

Revised Protocol

Domestic Abuse: Pregnancy and the Early Years

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1. Introduction

This protocol was developed to assist practitioners delivering maternity and early years services across all agencies in Highland to implement assessments around Domestic Abuse. It complements the good practice guides for NHS staff that have been produced by the Scottish Government each focusing on one form of gender-based violence.

The protocol contains reference to local and national guidance and the Multi Agency Risk Assessment Conferences (MARAC) processes and they should give staff in all settings more confidence in dealing with gender-based violence issues.

A summary of good practice points and flowchart have been added for midwives to enable the main points to be easily accessed and can be downloaded and displayed separately. This is attached as Appendix 1.

This is version 4 and the planning for Fairness process has been applied to these guidelines to ensure that they address equality and diversity considerations.

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2. Violence against Women

The term Gender-Based Violence (or Violence against Women) includes domestic abuse, prostitution, child sexual abuse and many other forms of violence that predominately affect women and are most commonly perpetrated by men. They are grouped together by the term "Violence against Women" to highlight this gender bias, ultimately founded on gender inequality, and to emphasise that women face risk of violence at home, in the community and politically. NHS Highland has adopted the same definition of Gender-Based Violence as the Scottish Government:

Gender-based violence is a function of gender inequality, and an abuse of male power and privilege. It takes the form of actions that result in physical, sexual and psychological harm or suffering to women and children, or affront to their human dignity, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. It is men who predominantly or exclusively carry out such violence, and women who are predominantly the victims of such violence. By referring to violence as "gender-based", this definition highlights the need to understand violence within the context of women's and girl's subordinate status in society. Such violence cannot be understood, therefore, in isolation from the norms and social structure and gender roles within the community, which greatly influence women's vulnerability to violence.

Accordingly, violence against women encompasses but is not limited to the following:

- *Physical, sexual and psychological violence occurring in the family, within the general community, or in institutions, including: domestic abuse; rape; incest and child sexual abuse;*
- *Sexual harassment and intimidation at work and in the public sphere; commercial sexual exploitation, including prostitution, pornography and trafficking;*
- *Dowry related violence; female genital mutilation; forced and child marriages; honour crimes.*

'Safer Lives: Changed Lives' The Scottish Government 2009:7

The detail of this protocol focuses on women who have experienced or are experiencing domestic abuse because it is so prevalent and because there are so many misconceptions about its nature and impact. CEL 41 requires maternity services to put in place routine enquiry of domestic abuse and each woman using maternity services must be asked, when appropriate, whether they are experiencing domestic abuse.

Across Scotland, the use of the Scottish Woman Held Maternity Record (SWHMR) which details a woman's physical and social history is completed throughout the duration of pregnancy has enabled the issue of domestic abuse to be raised at the booking appointment when this allows, through appropriate questioning. The details of discussions are recorded within the Maternity Summary section of the record held at base. During the discussions, women should also be asked about other forms of gender-based violence when suspicions are aroused; however domestic abuse necessarily remains a focus of this protocol.

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The following Scottish Government definition of domestic abuse recognised in Highland is:

Domestic Abuse (as a gender-based abuse) can be perpetrated by partners or ex-partners and can include physical abuse (assault and physical attack involving a range of behaviours), sexual abuse (acts which degrade and humiliate women and are perpetrated against their will, including rape) and mental and emotional abuse (such as threats, verbal abuse, racial abuse, withholding money and other types of controlling behaviour such as isolation from family & friends).

‘National Domestic Abuse Delivery Plan for Children and Young People’. The Scottish Government 2008a:9

This protocol details the requirements and expectations of staff involved in providing maternity and early years care to women and their children, but is not the only document relating to Domestic Abuse available to support staff. There is also the MARAC operating protocol and guidance related to completing the CAADA DASH Risk Identification Checklist when abuse has been disclosed.

3. MARAC

The MARAC (for domestic abuse, stalking and so called honour based violence) consists of a meeting where representatives from a number of organisations in Highland discuss the safety, health and wellbeing of people who are experiencing domestic abuse and together draw up an action plan to help keep them safer.

The aim of MARAC is to:

- Increase the safety , health and wellbeing of victims and their children – if there are any
- Reduce repeat victimisation
- Improve agency co-ordination and accountability
- Improve safety and support for staff involved in high risk domestic abuse cases

It does this by:

- Sharing information about high risk cases
- Jointly constructing, implementing and coordinating a safety plan that provides professional support to all those at risk and which reduces harm
- Reviewing cases and safety plans timeously and appropriately
- Retaining records of activity

Which agencies are involved in the MARAC?

- NHS Highland
- Police Scotland
- The Highland Council
- Women’s Aid
- Victim Support Scotland

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The majority of MARAC referrals come from Police Scotland, however individuals in all agencies are actively encouraged to submit referrals where relevant. This is because it is known that many high risk cases of domestic abuse never come to the attention of the police, with many women experiencing abuse being unwilling to report to the police.

If domestic abuse is disclosed, a risk assessment should be completed. If through completing the risk assessment 14 or more risk factors are identified, or if the professional judges it to be a high risk case, then the case will need to be referred into the MARAC.

If the MARAC referral criteria are not met through this assessment this should not exclude any other safety planning or additional support that may be required. Practitioners should also raise any concerns with their manager and through the Child Protection Advisors (CPAs) or Social work as required. While the risk assessment acts as the gateway to the MARAC, it is also useful for practice and informs how the woman can be supported in the future.

