their families in the course of their work and may come across families who are experiencing difficulties in looking after their children, including those experiencing DVA. Child protection legislation places a statutory duty on organisations and professionals to work together in the interests of vulnerable children. **All healthcare professionals, including those who do not have a role specifically related to child protection, have a duty to safeguard and support the welfare of children.**

DO:

- Understand and identify any children who may be at risk from direct/indirect harms in the context of DVA.
- Recognise the risks of DVA to an unborn child.
- Recognise the needs of adults who are experiencing DVA and inform them of your duty to protect the safety of any children involved.
- Make sure you have completed any relevant risk assessments for any children affected by DVA.
- Be familiar with local procedures for safeguarding children.
- Contribute to enquiries from other professionals (e.g. social care, DVA agencies) about the safety of a child and their family or carers.
- Liaise closely with other agencies including other health professionals, social care and relevant third sector organisations.
- Play an active part, through the child protection process, in safeguarding children from significant harm.

DO NOT:

- Ignore your concerns.
- Discuss your concerns with the suspected/alleged perpetrator of DVA.

For more information on how to handle cases of DVA involving children, you may find it useful to refer to other sections of this resource, such as information sharing, safety planning (appendix 1), or risk assessment.

You may also want to refer to the Department of Education's resource (2015) "What to do if you're worried a child is being abused: Advice for practitioners" or to the NICE guidelines on child maltreatment.

Perpetrators

Prevalence and risk of DVA perpetration by mental health service users

Data are limited for the prevalence and risk of DVA perpetration by mental health service users. Although only a minority of mental health service users perpetrate violence (25), increased risk (compared with the general population) of DVA perpetration has been reported for people with a range of mental disorders (e.g. **depression, panic disorder, generalised anxiety disorder, post-traumatic stress disorder, attention deficit hyperactivity disorder**, and **personality disorder**) (85-91).

Technology-based abuse

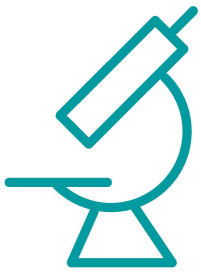
Evidence is limited but suggests a high prevalence of coercive control and technology-based abuse among people with substance abuse problems – one survey of English substance users established that 64% had perpetrated coercive control, and 33% had perpetrated abuse via technology (92).

For more information or for resources on technology-based abuse, see: Technology safety, and the UCL internet of things resource list.

What does the evidence say?

More work is needed to understand pathways between mental health problems and DVA perpetration, but some symptoms may indicate higher risk.

Some evidence suggests increased risk of violence amongst people experiencing delusions, especially if untreated (93, 45); there is evidence that psychotropic medications reduce violence, particularly in relation to severe mental illness where antipsychotics are associated with decreased rates of violent crime in real world settings and also with reduced aggression in trials (95). The evidence for antidepressants is less clear, but suggests that for most people, there is no association with violence but in younger people, individuals should follow prescribing guidelines (96, 97).



Other work examining the relationship between delusions and violence (98) indicates no association after controlling for other characteristics associated with DVA perpetration (99). The largest systematic review to date of the risk factors for violence amongst people with psychosis indicated that the strongest predictors of future violence were: a history of assault and violence, and substance use factors (100).

A study of domestic homicides committed in England and Wales between 1997 and 2008 showed that 14% of perpetrators of intimate partner homicide and 23% of perpetrators of adult family homicide had been in contact with mental health services in the year before the offence (101). More than a quarter of perpetrators convicted of the homicide of an adult family member in England and Wales between 1997 and 2008 had symptoms of psychosis at the time of homicide (101). Work examining domestic homicide in general indicates increased risk amongst individuals who are: highly controlling and coercive, who have threatened to kill, and who have previously used/owned a weapon (102).

Regardless of the issues underpinning the violence, it is important to remember that:

- DVA perpetration does not just occur within intimate relationships but can also happen within families.
- Mental health professionals must take care not to collude with DVA perpetration; violence and abuse is always unacceptable. Part of the aim of treatment should be to enable service users to take more responsibility for their abusive behaviours.
- Mental health professionals have a duty of care to respond to service users' needs.
- Mental health professionals have safeguarding responsibilities towards the family members and current and former partners of service users.

What about substance use?

There is evidence for an association between substance use and DVA perpetration, Around 40% men attending treatment for substance use have been physically or sexually violent towards a partner in the last 12 months (103,104), and the majority of violence perpetrated by people with a psychosis has been deemed largely attributable to co-morbid substance use (93,105).

Preparing to enquire about DVA perpetration

For a printable flowchart detailing key steps and considerations throughout the process of identifying and responding to people with experience of DVA, please refer to page 37.

1. Display information about DVA in the team base

Displaying information and resources about DVA perpetration and the relevant services can help to foster a disclosing environment by encouraging your service users to reflect on their behaviour. Make sure that any available posters on DVA perpetration are displayed around the team base, and that information is provided about where to seek help.

Respect: http://respect.uk.net/ helpline: 08088024040

2. Know your local DVA perpetration services

Familiarise yourself with your local DVA perpetration services – establishing close links with these services will improve your ability to help your service users, and will improve your confidence in handling cases of DVA perpetration. Make sure that you know:

- What services are available;
- What their protocols are for perpetrators with mental health problem;
- The procedures for a referral; and
- The criteria for a referral to be accepted.

The Respect accredited perpetration services operating in your area are:

Remember that your job is to help your service user in the context of a multi-agency support network, maintaining the safety of anyone affected by DVA as a priority. To remind yourself to do this, you may find it useful to consult the Respect principles for DVA perpetrator interventions:

- **Do no harm** – do not collude with the perpetrator or generate additional risks.
- **Gender matters** – understand that DVA occurs in a context of gender inequality.
- **Safety first** – prioritise the safety and wellbeing of survivors and children.
- **Sustainable change** – offer appropriate interventions for each perpetrator.
- **Fulfilling lives** – support service users to lead healthy lives free from abuse.
- **The system counts** – work within a multi-agency context to support your service users.
- **Services for all** – provide appropriate services to service users irrespective of background.
- **Respectful communities** – recognise that change occurs in a community context.
- **Competent staff** – know your local services and the limitations of your expertise.
- **Measurably effective services** – monitor the progress of your service users.

Asking about DVA perpetration

Analyses conducted by the UK Home Office and the UK National Confidential Enquiry into Suicide and Homicide by People with Mental Illness have found that mental health professionals often fail to assess for risk of DVA perpetration in their routine risk assessments (108,109). When asking your service users about their violence towards others, it is essential that you **specifically ask about** any history of violence towards:

- **Partners;**
- **Ex-partners;**
- **Family members; and**
- **Any children involved** – this might be children of the perpetrator or the adult experiencing DVA, siblings, other relatives that frequent the house, or even children that the perpetrator works with *e.g. if they foster children, including private fostering.*

Denial and minimisation

Before you begin your enquiry, you should be aware that perpetrators often **deny or minimise their behaviour**, and your enquiry should be persistent and probing. One study of perpetrators in contact with substance use services provides an example of a perpetrator minimising his use of sexual violence:

> *"Rape her, or as she says 'force her', I didn't force her. All I did was insist so much and be such a pain that for her to get any peace she said 'ok then do it quickly'... there wasn't agreement...but I didn't rape her" (103)* [8]

This quote seems to illustrate a perpetrator with little regard for the experience of his partner. This is sometimes at the heart of minimisation and denial; sometimes shame may be a factor and a strong motivator for abuse not to be exposed.