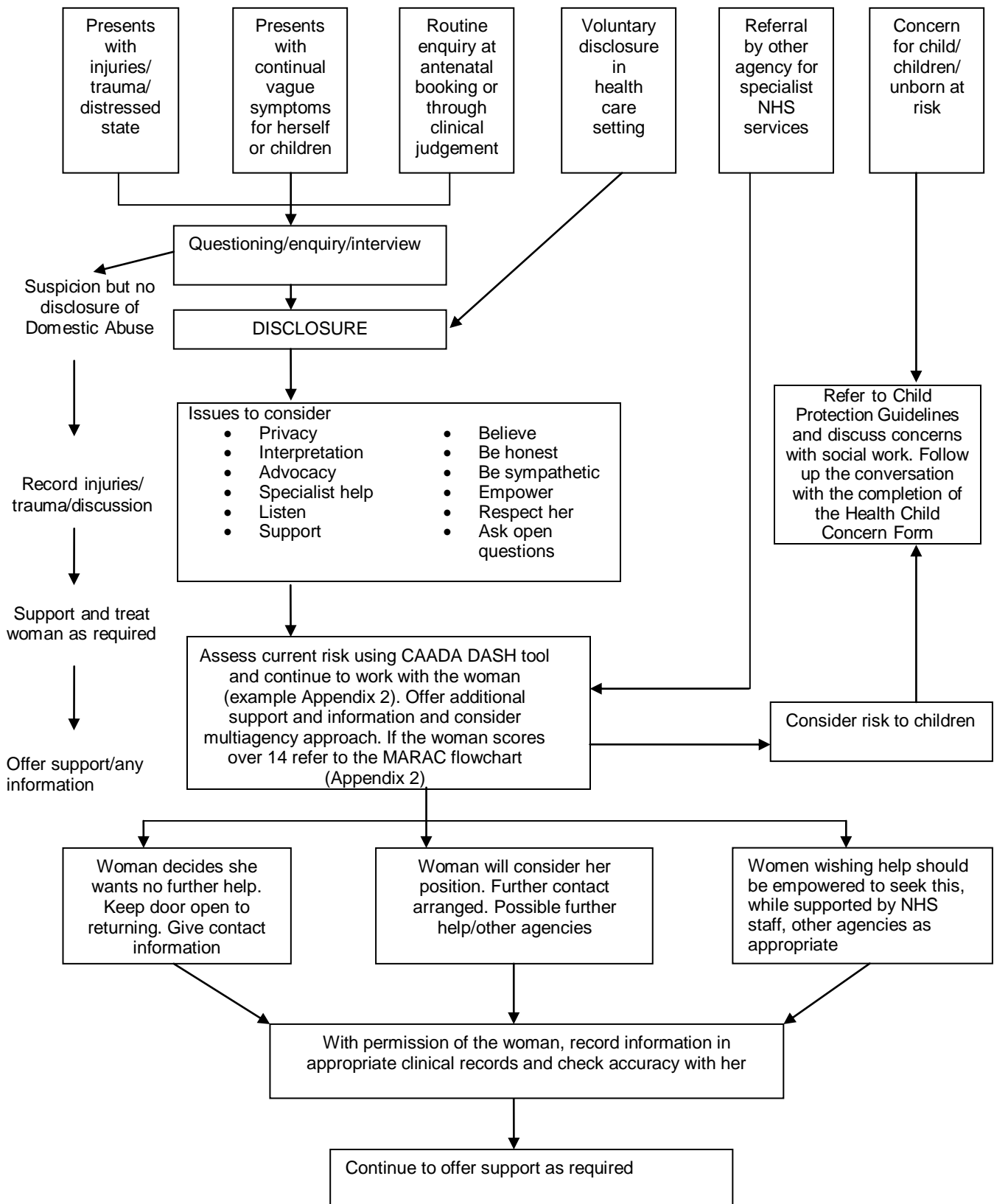
Appendix 2 details the MARAC flowchart for reference.

4. Care Pathway: responding to women who may be experiencing domestic abuse

The following pathway describes the route that services should take when supporting a woman who may be experiencing abuse. The opportunity to discuss domestic abuse may occur in many settings and women themselves may choose to disclose this with a practitioner they feel comfortable with without any prompting. That is why practitioners working with women and families should undertake regular training around domestic abuse which is available to all staff in all sectors.

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Care Pathway: responding to women who may be experiencing domestic abuse



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5. Pregnancy and domestic abuse

Far from pregnancy being a time of peace and safety for all women, a third of domestic abuse begins or escalates during pregnancy. This 'double intentioned violence' is both a form of child abuse and a serious aspect of domestic abuse and is supported by data which shows that abuse during pregnancy is linked to increases in risk of miscarriage and preterm birth (Humphreys et al, 2008).

Pregnancy can also be a very challenging time for women who are experiencing other forms of gender- based violence, or who have in the past. For example if a woman has experienced childhood sexual abuse or female genital mutilation, there may likely be a great deal of anxiety associated with any examinations and the delivery itself. The pregnancy could also be the result of rape or incest.

Pregnancy does not offer any protection for women in abusive relationships and because physical abuse at this time is generally focused on the abdomen, breasts and genitals it can be the cause of repeated miscarriage, antepartum haemorrhage and premature labour. The links between domestic abuse and adverse pregnancy outcomes suggest that maternity care providers should assume a proactive role in identifying its prevalence and identifying the risks for women and children.

Community midwives as the named midwife for the woman will provide the majority of her antenatal and postnatal care working as part of the wider maternity team with GPs and obstetricians. They therefore provide support and advice to women to consider all aspects of their care and in the case of domestic abuse an opportunity to open up discussion.

Significant research has been undertaken about the response of pregnant women to routine questioning in relation to domestic abuse. Evaluations have shown that most pregnant women do not object to being asked about domestic abuse however, the discussion of routine enquiry needs to be supported by training for all staff involved, both to ensure they feel comfortable about asking women questions and to ensure appropriate follow-on intervention should women disclose abuse.

Regular updating, training, supervision and support for practitioners is essential for successful implementation of routine enquiry and the training calendar is available on the For Highlands Children site: <http://www.forhighlandschildren.org/3-icstraining/>

Assessment of risk to a woman and her children (born or unborn) must be a priority for all staff and the requirement to ensure that information is shared appropriately and proportionately with others who may be supporting the pregnant woman or children.

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5.1 Routine enquiry

Routine questioning about domestic abuse which may be physical, sexual, psychological or emotional (including financial) should be included at booking or at another opportune time during the antenatal period. It must only be undertaken when a woman is alone and all women must be given the opportunity to be seen on their own at least once without their partner, friends or family during pregnancy to enable discussion and disclosure of abuse. An inability to ask the question during pregnancy must be discussed with the woman's GP or Health Visitor (HV) who may have additional information about the family.

Any discussion about domestic abuse should be documented in the Maternity Summary Sheet of the SWHMR kept at base. This private time should also occur on any occasions of any interview with a woman whether in person or by telephone where confidentiality must be observed. Suspicions about other forms of gender-based violence should be asked about and recorded in the same way. Key details to include in the record will be:

- Routine enquiry carried out or not – this must be stated and followed up
- If not carried out, why not (no private space, partner present, other pressing clinical priority). This information must be updated at each contact
- If an opportunity for discussion is never available this must also be discussed with the GP and HV to ascertain any concerns
- Whether disclosure took place
- The completed risk assessment and any associated notes
- Form of abuse
- Abuse happening currently or in the past
- Relationship and gender of perpetrator
- Response to disclosure (e.g. multi-agency working and safety plan put in place)

It is important that all staff responsible for discussing domestic abuse have adequate training in asking open-ended questions, talking with women in a sensitive and appropriate way and in managing the ensuing discussion effectively. Inappropriate questioning may further reinforce a woman's feelings of powerlessness and vulnerability.

The provision of a quiet, safe and private environment together with good principles of talking with women experiencing abuse is required. Women should always be asked if they feel comfortable with that place.

As previously stated, if an opportunity for routine enquiry does not occur during pregnancy for whatever reason it is important to raise this with the HV and woman's GP who may be able to offer further details of the family situation.

If the named midwife does not feel comfortable discussing domestic abuse with a woman she must raise this with her manager who must arrange for a colleague to undertake this discussion.

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Keeping detailed records of any concerns for the woman or any form of disclosure is important as this may help the woman with any future legal proceedings. She should be reassured that the details will be recorded in her case notes held at base and never in her hand held record.

Information may need to be shared with other agencies to ensure that women and children are kept safe and women should be asked for their permission for this. If there are any risks of significant harm particularly if a child (born or unborn) is at risk, Child Protection Procedures must be followed and information must be shared as appropriate even if the woman is not in agreement. It may be safer to share information than keep it confidential between services and a woman should be informed of this (NHS Scotland 2009).

Practitioners should recognise that domestic abuse can be present in any culture, any individual or any social group and therefore they must not make a decision not to discuss domestic abuse based on any of these assumptions. If any practitioner feels unable to support a woman around issues of domestic abuse they must seek advice and support from their manager.

5.2 Communication support services

Many women using maternity and early year's services will need differing forms of appropriate communication support. It is essential that professional interpreters are used where needed and it is unacceptable to use family or friends for this purpose which could prevent disclosure or put a mother at risk. Although professional interpreters who are employed by the NHS and Local Authority must maintain a client's confidentiality there may be some concerns by the woman around disclosure, particularly in rural communities where the interpreter may be known to the woman. This may hinder her sharing this information and staff should be aware of this and offer telephone interpretation services. Telephone interpretation may also be more appropriate in the first instance, particularly in short consultations

Many of the written resources used in maternity and early year's services are available in alternative languages and formats and should be available on the NHS Highland web site. Where the required resources are not available in the correct language, the guidance on obtaining translated information should be followed. If a woman does not have English as her preferred language then an interpreter should always be booked or the telephone interpretation service used.

British Sign Language interpreters are also available for any clients requiring support. For full details on how to use any of the communication support services, please see the guidance available on the following intranet links:

NSH

<http://intranet.nhsh.scot.nhs.uk/Staff/EqualityAndDiversity/Pages/Default.aspx>

The Highland Council

http://ntintra1/cx/service_management/cxoffice/policy_unit/equalopps/interpretation-and-translation.htm

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5.3 Supporting staff

It must be remembered that there will be a number of staff who are themselves experiencing abuse. Particular sensitivity must be shown to the difficulties they may face through undertaking this aspect of their work and where alternative arrangements should be made. This may include another member of the team or the manager undertaking routine enquiry.