Questions

As with people who have experienced DVA, your enquiry should start with open, non-judgemental questions if you hope to elicit a disclosure:

- *Who supports you at home?*
- *Which relationships do you feel are most important to you?*
- *How are things between you and your family? What happens when you argue? Has that ever led to violence?*
- *Has any family member/partner ever said that they feel frightened by you?*
- *Have you ever felt your behaviour get out of hand or violent? What is the worst that has happened?*
- *How do your [insert symptoms here e.g. irritable mood] affect those around you?*
- *What are the effects on those around you when you feel [insert symptoms here e.g. angry]?*
- *Have you ever shouted or smashed anything when you feel [insert symptoms here e.g. angry]?*

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8. From Gilchrist, G., Blazquez, A., Segura, L., Geldschläger, H., Valls, E., Colom, J., & Torrens, M. Factors associated with physical or sexual intimate partner violence perpetration by men attending substance misuse treatment in Catalunya: A mixed methods study. Copyright © 2015 by John Wiley Sons, Inc. Reprinted by permission from John Wiley & Sons, Inc.

More questions that ask them to engage with the impacts of their behaviour include:

- *Is your behaviour affecting those around you? How?*
- *How are any children in the household affected?*
- *Have you ever physically harmed anyone close to you?*
- *Have the police ever been called because of your behaviour towards your partner/ex-partner/family member?*
- *Do you feel unhappy/jealous about a partner/family member seeing friends or family? Do you ever try to stop that from happening?*
- *Did/has your behaviour changed towards your partner during pregnancy?*
- *Do you think your behaviour is getting worse?*
- *How do alcohol and drugs affect your behaviour?*

It is important that you are clear with your service users that violence and abuse is unacceptable, and that neither mental illness or substance use means that violent behaviour is okay. Otherwise, your response may be seen to collude with the perpetrator and justify his/her behaviour.

It is important to try and establish the extent of the violence or abuse and its impacts when enquiring about abusive behaviour. You could ask:

- *What is the worst that has happened and did this result in hospitalisation or attendance at an Accident and Emergency department?*
- *Have the police ever been called? Who called them? What happened?*
- *Do you have any history of convictions/prison for violence (or threats of violence) to partners/ex-partners/family members?*
- *Has anyone ever taken an injunction out against you?*

Remember, however, that an absence of a criminal record does not mean that the person does not pose a risk of harm to their partners, ex-partners, and family members.

Documentation

It is important to keep detailed records if your service user discloses abusive behaviour. This is important health information which will enable continuity of care. Good records will also be required in serious case and homicide reviews, and may help in any future legal proceedings which the person experiencing DVA or the police may take. Record the information and file in your service user's case notes. Although medical records are confidential, if an individual, especially a child, may be at risk of significant harm, the requirement to keep information confidential will be overridden.

If you want other mental health professionals to be aware of a current or ongoing risk, document DVA in your system's alerts. If you think it may be unsafe for your service user to access documented information about DVA, log the information in your system's third party information section. ***If a service user asks for their notes, remember that any information can be omitted if considered to increase risk.***

MARAC leads

If you are a MARAC lead, remember to be careful about how you document your MARAC cases. Unless criminal proceedings have begun you should document disclosed DVA perpetration as "alleged". The perpetrator is likely to be unaware that their case is being discussed at a MARAC, so be careful to document this in third party information and/or alerts in case the service user accesses their notes.

Response

It is important that you know the diverse range of factors contributing to DVA perpetration, and that you understand the dynamics of DVA (e.g. coercive controlling behaviour) and how damaging this can be to others. You can then acknowledge disclosures of DVA perpetration and, while conveying that this behaviour is unacceptable, reassure them that there is help available. You should aim to maintain a collaborative approach with service users who have disclosed DVA perpetration – be aware of your own judgements and how his may impact upon the therapeutic relationship.

When responding to DVA perpetration you must retain a neutral stance and seek to provide a collaborative (rather than a collusive or confrontational) response (see Box below) (108).

✗ **Collusive response:** Can you tell me what *really* happened?

✗ **Confrontational response:** Can you tell me what you *claim* happened?

✓ **Collaborative response:** Can you tell me what happened from your perspective?

When responding to a disclosure of DVA perpetration, key messages include:

- *Violence and abuse is never appropriate.*
- *It is okay to discuss violence and abuse and there are opportunities for change which you can help with.*

Asses risk and safety

DVA is not usually a one-off incident: 42% of people experiencing DVA experience multiple incidents within a 12-month period (8). It is therefore important that you assess for a pattern of behaviour if a disclosure of DVA is made. Be aware that (a) not all DVA entails physical violence, and (b) perpetrators will deny and minimise their behaviour.

When assessing potential risk of ongoing and future harm, key risk factors for repeated and/or escalating abuse include:

- *History of DVA or violence (100);*
- *Use of weapons (102);*
- *Threats to kill (102);*
- *Threats of suicide (107);*
- *Traditional conceptions of masculinity;*
- *Mental health problems; and*
- *Alcohol/substance misuse.*

If a service user has disclosed DVA perpetration, you may also find it helpful to speak to partners/family members/carers to establish the degree of risk, but only if private enquiry is possible and if it is safe to conduct it. Family members and friends often hold vital information about the degree of risk in serious DVA cases (109).

Other factors to assess include any information about a pregnancy or recent separation (102), and whether any children may be involved, including if there are any children present in the household born of previous relationships (102). With help on how to assess risk of DVA perpetration, please see the risk assessment section within this resource. Example risk assessment tools are also provided in appendices.

Provide information, resources, and referrals

If your service user has disclosed that they have perpetrated DVA, it is important that you consider the context of these actions, and the needs of your service user. You should consider discussing the case with your team, forensic psychiatry colleagues and/or collaborating with specialist DVA perpetration services on a case-by-case basis. Call the Respect phone-line (0808 802 4040) for advice and information if you are unsure of the appropriate actions to take or speak to your local Respect accredited services.

In your intervention for DVA perpetrators, it is important for you tailor your response to the individual, and determine whether there are potentially modifiable individual clinical risk factors for DVA that could be addressed:

Clinically modifiable risk factors may include: emotional dysregulation; overvalued jealousy and paranoia;; delusions or hallucinations that may lead to violence; irritability e.g. in depression, or PTSD-related hyperarousal and hyper-reactivity; impulsivity; substance use, and/or alcohol use (91).

Clinical responses to these risk factors therefore might entail talking therapies for underlying traumas and emotional regulation, antipsychotics for delusional beliefs and command hallucinations, and interventions for substance/alcohol use. However, it is important to remember that throughout your support of your service user you must be clear that violence and abuse is unacceptable, and that you are working towards a safe relationship. Perpetrators often want to find solutions for their violence too.

Your service users may find it helpful if you provide psychoeducation about the potential impacts of DVA, and explain the importance of disclosing information about violence or threats of violence to avoid risks to the family. Locally provided DVA perpetrator programmes may or may not be appropriate for your mental health service user; for advice, speak to your local Respect accredited provider or call the Respect helpline.

It is NOT the case that "anything is better than nothing". Some interventions can increase risk of harm from DVA perpetrators, so make sure that you administer an appropriate intervention for your service users:

- **Couples therapy** is inappropriate for DVA perpetrators while they are in the process of recovery, as they may control and manipulate their partner/family member to lie about their behaviour.
- **Anger management** interventions may be inappropriate for DVA perpetrators (110).

In determining appropriate interventions, therefore, it is essential that you undertake a careful assessment of the risks your service user may pose, and the factors that could exacerbate their behaviour and discuss these in supervision and with your team.

What about confidentiality?