All practitioners required to undertake routine enquiry must be made aware of counselling and occupational health services supervisory mechanisms and support arrangements available within their organisations for them to access. Managers and team leaders are offered training to enable them to provide a supportive network to all members of their team.

For further advice and guidance on supporting staff who are experiencing gender-based violence, please refer to the NHS Highland gender-based violence PIN policy and the Highland Council Domestic Abuse Employee policy – both available from HR departments or in the HR area of the intranet.

Gender-based violence can present dangers for staff who are home visiting and this is particularly relevant to community midwives, HVs and home based support workers. Staff should familiarise themselves with the lone working policy in their organisation and ensure that there is a mechanism within their team to keep each member of staff safe.

To access the full calendar of training on gender-based violence offered to all NHS Highland and The Highland Council staff: <http://www.forhighlandchildren.org/3-icstraining/>

6. Suspicion of abuse

There is a particular role for staff working in maternity, general practice, health visiting and early year's services to respond to domestic abuse. Although a requirement of routine questioning about domestic abuse during pregnancy is recommended, a woman may present having experienced other forms of gender-based or other violence and so should be asked about these issues if any suspicions are raised.

It is also important to recognise that women may present at other services as a result of gender-based violence. They may attend their local primary care providers or other healthcare premises including Accident and Emergency or sexual health services, with a variety of symptoms which may indicate a need for help (Table 1).

If abuse is suspected, the role and responsibility of the healthcare professional is to provide helpful information about the services and resources available locally, and ensure appropriate agencies such as Women's Aid, housing or benefits support contact details are available to women.

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Table 1 Indicators of domestic abuse relating to pregnancy

- Late booking
- Unplanned or unwanted pregnancy
- General unhappiness about the birth of the baby
- Poor/non-attendance at antenatal clinics
- Frequent visits with vague complaints or symptoms 'of an unknown clinical cause' and without evidence of physiological abnormality
- Recurring admissions usually for reduced fetal movements/abdominal pain/investigations of UTI (although these are common in pregnancy), gynaecological difficulties and chronic pelvic pain
- Repeat presentation with depression, anxiety, self-harm and psychosomatic symptoms
- Minimisation of signs of violence on the body with vague explanations for injuries
- Poor obstetric history with a higher incidence of miscarriage, termination, intrauterine growth restriction, low birth weight, fetal injury, stillbirth, pre-term labour, prematurity, placental abruption
- Recurrent sexually transmitted infections
- Non-compliance with treatment regimens or early self-discharge from hospital
- Constant presence of partner at examinations, who may answer all the questions for her and be unwilling to leave the room
- The woman appears evasive or reluctant to speak or disagree in front of her partner
- The woman may talk excessively when her partner is present and become very quiet when she is alone
- On admission to hospital the woman has very little personal belongings including toiletries, underwear, nightwear and money. Also, very little to spend on the baby
- Evidence or a history of postnatal depression
- Postnatally, early removal of perineal sutures (other than by health professional)

The Confidential Enquiry into Maternal And Child Health 2004. Domestic Abuse: What health workers need to know (good practice guidance) NHS Scotland 2009

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The Highland Practice Model (GIRFEC) principles of early assessment, early support and early intervention should be considered for women who may be experiencing domestic abuse and their additional needs must be assessed. The named midwife should complete an Antenatal Plan – additional support for mother and unborn baby as appropriate when additional needs have been identified.

It should be remembered that vulnerable women who have socially complex lives are less likely to engage with services and stay in regular contact with maternity providers, which may be through choice or because they are discouraged by the abuser from doing so. Therefore staff should remain sensitive to the reasons why women may not be attending for routine care and ensure individualised care plans are in place and individual needs are being met.

6.1 Risk assessment

Risk is dynamic and therefore ongoing risk assessment can help to determine which pathway of care a woman should follow, when there are issues of domestic abuse. The care schedule for Domestic Abuse: Pregnancy and the Early Years offers practitioners a framework to consider how women and children should be supported (see page 14). This schedule details the minimal contact a woman should receive as detailed in the Pathways for Maternity Care (NHS QIS), however professional judgement and other risk assessment tools can guide decision making around additional support requirements.

Risk assessment can help a woman in several ways:

- Identify the level of risk she is facing, particularly if she is minimising her experiences
- Reduce the opportunity for repeat victimisation by the perpetrator
- Help agencies plan for how to manage the risks she faces
- Support the safety planning process
- Consider Pre-Risk Assessment

Before using any risk assessment tool, consider:

- How much time does she have to talk to you?
- “*Is it safe to talk now?*” If not, what is a safe way to contact her and when would be best?
- Is she happy to be involved in the risk assessment process?
- Explain why you are asking these questions – it helps us to identify the risks she may be facing and will support the safety planning process
- Explain that if she is facing high risk you may have to share the information with
- other organisations in order to provide her with the best protection – this gives her an option to refuse the risk assessment process

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Care schedule for domestic abuse: pregnancy and postnatal care

Rationale: Risk is dynamic and changes therefore ongoing, individual risk assessment will indicate if the woman requires additional/ intensive support requiring more contact.

Pre-pregnancy	Discuss general health and wellbeing, mental health, relationships, substance misuse (smoking, alcohol, and drugs). Give advice on healthy diet, folic acid, and screening. Ensure women have access to details of how to contact local community midwife.
First point of contact	Undertake initial risk assessment of medical, obstetric and social needs that may determine the woman's pathway of care. Information given on screening and public health issues and maternal emotional health and wellbeing explored as per Highland Information Trail.
8-12 weeks/ 15-16 weeks/ 22-25 weeks	<ul style="list-style-type: none"> Commence maternal history taking using SWHMR. If alone and a safe environment, undertake routine enquiry of domestic abuse as detailed in the maternity summary sheet. Document any discussions in further information/details of maternity care section. Ensure information is shared as appropriate (GP, Obstetrician, HV, others as necessary). Follow maternity care pathway and undertake risk assessment of mother's need to support herself and her unborn baby, ensuring this is detailed in her records. If opportunity to discuss domestic abuse is not favourable, document and ensure this is undertaken at next appointment. If no opportunity has arisen ensure this is communicated to GP and HV. Ensure women know the door is always open to discuss domestic abuse and continue ongoing risk assessment. Undertake assessment using the Highland Practice model (GIRFEC) for the mother and unborn baby and complete an Antenatal Plan: additional support for mother and unborn baby if required. If immediate concerns of safety are raised then communicate with Child Protection Advisor (CPA), social work and complete a child concern form. If domestic abuse is disclosed ensure the woman is given details of local support agencies and undertake risk assessment using CAADH DASH form. Consider the risks to the woman, the unborn baby and any other children in the family and discuss with the CPA for your area. Discuss the need for appropriate information sharing with the woman and seek formal agreement for multiagency working and liaison as required. Consider the MW to HV handover protocol that states that women with additional support needs should have agreed joint plans in place. Share information with GP, HV, CPA and Obstetrician. If domestic abuse is disclosed care must be managed by the wider maternity team and others such as social work included in the plan.

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28 weeks/ 31-32 weeks	<ul style="list-style-type: none"> • Pre-birth planning meeting to re-assess social circumstances/risk - complete or update antenatal plan/child's plan/child protection child's plan as required. • Preparation for parenthood, labour and delivery. • Discuss birth plan. • Close liaison should continue with HV as per handover protocol and GP.
34-36 weeks 37-38 weeks 39-40 weeks	<ul style="list-style-type: none"> • Midwife to undertake additional appointments as required including home assessment for women with additional needs. • HV to undertake antenatal contact as per Hall 4 Guidance if additional needs identified by the midwife. • Remember - Consider lone working policy if undertaking home visits where violence is an issue. Do not put yourself at risk and always seek advice.
Delivery/ postnatal	<ul style="list-style-type: none"> • Continue to offer support to the woman and baby and advice about local support agencies for those experiencing domestic abuse. • Accurate documentation and record keeping are essential even if the woman does not wish to proceed with criminal charges at this time – it may help her later. • Discharge arrangements from hospital/midwifery unit should be completed - copies to CMW/GP/HV. • On handover from MW to HV, complete SWHMR discharge pages and share with HV. Ensure any details around domestic abuse are communicated and documented and the GP is included in arrangements. • Continue multidisciplinary support as discharge plan. • Ensure handover protocol is followed – 'Communication and Handover of Health and Social Information between Midwife and Health Visitor'. • Assessment and support by the HV will continue as per Hall4 programme. • The GP remains an integral part of the support network for the woman. • Remember – the woman and her children may have a different GP to her partner – effective communication and information sharing must occur to ensure they are protected – everyone has a responsibility to protect children and practitioners must seek advice from their manager, CPA and social work in such cases if they are unsure.

Remember: A risk assessment is not a definitive measure of risk; it serves as a guide and should help you identify areas you may wish to question individuals about further. It should provide you with a structure to inform your judgements. Most often, the best assessment of risk comes from the woman herself so it is vital that she is a partner in the risk assessment process. Risk assessment needs to include risk from an unborn baby or child perspective and their wellbeing must be considered as well as the mother's.

Following any form of risk assessment the woman you have conducted the risk assessment with must be made aware of the results. Telling someone that they are at high risk of serious harm or homicide may be frightening or overwhelming to hear. It is important that you state concerns using the answers given to you and your professional judgement.

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The Highland Community Planning Partnership multiagency guidance on Violence Against Women details more information about risk assessment and recommends the CAADA DASH risk identification checklist should be used by practitioners in cases of disclosure of domestic abuse and the woman referred the into MARAC if needed. A copy of the risk assessment outlined in that guidance is attached as Appendix 3 for reference. The guidance is available at:

http://highlandlife.net/highland_life/community/equality_and_diversity/tackling_violence_against_women_in_the_highlands

7. Disclosure of abuse

The National Pathways for Maternity Care support the need for women to be provided with evidence based information and be involved in decisions made about their care (NHS QIS 2009). Continuous risk assessment throughout pregnancy is essential to ensure that women receive appropriate care to meet their needs which may involve the wider maternity team or multiagency partners.

When a woman makes a disclosure of domestic abuse or any other form of gender- based violence, she requires support, information and risk assessment delivered in a non-judgmental and supportive way. She must be given advice as to where she can get help and be provided with continuing support whatever her decisions may be (see links in Appendix 4). Assessment of risk to her, her baby (born or unborn) or any other children should be considered.

Midwives and other healthcare staff need to reassure women that they will act in their best interests but also make clear the limits of confidentiality if they have concerns about an unborn baby or any child in the family where they may need to share those concerns to protect a child.