If you are concerned about your duty of care to service users who disclose DVA perpetration, remember:

1. **If your service user has disclosed DVA perpetration to you, they will have done so for a reason**. Your service user will either have told you about their behaviour because they are trying to manipulate you into "colluding" with them and taking their side, or because they want to get help. In either case, the appropriate action is for you to intervene and refer them/share information appropriately and proportionately.

2. **Your duty of care is not incompatible with acting to reduce risks of harm.** Any violent or abusive behaviours perpetrated by your service user towards a close family member or partner will have a negative impact on the perpetrator as well. In providing them with the appropriate measures to eradicate the DVA, you will be protecting both anyone experiencing DVA and the perpetrator themselves.

3. **Abusive relationships are not protective.** While the existence of relationships between your service user and their family/partner may be seen as a protective factor for their mental illness, no abusive relationship is protective. DVA causes harms to both the perpetrator and anyone experiencing the abuse, and it is part of your role to protect people from such harms.

4. **If you are sharing information you should tell the perpetrator that you are going to do so, unless this is likely to increase risk of harm to them or someone else.**

Useful resources

If you are concerned that the perpetrator is too high risk for you to disclose your duty to share information, consider seeking to share information without seeking the consent of your service user by consulting the appropriate section of this resource, and document your actions in an area of the notes that the perpetrator will not be able to access. Be aware of the limitations of your expertise and when other people need to be informed.

The national **Respect phone-line** (0808 802 4040) offers a clear, non-collusive response to men concerned about their abusive behaviour and advice on short-term strategies to prevent further abuse. Respect can also advise you as a professional on the best steps to take.

*For information about where to refer people and who to share information with, refer to the information sharing and safeguarding section.

Risk assessment & management

1. Think safety

The first priority in risk assessment for cases of DVA is the safety of the person experiencing the abuse, and the safety of any children involved. You should work together with the people who are experiencing DVA, so as not to collude with the perpetrator: the best way to keep a child safe is to keep them with a non-offending parent. This process involves a delicate balance between working with your service user to make changes to protect the safety of themselves and any children, and continually reviewing risk to override this where necessary. In situations of high risk, a Multi-Agency Risk Assessment Conference (MARAC) referral may be indicated (see information on MARACs).

2. Continuous risk assessment and recording

Be aware that risk may change over time. It is important that you assess and manage risk on an ongoing basis, and that you consistently document what has and has not been done. Risk assessment is a dynamic process, and you must ensure that you and your colleagues are responding to and documenting risk appropriately: any ongoing risks identified should by documented in your system's alerts, and information that may lead to risk of harm if disclosed to a service user should be documented as third party information.

3. Understand DVA

It is important that you believe and validate any service user who discloses to you that they are experiencing DVA. It is similarly important that you acknowledge disclosures of DVA perpetration, are aware of dynamics in DVA (e.g. coercive controlling behaviour) and, while conveying that this behaviour is unacceptable, reassuring them that there is help available. You should aim to maintain a collaborative approach relationship with service users who have disclosed DVA perpetration – remember that they will have disclosed to you for a reason and that help is available.

4. Tools

1. When assessing risk in cases of DVA, you can use your local Trust risk assessment tool, the Domestic Abuse Stalking and Harassment (DASH) checklist for people experiencing DVA (appendix 3), which is used to refer to MARACs, (though not validated in psychiatric populations), or the Respect risk identification checklist for perpetrators (appendix 4). Remember that perpetrators often act to hide, deny, and minimise their abusive behaviours. Risk assessment tools should not be used purely to generate a risk score, but rather as an aide memoir for areas of risk that should be enquired about. Risk assessment tools should be used to gather contextual information and if cause for concern is identified you should discuss with your team and with your line manager.

Remember to assess:

- Risks to/from family members (particularly those who are informal carers), partners, and ex-partners irrespective of gender or sexuality.
- The pattern of the perpetrator's behaviours·
- Any harms caused to adults or any children involved.
- The context of the abuse including alcohol or substance misuse, mental health status, changes in psychosocial circumstances (e.g. partner has moved out, financial difficulties).

If there is doubt as to who is the person experiencing DVA and who is the perpetrator, you may find it helpful to consult with Respect on how to assess risk, or conduct a DASH risk assessment for both parties (107).

5. Context

A risk assessment is an opportunity to gather contextual information about the context of the DVA – whether the perpetrator is exhibiting a *pattern* of abusive behaviour, the nature of static risk factors e.g. LGBTQ+ relationship, and dynamic factors such as substance use.

6. Sharing information

Once you have all the information, you will be able to discuss the degree of risk with your supervisor, your Multi-Disciplinary Team (MDT), or your local safeguarding lead. Refer to the information sharing section in this resource for more information on next steps. **If it was not possible to conduct a comprehensive risk assessment (e.g. lack of information from other sources), make sure that you document this so that these issues are assessed as soon as possible.**

Information sharing & safeguarding

More than three-quarters of domestic homicide reviews highlight problems relating to information sharing (107). If you are concerned for the safety of **anyone** in relation to DVA, consider whether information should be shared. This should be a collaborative, strengths-based process as far as possible – you should empower your service users to be able to make decisions that are in their (and any children's) best interests. Your role is to support your service user to use services as they see fit, assuming it is safe to do so, and to work together to continuously monitor risks and take measures to increase the safety of the family throughout the process.

When considering sharing information, remember the seven key principles for information sharing (111):

- **The Data Protection Act and General Data Protection Regulation are not barriers to sharing information**, but frameworks to ensure that information is shared appropriately.
- **Be open and honest** about why you believe information should be shared, who it will be shared with, and how it will affect your service user. You should work with your service users to protect their safety and that of any children involved; transparency about how and why you intend to do this is important wherever possible. For example, be clear that the person experiencing DVA is not the risk factor, and that sharing information with social services will not necessarily mean removal of their child.
- **Seek advice** if you are in doubt, without identifying the person if possible.
- **Share with consent where appropriate,** and respect the wishes of service users who do not want their information shared, if possible. *It is not appropriate to seek consent from a perpetrator of DVA if you are considering sharing information/reporting a crime.*
- **Consider safety and wellbeing.** Base your decisions about information sharing on risks to the safety of both the person experiencing DVA and anyone else who may potentially be at risk of abuse from the same perpetrator.
- **Sharing should be necessary, proportionate, relevant, accurate, timely, and secure.** Ensure that only necessary information is shared with the appropriate people, and that the information you share is up-to-date and secure. Think about how you are sharing information and whether it is safe for your service users to access their own mental health records.
- **Document** your actions, your decisions, and the reasons for them. Using a risk assessment tool provides a formal justification for a decision to share information, and you may find this useful in your practice. **If there are any current or ongoing risks you must document this in your system's alerts or equivalent so that other people are aware of these risks; see local policies for details.**

There are several agencies with which you may be required to share information in cases of DVA. These include, but are not limited to:

- **Police –** if a crime has been committed/suspected.
- **Social care –** if a child or vulnerable adult is at risk of harm.
- **Multi-Agency Risk Assessment Conference (MARAC) –** for people experiencing DVA and/or perpetrators.
- **Multi-Agency Public Protection Arrangements (MAPPA)** – for perpetrators who have been convicted of violent and/or sexual offences. This is the process by which the police, probation, and prison services share information with other services to assess and manage risks and protect the public from harm.
- **Multi-Agency Safeguarding Hub (MASH)** – pathway for children who are in need/at risk of harm into social services.

Consent (112)

When thinking about breaching confidentiality, it is important for you to consider whether the service user has capacity to give informed consent. If you are concerned about this you **must**:

- Make sure that you have taken every possible approach to help your service user understand what they are/are not consenting to.
- Consider whether you have made any assumptions about consent based on: age, appearance, or medical condition.
- Encourage the person who lacks capacity to participate in the information sharing process to the fullest extent possible.
- Consider the person's past/present values, beliefs and feelings.
- Take into account the views of friends, appropriate family members, and any agencies the service user is involved with.
- Consider whether the person will have capacity for consent in the future.

For further resources on information-sharing in the context of domestic abuse and the new Data Protection guidelines, please refer to the SafeLives website.

Contacts, referrals, and policies

Contacts

Local safeguarding children leads:

Local safeguarding adults leads:

Your local Multi-Agency Risk Assessment Conference (MARAC) representative is:

Your local Multi-Agency Public Protection Arrangements (MAPPA) representative is:

Local Multi-Agency Safeguarding Hub (MASH) representative:

Nominated team member to share information with the Police:

Referrals

The DVA agency working with your Trust is:

Your local substance use support programmes are:

Local DVA perpetration programmes which accept people with mental health problems are:

Policies

Your local safeguarding policies are available here:

Local DVA training opportunities:

Online DVA training opportunities:

Your Trust has more information about DVA available here:

Other relevant local policies and strategies:

Your Caldicott guardians are:

Making provisions for staff

Your Trust should ensure that there are clear policies to support staff who have experienced DVA. Fostering an open and honest working environment is helpful, so that any staff members who have experienced DVA feel able to disclose and discuss this with their supervisor, or with the team. Experience of DVA can be an asset among staff, due to their increased proximity to and understanding of the experience: some mental health interventions for people who have experienced DVA even require that the facilitator have lived experience of DVA for this reason (66, 113).

If you are a staff member who has experienced DVA and you would like support with this experience, you can access counselling and support using the resources provided in the appendices of this resource, and/or you can alert your line-manager to any concerns or difficulties you may be experiencing.

Due to the high prevalence of DVA, it is also likely that some staff members will be perpetrators of DVA. Respect provides advice and support to perpetrators of DVA, as well as any family members, friends, intimate partners, or frontline workers who work with perpetrators of DVA. Ensure that the Respect website and phone number is advertised around the team base, so that anyone who is concerned about the behaviour of either themselves or others can access more information.

Make sure to consult the appendices of this resource for further information, and to display information about DVA around your team base. You can print out our flowcharts from the next two pages of this resource for this purpose, and you can consult your Trust intranet and the websites of DVA agencies for upcoming DVA training opportunities.

Respect: http://respect.uk.net/, telephone: 0808 802 4040

Guidance on supporting NHS staff with experience of DVA

Further resources for employees who have experienced DVA and their colleagues

Supporting people who have **experienced** DVA in Mental Health Services

1. Team considerations

- ☐ Have you displayed DVA information in the team base?
- ☐ Have you made provisions for staff who have experienced DVA?

2. Enquiry

- ☐ Is the service user alone?
- ☐ Have you chosen an appropriate interpreter if necessary?
- ☐ Have you explained the limits of confidentiality?

Remember to enquire at assessment and follow-up appointments.

Historical DVA?

No → Disclosure?

Yes → Provide therapeutic intervention and use the LIVES response

Disclosure?

No → Historical DVA?

Yes → 3.

3. LIVES response

- **Listen** to your service user with empathy, and without judgement.
- **Inquire** about needs and concerns.
- **Validate** your service user. Show that you understand and believe them, and that they are not to blame.
- **Enhance safety**, discuss making a *safety plan.*
- **Support** your service user by connecting them to information, services, and support.

4. Risk assessment

Conduct a risk assessment using an appropriate tool.

Remember to consider risks to: your service user, their family, and any children involved.

5. Information sharing

- Is there an immediate risk of harm to your service user/any children that warrants safeguarding procedures/ a MARAC referral?
- Has a serious crime been committed and should the Police be informed?
- Is it necessary that information be shared with any other agencies (e.g. GP, social services)?

No/Not sure

Discuss the case with your line manager / Multi-Disciplinary Team and **re-assess risk at follow-up**

Yes

Explain to your service user:
(1) What information you would like to share, with who, and why.
(2) The likely next steps once the information is shared.

What about consent?

If you think that your service user does not have capacity to consent, **assess** whether you have made any assumptions about whether they are able to consent, **explore** all possible approaches to help them understand, and **involve** them in any information sharing processes as far as possible.

6. Contact the appropriate person

Your local safeguarding leads are:

Your local MARAC representative is:

To share information with the Police contact:

To share information with other services:

The DVA agency working with your Trust is:

7.

<u>Document</u> everything that has been asked, the decisions that have been made, and why. Re-assess risk at future appointments.

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Supporting people who have **perpetrated** DVA in Mental Health Services

1. Team considerations

- ☐ Have you displayed DVA information in the team base?

2. Enquiry

- ☐ Is the service user alone?
- ☐ Have you chosen an appropriate interpreter if necessary?
- ☐ Have you explained the limits of confidentiality?

Remember to enquire at assessment and follow-up appointments, and be alert to denial and minimisation.

Disclosure?

No

Yes

3.

4. Risk assessment

Conduct a risk assessment using an appropriate tool.

Remember to consider risks to: your service user's partners, ex-partners, family, and any children involved.

Remember to review case notes to assess for a pattern of behaviour.

Response

- Be clear that violence and abuse is **unacceptable**, and that mental illness is not an excuse for violence.
- Assess context to identify potentially modifiable risk factors.
- Be aware of the limits of your expertise and of potentially appropriate services.

5. Information sharing

- Is there an immediate risk of harm to your service user/any children that warrants safeguarding procedures/ a MARAC referral?
- Has a serious crime been committed and should the Police be informed?
- Is it necessary that information be shared with any other agencies (e.g. GP, social services, MAPPA)?

No/Not sure

- **Discuss** the case with your line manager / Multi-Disciplinary Team
- **Re-assess** risk at follow-up
- **Consider** whether any services/referrals/therapy may be appropriate

Yes

Consider whether it is safe to discuss information sharing with your service user. Explain your actions if appropriate, and document them in third party information/alerts if not.

6. Contact the appropriate person

Your local safeguarding leads are:

Your local MARAC representative is:

Your local MAPPA representative is:

To share information with the Police contact:

Potentially relevant local services are:

7.

Document everything that has been asked, the decisions that have been made, and why. Consider whether your service user may access their notes in future when choosing where to document the enquiry, and re-assess risk at future appointments.

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Appendix 1: Making a safety plan

It is important that you understand the complexity of people's decisions to stay or leave an abusive relationship. Leaving an abusive relationship is not always the safest or easiest option. In leaving, people may lose financial resources, childcare, a home, and will also experience significantly increased risk of violence (10). Conversely, in choosing to stay, they may receive positive enforcement from their friends, their family, or their religion (114).

Do not insist that your service user leave their relationship with the abusive family member/partner. Discuss the purpose and process of making a safety plan and ask whether they would like to go through it – making a plan doesn't mean your service user has to act on it, but it may increase their safety (and the safety of any children involved) in the future.

When formulating a safety plan, use the results of your risk assessment to discuss with your service user:

- **Risk factors presented by the perpetrator** (e.g. substance use, escalation of violence).
- **Protective factors for the person experiencing DVA** (e.g. support network, access to services, level of fear).
- **Strategies that your service user has used successfully in the past to keep themselves safe.**

When formulating a safety plan, use the results of your risk assessment to discuss with your service user:

1. If I do decide to leave, I will know how to get myself and any children out safely

You should help your service user to construct an escape route out of their home. The route should avoid rooms with any weapons like the kitchen/garage, and difficult rooms to get out of like the bathroom. Ideally, your service user would rehearse this escape plan with any children involved at least once. *Consider any risks posed by technology – smart homes can be locked remotely, and so can most cars.*

2. I will have important items ready and easily accessible

Provide suggestions to pack an emergency bag for your service user and their children (e.g. passports, money/an alternative bank account, records of abuse, any medication, driving license, bank details, clothes and toys), and hide it somewhere safe (for example, at a trusted neighbour's house – ideally not with anyone who is friends with the perpetrator).