7.1 Assessment

The agreed CAADA DASH Risk Identification Checklist should be used and referrals made as appropriate according to score:

- If the woman scores 14 or more ticks using the CAADA DASH tool, then you must refer the case into the local MARAC. You should tell the woman you are going to do this, unless it is not safe to do so. You can also refer the woman into MARAC if she scores less than 14 ticks, but in your professional judgment she is at significant high risk and may be minimizing.
- If the score is between 12 and 14 an assertive referral should be made to the local Women's Aid organisation, with the woman's consent. If the score is below 12, then information and advice should be provided. A leaflet for supporting women who score below MARAC criteria is currently being developed by the VAW strategic group and will soon be available for staff.

Women with known domestic abuse should be regarded as 'high risk' and should have their and needs addressed appropriately. An integrated approach with multidisciplinary and multiagency care should provide access to a range of services that may be required. Women should have their maternity care managed by an obstetrician, with a multiagency plan in place that includes social work taking the Lead Professional role on social aspects of care, where there is risk of significant harm or Child Protection concerns.

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7.2 Multiagency planning

The multiagency plan should be agreed with all partners who will be providing care to the woman and her children. Child Protection Policy Guidelines should be followed and practitioners should seek advice from the CPA for their area or their manager if they have any concerns.

The named midwife will continue to provide most of the woman's antenatal and postnatal care but will work closely with the wider team to ensure all assessment of risks and needs are considered. This may include admission.

Health professionals may receive information about incidents of domestic abuse from the police and not the woman herself, as they may have been called to attend. The Highland Practice Model (*GIRFEC*) supports the role of the named midwife as the point of contact in pregnancy for all agencies. This means that the police are now communicating this information to the named midwife as part of the police investigation, supported by the police child concern form.

When the police respond to a domestic abuse situation and the woman is assessed as 'high risk' they will offer the woman contact with a Domestic Abuse Liaison Officer (DALO). These officers are specially trained to provide support and advice to women and will explain the police process. They are also able to provide details of other services the woman may wish to access in order to get support.

7.3 Ongoing care

Healthcare providers should remember that their role should be one of enquiry and information giving and may not extend to in-depth support that other agencies can offer. However they still have an important role to provide additional support to women. Their role is fundamental to the process of disclosure through appropriate questioning in a safe environment and ensuring that risk assessment is undertaken. Women should be reassured that disclosure of domestic abuse will not be communicated to the perpetrator.

For families where there is known domestic abuse, it is important for professionals involved in supporting the mother to consider appropriate child care arrangements for any other children when she attends antenatal appointments or when she is in hospital and away from the family home. These discussions must take place with the woman as soon as possible or this could impact as a considerable stress factor for her. The details must be recorded in her plan of care so that it is clear that arrangements are in place and the children are kept safe.

It is important to remember that leaving an abuser is most often not a single act but a process. Ending a relationship does not always mean that the violence ends. Stalking behaviour and assault may still occur. Many women face multiple obstacles in escaping abuse, often the same obstacles that make disclosure difficult. The one thing that a woman may have control over is in whom she confides, and she may take many months to disclose, if at all. A woman may also withdraw at a later date, what she has said during disclosure. This should not discourage or dissuade staff from continuing to offer information and support.

There is also a need to provide a coherent out-of-hours service which can respond appropriately to women experiencing abuse. Out-of-hours services are provided by a variety of organisations, therefore it is essential that multiagency working is in place in localities that effectively ensures information is shared appropriately and proportionally with those providing care and support. For details of available training: <http://www.forhighlandchildren.org/3-icstraining/2-violenceagainstwomen.htm>

Table 2 details some additional points to consider following disclosure.

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Table 2 After disclosure

Respect & Validation

It may have taken a woman months or years to reach the point of disclosing her abuse, so how she is treated is likely to have an impact on whether she is able to disclose more and find help. Fear of being blamed or not being believed can stop her talking about her experiences.

You must ask yourself if your intervention will leave the woman and any dependents she has in greater safety or greater danger. This requires the following good practice:

- Ensuring the safety of the woman (and any dependents) is of paramount consideration. A woman is deemed to be 'safe' once she feels that she is.
- Respond empathically – women who have experienced gender-based violence are often trying to find a solution to a dangerous and frightening situation. How you respond can crucially affect whether she can escape the abuse and make appropriate choices about her future. Acknowledge her courage in telling you about it. Asking for help is never easy, particularly if you are feeling vulnerable and powerless, so your response is especially important on each and every occasion she makes contact, whether it is by phone or in person.
- Believe her. Domestic abuse, especially, can lead to death. Recognise she is the best person to assess the danger.
- Remember that physical abuse is only one part of the problem so you should never ask a woman to prove the physical violence has taken place.
- Breaking the links with an abuser can be a long process. Be careful not to seem to pass judgment or blame the woman for her situation. Don't ask her to justify her actions, for example "*Why on earth did you go and see him?*" Accept that she will have had her reasons for making any such decision.
- Seek to empower the woman to make informed decisions and choices; give her time to consider the options that you present to her and try not to put pressure on her to do anything that she isn't ready to do.
- Respect confidentiality and privacy and recognise the real dangers that may be created if this is breached. Experience shows that perpetrators who are trying to track down women are often very persistent and vindictive. Let her know in advance the limits to the level of confidentiality you can offer her.
- Be prepared to deal with disclosure over several meetings and make sure she knows she can approach NHS staff again in the future

Highland Community Planning Partnership Violence Against Women Multi Agency Training: Asking the Questions 2010.