3. If I do decide to leave, I have considered ways in which my abuser will try to find me

It is important that you discuss with your service user the measures they can take to ensure that they will not experience further abuse. This will include thinking about safe routes in and out of work and any schools, and schools should also be notified of the situation so that they do not allow any children to go home with the perpetrator, and so they do not share the contact details of the non-offending parent. *Consider any risks posed by technology – a perpetrator may be able to access your service user's location via their smart phone, smart watch, or even their car.*

4. I will discuss the possibility of an emergency with any children involved

Suggest your service user teach any children to call 999 in an emergency, and what they would need to say (for example, their full name, address and telephone number). It may also be useful to teach any children a codeword to be used in front of the perpetrator to indicate what they should do and where they should go.

5. If I do decide to leave, I will know where to go

First option: *e.g. relative, friend, DVA service*

Second option: *e.g. relative, friend, DVA service*

6. If I do decide to leave, I will have contact details for necessary services

DVA agencies:

GP:

Social worker:

Children's school:

National DVA helpline: 0800 2000 247

If your service user has left their abusive relationship, but is still being abused:

- Ask them to tell you details of each incident, so that you can document these formally: suggest they keep a diary of all events, and take photos of any damage/injuries where possible.
- If your patient has a restraining order, or an injunction with the power of arrest, then suggest they speak to the Police to ensure this is enforced.
- Suggest they access the Women's Aid website for further resources on legal options.

In an emergency, always call the police on 999.

If your service user would like to conduct a safety plan solely identifying risks posed by technology, please refer to the resources available.

Your local DVA agency is expert at making safety plans so do also discuss with your service user a referral to your local DVA service.

Appendix 2: Questions to ask about experiencing DVA

Physical DVA

- *Has s/he shaken you or grabbed you roughly?*
- *Has s/he shoved you or made you fall?*
- *Has s/he slapped you or smacked you?*
- *Has s/he tried to hit you with something, used an object as a weapon?*
- *Has s/he punched you?*
- *Has s/he tried to choke you or put their hands round your throat?*
- *Has s/he pushed you against the wall or thrown you down?*
- *Has s/he pulled your hair?*
- *Has s/he burnt you or scalded you with something?*
- *Has s/he threatened you with a knife or gun?*
- *Has s/he hurt you while you were pregnant?*

Sexual DVA

- *Do you ever feel you have to have sex even though you don't want to?*
- *Have you felt forced into sex because of what your partner might do?*
- *Has s/he made you have sex or carried on when it was painful?*
- *Has s/he made you have oral or anal sex when you didn't want to?*
- *Has s/he used an object in a sexual way that you didn't like?*
- *Has s/he made you do things or perform sexual acts you didn't like?*
- *Has s/he refused safe sex or to use birth control?*
- *Has s/he made you have sex with another person?*
- *Has s/he talked about sex or done things in a way you didn't like?*

Psychological DVA

- *Does anyone insult you, call you names or swear at you?*
- *Does anyone make it difficult for you to see friends/family or leave the house?*
- *Does anyone act in a jealous way or keep track of where you go?*
- *Does anyone put you down, embarrass you or criticise you?*
- *Does anyone undermine your independence or try to make you feel small?*
- *Does anyone make you feel as if you have to walk on eggshells or as if you do nothing right?*
- *Does anyone order you around like a servant?*
- *Does anyone blame you for things that are not your fault?*
- *Does anyone send you persistent text messages or emails or follow you to places?*

Financial DVA

- *Does anyone control your money?*
- *Does anyone make you ask for money or claim benefits in your name?*
- *Does anyone stop you from earning or having a job?*
- *Has anyone racked up debts in your name?*
- *Does anyone stop you from buying clothes or eating food?*
- *Has anyone ever forced you to take out a loan?*

Appendix 3: The SafeLives Domestic Abuse, Stalking and Harassment risk checklist

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

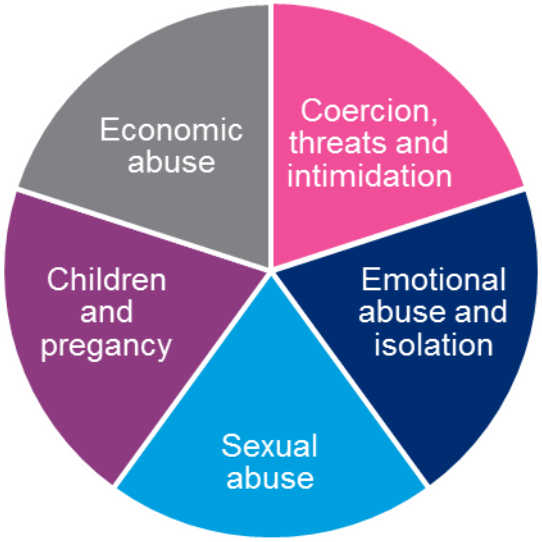
Be sure that you have an awareness of the safety planning measures you can offer, both within your own agency and other agencies. Be familiar with local and national resources to refer the victim to, including specialist services. The following websites and contact details may be useful to you:

- **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.**

What this form is not

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

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

Name of victim: Date: Restricted when complete

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

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

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

For consideration by professional

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

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

Practitioner's notes

This appendix reflects work undertaken by SafeLives in partnership with Laura Richards, Consultant Violence Adviser to ACPO. SafeLives 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. SafeLives 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.

Appendix 4: The Respect risk checklist

Respect have an alternative risk identification checklist (RIC) designed for use with perpetrators of DVA. You may find this checklist useful for informing your assessment of risk of identified DVA perpetrators.

1. RIC version to use directly with perpetrators

Please enter in any relevant information you have gathered from the perpetrator from his assessment, group work, individual sessions or in other ways. You should let him know that you are monitoring the level of risk you think he poses to his victim and others.	Yes	No	Source of info
1. Did the current or most recent incident result in an injury to your partner/ex?			
2. Do you think your partner/ex is frightened of you?			
3. Do you think your violence to your partner is getting worse? Do you think you are likely to use violence again?			
4. Have you ever tried to stop your partner/ex from seeing friends/family/doctor/colleagues or made life difficult if she did? Are you doing that at the moment?			
5. Do you think your partner/ex is having depressed or suicidal thoughts at the moment?			
6. Have you and your partner separated from each other or tried to separate in the last year? HAS your partner ever tried to separate from you and you haven't wanted this? [are there other women with whom you are in conflict about child contact, for example informal or formal foster carers, ex-partner mother of children]			
7. [Do you have children that you do not live with –if so do you and your ex-partner currently disagree or get into arguments about the child contact? *[please note that there are additional questions to help identify other potential or actual victims, which may then prompt the need for another RIC for this pairing of perpetrator-potential victim. See below]*			
8. How often do you text, facebook, phone, contact, follow your partner or ex or turn up at their work or friends etc when they weren't expecting you? Do you do these things a lot and is this getting worse?			
9. Is your current or most recent partner pregnant or had a baby within the last 18 months? [Are there other women you have children with are and any of these currently pregnant or recently had babies – this will alert you to possible widening of range of victims]			
10. Do you think your abuse is getting worse?			
11. Do you think you are being abusive more often than you used to be?			
12. Do you try to control what your partner does in some ways? Are you jealous – for example, do you get upset if they talk to another man or when they go out without you?			
13. Have you ever used an object, such as cutlery, a chair, something else, to hurt or threaten your partner ? Have you ever used a weapon to hurt anyone? Does this include your partner? Have you ever threatened to hurt your partner with a weapon?]			
14. Have you ever threatened to kill your partner or ex, or someone else in your family? If so, do you think you might have made them believe this, at least at the time?			
15. Have you ever put your hands round your partner's throat and hurt them that way? Or held them down in water?			

Please enter in any relevant information you have gathered from the perpetrator from his assessment, group work, individual sessions or in other ways. You should let him know that you are monitoring the level of risk you think he poses to his victim and others.	Yes	No	Source of info
16. Have you touched your partner sexually in ways that you suspect, or knew made her feel uncomfortable or hurt her or someone else? (If someone else, specify who.)			
17. Have you ever involved someone else in threatening your partner/ex or other family member? E.g. friend or relative who is on your side. If so, who is this?			
18. Have you ever hurt anyone beside your partner/ex? Someone like an ex-partner, but also any other family member, friend, colleague, someone you know casually, someone you don't know well, a stranger? If so, please say who (make a list if necessary) : Children Another family member Someone from previous family relationship Ex-partner's new partner; Acquaintance			
19. Have you ever mistreated the family pet or other animal, such as neighbour's dog or something like that?			
20. Do you currently have money worries or have you recently lost your job or worry about losing it? Do you feel under financial pressure? Are you currently in disagreement with your partner/ex over money problems and do these sometimes cause big arguments? [tick yes if he answers yes to any of these – they are all just different ways of asking about risks arising from finance]			
21. Are you using any drugs or have you in the last few years used drugs or alcohol to the point where people tell you it is a problem or you start to worry it is a problem or start spending money you can't afford on drugs or alcohol or pass out from drug or alcohol use? Are you currently depressed or have any other problems with your mental health? Are you taking any medication for depression or other mental illness?			
22. Have you ever thought about or threatened suicide or tried to kill yourself?			
23. Have you ever had a bail order or injunction/order telling you not to contact or hurt your partner/ex or the children? If so, have you ever ignored that order and done something it said you shouldn't do, like calling on them to give the kids presents or something else like that?			
24. Have you ever been in any trouble with the police? Do you have any criminal convictions [you can emphasise that you can ask the police to check their records but would prefer it if they were honest with you in the first place. If they don't reveal past criminal history which you already know about or subsequently find out about, this denial should be taken into account] If so what type of criminal activity			

2. Additional specific questions for perpetrators

Please enter in any relevant information you have gathered from the perpetrator from his assessment, group work, individual sessions etc.	Yes	No	Source
Are you/*is he* in a new relationship since ending the one with the primary victim? Does your/*does his* new partner have children? *[the new partner may not consider herself to be at risk from the perpetrator but you should consider her as potentially at risk and if possible the ISS support worker should make proactive contact with her and carry out a risk assessment. Remember that the presence of step-children increases risk of violence]*			
Is your/*is his* ex-partner in a new relationship? Do you/*does he* feel worried, angry, upset about that? Have you/*has he* threatened your ex-partner's new partner? *[ex-partner starting new relationship may increase risk to her and also to him]*			
Are there other women who are or have been important in your/*his* life, such as a previous partner who is mother of children, sister, mother who may be looking after your/*his* children? *[this may indicate other people who are potentially at risk from this perpetrator. Keep note of this and remain alert in group or individual group work to other information about this perpetrator's behaviour to this woman. You may find out about these women from things he says in groupwork]*			
Have any of these women ever asked you/*him* to get help for your/*his* abusive behaviour? Did you/*he* refuse to seek help? *[if any of them have asked him, particularly if he has refused, may indicate they were also at risk from him]*			
Have you/*has he* ever frightened any of these women? Have you/*has he* ever used violence against any of them or threatened them? *[if he answers yes or indicates this in groupwork etc. to either of these questions this should now confirm the need for an additional RIC about this perpetrator with this specific additional potential victim]*			
Has your/*has his* partner ever used any force against you/*him*? *[if victims are using violence to protect themselves this can heighten the risk of serious violence as the abuser will usually increase levels of violence in return; also victim may then use a weapon, which increases levels of risk to both]*			
Do you keep a knife or gun at home or other sort of weapon, even if it is just for show? DO you have any hobbies which allow you contact with weapons? Does your job put you in contact with weapons? Have you been trained in combat techniques – such as in TA, martial arts etc? *[on its own, having a hobby like these would not necessarily mean a risk of violence; however, coupled with history of violence and other indicators of future risk, it increases the likelihood that any future violence will be dangerous]*			

Need for a new RIC IF any of these questions reveal the existence of other people the perpetrator may be a risk to, such as a carer of his child (foster parent, family member) an ex-partner, particularly if they are the mother of a child of his, a new partner, his ex-partner's new partner, this should prompt you to collect evidence you have about this pairing of perpetrator and potential victim, on a separate RIC. You will usually make proactive contact with any potential or likely victim, as part of the work of the Integrated Support Service for victims/partners/ex-partners. This will provide you with information you can combine with the information from the perpetrator.

3. Third person version to combine information from all sources

Please enter in any relevant information you have gathered from the victim, perpetrator, referring agency, any other relevant agency, policy records etc	Y	N	d.k.	Source
1. Did the current or most recent incident result in an injury to victim? (is perpetrator denying this?)				
2. Is victim frightened of perpetrator? (is perpetrator aware of this and possibly making use of it)				
3. Is violence getting worse or more frequent?				
4. Is victim being kept from seeing friends/family/doctor etc?				
5. Is perpetrator suicidal or depressed?				
6. Is separation imminent? Has victim tried to separate before?				
7. Is there disagreement about child contact?				
8. Is perpetrator constantly checking up on victim (stalking)?				
9. Has victim recently had baby or is she pregnant?				
10. Is abuse getting worse or more controlling in effect?				
11. Is abuse more frequent than it used to be?				
12. Is perpetrator very jealous and controlling about victim's contact with men?				
13. Has perpetrator ever used weapon against this victim or previous one?				
14. Has perpetrator ever threatened to kill victim or previous partner or someone else in family in ways which made them believe it?				
15. Has perpetrator ever attempted to choke, strangle, suffocate or drown victim or someone else?				
16. Does the perpetrator denigrate their partner (ex-partner) sexually or physically abuse them (or others) sexually or coerce them into sexual behaviour that they are not comfortable with.				
17. Are other people involved in hurting or threatening or policing victim?				
18. Has perpetrator hurt others? Has perpetrator abused past partners?				
19. Has perpetrator ever abused animal, particularly family pet?				
20. Is perpetrator in financial crisis or making victim dependent on him for money, or facing unemployment?				
21. Is perpetrator using drugs or alcohol in problematic ways? Is perpetrator currently depressed or have any other problems with mental health or taking any medication for depression or other mental illness?				
22. Has perpetrator ever thought about or threatened suicide or tried to kill yourself?				
23. Has perpetrator ever broken bail order or injunction? Are they denying this?				
24. Does perpetrator have criminal record? Is any of this for domestic violence? Are they denying this?				

Appendix 5: Services for women experiencing DVA

In an emergency always phone 999.

Non-emergency calls can be made direct to 101, available 24 hours a day.