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7.4 Safety planning

Remember that a woman is often the best judge of how to minimise risk to herself and/or her children, and she may believe that at that particular point in time staying is a safer option than leaving. It will be useful to safety plan with a woman to ensure that you share an understanding of the risks involved. The Highland Violence Against Women Multiagency Guidance offers further details on this.

Domestic abuse has a very high repeat victimisation rate. After a woman has disclosed abuse to you, it is vital to ask her how safe she feels she is now. Some motivational interview style questions that you could ask would include:

- What do you need to be safe?
- How do you feel about the situation, are things getting any worse?
- Do you want/need to take any action today?
- What have you done in the past to get safe and how helpful was this?
- Do you have anyone who can help?
- When you are safe what will you see and hear?
- How will you know you are safe?
- Is there anything else that you need to be safe?
- What is your next step?'

You should also complete a risk assessment with the woman if the abuse is current and her risk is immediate.

It is important to establish what a woman wants from you and the service you provide. It may be that her expectations cannot be met and you must be clear about this to her. This does not mean, however, that you do not offer her any assistance. You can always help her get in touch with other organisations at the very least.

Table 3 offers practitioners advice that can be given women to help them stay a bit safer, while they are living with abuse. Other useful contacts for local support can be found in Appendix 4.

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Table 3 - Protecting yourself now

- Tell someone you trust about the abuse.
- Keep important and emergency numbers with you e.g. your local Women's Aid Group, the police.
- If you have children, teach them to call 999 in an emergency, and what they would need to say; e.g. their full name, address and telephone number. Teach them it is important to keep safe when there is abuse. Tell them not to get between you and the abuser if there is violence. Plan a code word to signal they should get help or leave.
- Rehearse an escape plan, so in an emergency you and the children can get away safely.
- You might also want to talk to your children about ways they can keep themselves safe, e.g. by having a safe place to hide like a cupboard under the stairs, or in a shed that can be bolted on the inside – it could be useful to identify a neighbour or relative that they can run to.
- Pack an emergency bag for yourself your family, and hide it somewhere safe like at a neighbour's or friend's house. Things to keep in an emergency bag include important documents like birth certificates, passports, bank cards, any papers relating to the abuse (police reports and court orders) and personal items like family photos, jewellery, small items of sentimental value, clothing and toiletries for you and your children and your children's favourite small toys.
- If you can, try to keep a small amount of money on you at all times.
- If you can keep a record of abusive incidents, it may be helpful in the future during legal action or when seeking support from services – only do this if you can keep it in a safe place, e.g. at a friend's house.

In an emergency

- Know where the nearest phone is and if you have a mobile phone, try to keep it with you.
- If you think that your abuser is about to attack you, try and move to a place where there is a way out and access to a telephone. Try and avoid areas like the kitchen or garage where there are likely to be knives or other weapons.

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8. Keeping children safe

Assessment of risk and need is fundamental in planning care and it is important that all staff working with parents and carers consider that children (born or unborn) may be in need of protection. There are many agencies that may have contact with pregnant women and their children and this does not just include maternity and early year's services. Workers in adult services including substance misuse, smoking cessation, mental health, Third sector and others may be the first point of contact for pregnant women. Where there are any concerns or risks to the unborn child or any other children in the household these risks must be acted on appropriately.

All women should expect that the information that they share with healthcare workers will be treated as confidential. However, it is important when discussing abusive situations with women that they are made aware at the beginning of the consultation that any information they wish to divulge, but which may highlight that a child is at risk, will be shared in a controlled and confidential manner with other health professionals or agencies.

It is everyone's job to promote the safety and wellbeing of children. Every agency, manager and practitioner that works with children or their families, including services that work primarily with adults, must take responsibility for their contribution to the safety and wellbeing of children, and responding to any request for help.

Highland Child Protection Committee: Interagency Guidelines to protect children and young people in Highland. October 2013:5

Domestic abuse can have a damaging effect on the health and development of children which can begin even before birth through the increased emotional stress of the mother and risk of physical injury to the mother and baby in utero. It is vital that healthcare workers remain proactive and vigilant to issues of domestic abuse to ensure women and children in their care have their needs met effectively and safely.

Women should be offered information and advice about the need for all agencies to work together to protect them and their children. Sharing information should be undertaken in a proportionate way and in consultation with the woman to allay any fears that she may have whilst ensuring she is made fully aware of the situation when concerns are raised and must be escalated.

300,000 British children have themselves suffered domestic violence while trying to stop arguments between adults.

NSPCC, January 2009

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The impact on children of any violence against women can pose a risk to them both in the short and long term. The mental health and wellbeing of children living with domestic abuse can trigger not only emotional and physical disturbance but also a disruption to their lifestyle.

This may include:

- Feelings of anger, guilt, isolation, fear
- Anxiety, self-harm, low self-esteem, depression, withdrawal
- Asthma, eczema, bed-wetting, tiredness, injury
- Homelessness, poverty, social exclusion
- disruption to schooling, behaviour issues
- Loss of family, friends, pets, possessions

Children may exhibit other symptoms of failure to thrive and anxiety and health professionals should recognise the importance of secure attachments. Any interruption to a child's sense of wellbeing can affect their psychological, social and emotional growth both in the short and long term. This includes their life-long sense of security and ability to maintain relationships (Buchanan 2008). The infant mental health best practice guidelines: pre-birth to 3 years can offer staff further advice and information where there are concerns around infant mental health, and are available on the For Highlands Children site:

http://www.forhighlandschildren.org/4-icspublication/index_56_3923857013.pdf

Disclosure of domestic abuse must give rise to concerns for any children that live within the household or children who may visit the household and this should include assessment of risk for an unborn baby. HVs are in a prime position to assess the needs of children and concerns for any children must be based on an individual assessment which will need to include:

- Seeing the child/children
- Assessing their development stage and understanding the family context in which they live
- Awareness and understanding of those who care for the child/children about the effects of domestic abuse
- Awareness and understanding of the needs of families from diverse ethnic and cultural backgrounds

Domestic Abuse should significantly increase suspicions that any children in the family may be at risk therefore when considering children's safety, including that of unborn babies, healthcare workers should contact their local CPA who can offer advice, guidance and support to staff including advice on the need for social work or the police to be included. This should be recorded in the completion of the Child Concern Form.