National resources and helplines

Domestic Violence Helpline run by Women's Aid and Refuge
Confidential emotional support, information on housing, welfare, health and legal rights, referral to refuges (places of safety) across the country, referrals to temporary emergency accommodation, help with the police, ***emergency services, and support agencies. Helpline is run by women only.***
Phone: 0808 2000 247
Phone available: 24/7
Email 1: info@womensaid.org.uk
Email 2: helpline@refuge.org.uk
Website 1: https://www.womensaid.org.uk/
Website 2: https://www.refuge.org.uk/

Victim Support: Supportline
A free support and information service for anyone affected by crime in England and Wales.
Phone: 0808 1689 111
Phone available: 24/7
Email support available here: https://www.victimsupport.org.uk/help-and-support/get-help/supportline/email-supportline
Website: https://www.victimsupport.org.uk/help-and-support/get-help/supportline

Rape Crisis helpline
Confidential support and information about services available for people who have experienced sexual violence.
Phone: 0808 8029 999
Phone available: Every day between 12pm-2.30pm and 7pm-9.30pm
Website: https://rapecrisis.org.uk/

Rights of Women: Family law
Free confidential legal advice for women by phone. For advice on DVA, harassment, and divorce. For advice on sexual offences, child contact and residence, trafficking, criminal justice system.
Phone: 0207 2516 577
Phone available: Monday-Thursday (7pm-9pm), Friday (12pm-2pm)
Website: http://rightsofwomen.org.uk/get-advice/family-law/

Rights of Women: Immigration and asylum law
Provides advice to women who have insecure immigration status who have experienced violence and for the professionals that support them.
Phone: 0207 4907 689
Phone available: Monday (10am-4pm), Thursday (10-4pm)
Website: http://rightsofwomen.org.uk/get-advice/immigration-and-asylum-law/

Rights of Women: Criminal law
Provides legal advice to women in England and Wales to assist with the criminal justice process.
Phone: 0207 2518 887
Phone available: Tuesday (11am-1pm)
Website: http://rightsofwomen.org.uk/get-advice/criminal-law/

National resources and helplines continued

Samaritans
Listening and support service for anyone in distress.
Phone: 116 123
Phone available: 24/7
Email: jo@samaritans.org (UK) jo@smaraitans.ie (ROI)
Website: https://www.samaritans.org

AAFDA (Advocacy after Fatal Domestic Abuse)
Support, information and advocacy for families who have suffered fatal (or near-fatal) DVA
Phone: 0776 8386 922
Phone available: Monday-Friday (9am-5pm), Saturday (9am-12pm)
Email: info@aafda.org.uk
Website: www.aafda.org.uk

National Stalking Helpline
A helpline run by Suzy Lamplugh Trust providing information and support to people who have experienced stalking.
Phone: 0808 8020 300
Phone available: Monday, Tuesday, Thursday, Friday (9:30am-4pm), Wednesday (1pm-4pm)
Website: https://www.suzylamplugh.org/Pages/Category/national-stalking-helpline

Forced Marriage Unit
Provides advice and support to anyone in the UK at risk of forced marriage and any British nationals at risk abroad. **Phone:** 0207 0080 151
Email: fmu@fco.gov.uk
Website: https://www.gov.uk/guidance/forced-marriage

Parentline
Provides helpline support on any aspect of parenting/family life.
Phone: 0808 8002 222
Phone available: Monday-Friday (9am-9pm), Saturday-Sunday (10am-3pm)
For families in Scotland: 0800 0282 233, Monday-Friday (9am-9pm)
Website: https://www.familylives.org.uk/how-we-can-help/confidential-helpline/

Regional resources and helplines

Scotland's domestic abuse and forced marriage helpline (Scotland)
Organisation providing support to anyone who has experienced DVA or forced marriage in Scotland. Information available in: Arabic, Chinese, French, English, Polish, Punjabi, Spanish, and Urdu.
Phone: 0800 0271 234
Phone available: 24/7
Email: helpline@sdafmh.org.uk
Website: http://sdafmh.org.uk/

Live Fear Free (Wales)
Support and information service for anyone who has experienced DVA or sexual violence in Wales.
Phone: 0808 8010 800
Text: 0786 0077 333
Email: info@livefearfreehelpline.wales
24-hour live chat service available online: https://livefearfree.gov.wales

Northern Ireland Women's Aid Federation (Northern Ireland)
A service for women who have experienced DVA in Northern Ireland.
Phone: 0808 8021 414
Phone available: 24/7
Email: info@womensaidni.org
Website: http://www.niwaf.org/

Appendix 6: Services for men experiencing DVA

In an emergency always phone 999.

Non-emergency calls can be made direct to 101, available 24 hours a day.

National resources and helplines

The Men's Advice Line
This is a confidential helpline offering support, information and practical advice to men experiencing DVA.
Phone: 0808 8010 327
Phone available: Monday-Friday (9am-5pm)
Email: info@mensadviceline.org.uk
Website: http://www.mensadviceline.org.uk/

Mankind
For men who have experienced DVA and anyone concerned about them.
Monday-Friday: 10am-4pm
Phone: 0182 3334 244
Phone available: Monday-Friday (10am-4pm)
Website: www.mankind.org.uk

Victim Support: Supportline
A free support and information service for anyone affected by crime in England and Wales.
Phone: 0808 1689 111
Phone available: 24/7
Email support available here: https://www.victimsupport.org.uk/help-and-support/get-help/supportline/email-supportline
Website: https://www.victimsupport.org.uk/help-and-support/get-help/supportline

Samaritans
Listening and support service for anyone in distress.
Phone: 116 123
Phone available: 24/7
Email: jo@samaritans.org (UK) jo@smaraitans.ie (ROI)
Website: https://www.samaritans.org

Survivors UK
Information, support and counselling for male survivors of sexual abuse and rape.
Text: 020 3322 1860
Whatsapp: 074 9181 6064
Online chat: https://www.survivorsuk.org/ways-we-can-help/online-helpline/
Chat available: Monday-Friday (10:30am-9pm), Saturday-Sunday (10am-6pm)
Website: https://www.survivorsuk.org/

AAFDA (Advocacy after Fatal Domestic Abuse)
Support, information and advocacy for families who have suffered fatal (or near-fatal) DVA
Phone: 0776 8386 922
Phone available: Monday-Friday (9am-5pm), Saturday (9am-12pm)
Email: info@aafda.org.uk
Website: www.aafda.org.uk

National Stalking Helpline
A helpline run by Suzy Lamplugh Trust providing information and support to people who have experienced stalking.C
Phone: 0808 8020 300
Phone available: Monday, Tuesday, Thursday, Friday (9:30am-4pm), Wednesday (1pm-4pm)
Website: https://www.suzylamplugh.org/Pages/Category/national-stalking-helpline

Regional resources and helplines

Scotland's domestic abuse and forced marriage helpline (Scotland)
Organisation providing support to anyone who has experienced DVA or forced marriage in Scotland. Information available in: Arabic, Chinese, French, English, Polish, Punjabi, Spanish, and Urdu.
Phone: 0800 0271 234
Phone available: 24/7
Email: helpline@sdafmh.org.uk
Website: http://sdafmh.org.uk/

Live Fear Free (Wales)
Support and information service for anyone who has experienced DVA or sexual violence in Wales.
Phone: 0808 8010 800
Text: 0786 0077 333
Email: info@livefearfreehelpline.wales
24-hour live chat service available online: https://livefearfree.gov.wales

Appendix 7: Services for LGBTQ+ people who are experiencing DVA

In an emergency always phone 999.

Non-emergency calls can be made direct to 101, available 24 hours a day.

National LGBT+ Domestic Abuse Helpline
A helpline run by Galop that provides support to LGBT+ people who have experienced DVA in the UK.
Phone: 0800 9995 428
Phone available: Monday, Tuesday, Friday (10am-5pm), Wednesday-Thursday (10am-8pm)
Email: help@galop.org.uk
Website: http://www.galop.org.uk/how-we-can-help/

Safe Lives Spotlight on LGBT+ DVA
An online resource providing resources about LGBT+ people who have experienced DVA
Website: http://www.safelives.org.uk/knowledge-hub/spotlights/spotlight-6-lgbt-people-and-domestic-abuse

Stonewall Housing
Housing support for LGBT people.
Phone: 0207 3595 767
Email: info@stonewallhousing.org
Phone available: Monday-Friday (10am-1pm)
Website: http://www.stonewallhousing.org/

London Lesbian and Gay Switchboard
Support service run by and for LGBT+ people.
Phone: 0207 8377 324
Phone available: Every day (10am-10pm)
Email: chris@switchboard.lgbt
Website: https://switchboard.lgbt/

Appendix 8: Services for BAME people experiencing DVA

In an emergency always phone 999.

Non-emergency calls can be made direct to 101, available 24 hours a day.

Southall Black Sisters
Information on domestic & sexual violence, immigration issues, family law, human rights and mental health; advocacy and counselling for women, particularly Asian women.
Phone: 0208 571 0800
Phone available: Monday, Wednesday, Friday (9:30am-12:30pm & 1:30pm-4:30pm)
General Enquiries: 0208 571 9595
General Enquiries available: Monday-Friday (9am-12:30pm & 1:30pm-5pm)
Website: https://www.southallblacksisters.org.uk/

Iranian & Kurdish Women's Rights Organisation
Provides support and counselling for Middle Eastern, North African and Afghan women and girls living in the UK. Information available in: Arabic, Farsi, Dari, Kurdish, Pashto, Turkish, and English.
Phone: 0207 9206 460
Phone available: Monday-Friday (9:30am-5:30pm)
For urgent enquiries outside of normal hours: 07846 275 246 (Kurdish/Arabic/English), 07846 310 157 (Farsi/Dari/English)
Website: http://ikwro.org.uk/need-help-now/

Muslim Community Helpline
Listening, counselling and information for Muslim men, women, and girls in the UK.
Phone: 0208 9048 193 or 0208 9086 715
Phone available: Monday-Thursday (10am-4pm), Friday (10am-4pm)
Website: http://muslimcommunityhelpline.org.uk/about-us/

Jewish Women's Aid Helpline
Advice and support for Jewish women and children.
Phone: 0808 8010 500
Phone available: Monday-Thursday (9:30am-9:30pm)
Website: http://www.jwa.org.uk/contact-us/

Sharan Project (South Asian Women Help & Support)
Provides information and advice on a variety of issues including health, housing, and legal advice for South Asian women.
Phone: 0844 504 3231 (5p/minute)
Email: info@sharan.org.uk
Website: http://www.sharan.org.uk/

Karna Nirvana,
Support for people at risk of forced marriages and honour-based violence.
Phone: 0800 5999 248
Phone available: Monday-Friday (9am-5pm)
Email: info@karmanirvana.org.uk
Website: http://www.karmanirvana.org.uk/help/

Forced Marriage Unit
Provides advice and support to anyone in the UK at risk of forced marriage and any British nationals at risk abroad.
Phone: 0207 0080 151
Email: fmu@fco.gov.uk
Website: https://www.gov.uk/guidance/forced-marriage

Forward
Provides information on services and one-to-one support for people who have experienced female genital mutilation.
Phone: 0208 9604 000
Phone available: Monday-Friday (9:30am-5:30pm)
Email: forward@forwarduk.org.uk
Website: https://forwarduk.org.uk

Appendix 9: Services for children and young people experiencing DVA

In an emergency always phone 999.

Non-emergency calls can be made direct to 101, available 24 hours a day.

National resources and helplines

Childline (NSPCC)
Confidential counselling service to support any children who are experiencing difficulty.
Phone for children: 0800 1111
Phone for those concerned about children: 0808 8005 000
Phone available: 24/7
Website: https://www.nspcc.org.uk/services-and-resources/childline/

Barnados
First point of contact for young people in distress, providing signposting to useful services.
Phone: 0208 5508 822
Phone available: Monday-Friday (9am-5pm)
Email: supporterrelations@barnados.org.uk
Website: http://www.barnardos.org.uk/what_we_do/contact_us.htm

The Crush
An awareness raising programme about healthy relationships in young people.
Phone: 0800 0149 084
Website: http://www.westmerciawomensaid.org/crush

Disrespect Nobody
A website with information about healthy relationships in young people.
Website: https://www.disrespectnobody.co.uk/

Love don't feel bad
A website about coercive control aimed at 16-25 year olds.
Website: http://www.lovedontfeelbad.co.uk/

Brook
A confidential sexual health and wellbeing service for under 25s.
Website: https://www.brook.org.uk/

The Hideout
A resource for young people and children affected by DVA.
Website: http://thehideout.org.uk/

STIRitAPP
An interactive website with quizzes and research about the prevalence of DVA among young people.
Website: http://stiritapp.eu/

Freedom charity
Organisation providing support for young people at risk of forced marriage and female genital mutilation.
Phone: 0845 6070 133
Text 4freedom to 88802
Website: https://www.freedomcharity.org.uk/

HOPELineUK
For young people (under 35) having suicidal thoughts, and anyone concerned about them.
Phone: 0800 0684 141
Phone available: Monday-Friday (10am-10pm); Saturday, Sunday, and Bank Holidays (2pm-10pm)C**Text**: 0778 6209 697
Email: pat@papyrus-uk.org
Website: https://www.papyrus-uk.org/help-advice/about-hopelineuk

NYAS (National Youth Advocacy Service)
Advice and support for young people with any problem.
Phone: 0808 8081 001
Email: help@nyas.net
Website: https://www.nyas.net/services/helpline/

The Children's Legal Centre
Free legal advice on issues affecting children and young people.
Website: https://www.childrenslegalcentre.com/get-legal-advice/

Family Matters
Counselling support for sexual abuse survivors aged 8 and over.
Phone: 0147 4536 661
Phone available: Monday-Friday (9am-5pm)
Email: admin@familymattersuk.org
Website: www.familymattersuk.org

Action For Children
Advice and information for families and children.
Phone (Watford): 0192 3361 500
Phone (London): 0203 1240 600
Phone (Scotland): 0141 5509 010
Phone (Wales): 0292 0222 127
Phone (Northern Ireland): 0289 0460 500
Phone available: Monday-Friday (9am-5pm)
Email: ask.us@actionforchildren.org.uk
Website: https://www.actionforchildren.org.uk/support-for-parents/support-near-you/

The Mix
General support and information service for people under 25 available to answer any questions without judgement.
Phone: 0808 8084 994
Phone available: Sunday-Friday (11am-11pm)
Email service available here: http://www.themix.org.uk/get-support/speak-to-our-team/email-us
Website: http://www.themix.org.uk/get-support

Appendix 10: Services for perpetrators of DVA

In an emergency always phone 999.

Non-emergency calls can be made direct to 101, available 24 hours a day.

Respect Phoneline
Helpline offering information and advice to people who are abusive towards partners, ex-partners, or family members and want help to stop.
Phone: 0808 802 4040
Phone available: Monday-Friday (9am-5pm)
Website: http://respect.uk.net/information-support/domestic-violence-perpetrators/

NHS resources on suicidal thoughts
A website offering a list of relevant services and helplines for people experiencing suicidal thoughts
Website: https://www.nhs.uk/conditions/suicide/

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