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Assessing risk to children should be elevated when there has been previous history of abuse or neglect or if there are additional stresses in the family such as substance misuse, chaotic lifestyle, homelessness or mental health issues (NHS Scotland 2009). It is also important to consider the additional needs of children affected by disability or with communication difficulties.

A recent guide (5) 'The impact on children' has been added to the suite of guidance developed by the Highland VAW strategic group.

All professionals should have knowledge and understanding of their local Child Protection Policy Guidelines and Managers should ensure that all staff undertake regular Child Protection training at least every three years. Staff who work more closely with women and families may require a higher level of training which addresses more in depth issues. to all. <http://forhighlandchildren.org/3-icstraining/>

<http://www.forhighlandchildren.org/3-icstraining/2-violenceagainstwomen.htm>

Gender-based violence traverses all social groups, ethnicities and ages it is therefore important that all staff who provide care to children and/or their families access the wide programme of gender-based violence training which is available to all NHS Highland and Highland Council staff.

In assessing risk, safety issues will be prominent. The impact of risk on other aspects of children's development must be taken into account, as part of the Highland practice model for risk assessment and management.

Highland Child Protection Committee: Interagency Guidelines to protect children and young people in Highland. October 2013:14

8.1 Highland Practice Model (GIRFEC)

All practitioners in Highland should follow the Highland Practice Model (GIRFEC) which promotes a coordinated response to the woman and her family (Highland Council 2013). This also includes practitioners who work in adult services who should consider the needs not only of the mother or partner that they may be working with, but also the risks to the unborn baby and any other children he/she may have living in the family home or that he/she has contact with.

When considering if additional support may be required for the mother the 5 adapted GIRFEC questions should be asked:

- What is getting in the way of this woman or baby's wellbeing?
- Do I have all the information I need to help this woman or baby?
- What can I do now to help this woman or baby?

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- What can my service do to help?
- What help, if any, may be needed from others?

If there are any concerns raised by any service that has contact with a woman that has the potential to affect the wellbeing of her or her baby, these should be shared with the named person (named midwife in pregnancy, named HV for the child). Further guidance about GIRFEC and maternity services can be found in the 'Guidelines for maternity Services Getting it Right for Every Mother and Child' (NHS 2015)
http://www.forhighlandchildren.org/4-icspublication/index_135_935625167.pdf

9. Follow-up

The links between adverse pregnancy outcome, vulnerability and social exclusion are well evidenced and vulnerable women with complex lives are far less likely to seek antenatal care in pregnancy or attend appointments. Maternity services should ensure that they are accessible and welcoming to all women including those who find it difficult to access care.

Domestic abuse should raise immediate concerns that women and children (born or unborn) maybe at risk of significant harm. Health staff should undertake risk assessment using the Highland Practice Model to raise their concern. This assessment should be shared as appropriate and child protection procedures should be followed when an immediate response is required. CPAs can support staff with decision making.

In relation to domestic abuse it is important to remember that if a pregnant woman is being abused, this may not stop once the baby is born, in fact it may escalate. The greatest risk of moderate to severe injury is after the baby is born. Similarly if an infant is removed for the child's safety, the distress that this may cause can make a woman particularly vulnerable to depression, suicide and substance misuse (CEMACH 2007). Vigilance and support for the mother should always be ensured.

90% of children in violent homes will either be in the same or next room when violence occurs. Between 40-60% of children who live with domestic abuse are likely to have been abused by the same perpetrator.

Responding to Domestic Abuse: Guidelines for Healthcare Workers, Scottish Executive 2003

Close liaison and effective handover with the family's HV and GP must be maintained throughout pregnancy and the postnatal period to ensure appropriate support, provision of accurate information and sources of further help.

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The revised procedure: The Communication and Handover of Health and Social Information between Midwife and Health Visitor (NHS Highland 2014) details the roles and responsibilities required for effective practice. This should be available to staff working in clinical areas.

http://www.forhighlandchildren.org/4-icspublication/index_126_3619633817.pdf

Plans for follow-up care such as additional appointments or appointments in alternative settings should be arranged in a place where the woman feels comfortable. Allowing time for women is important. Continuing care from the HV should ensure ongoing assessment of risks and needs, with additional support provided as required and a Childs Plan should reflect the assessed needs of children. The ultimate result of domestic abuse may be maternal death and the consequences of this will result in a child who faces a far poorer start in life. Children who are already living in complex and excluded families are at greatest risk of health inequalities and social exclusion (Scottish Government 2008d).

Staff should also consider the possibility that a woman who is subject to domestic abuse may meet the definition of an adult in need of support and protection and therefore be subject to the provisions and protections available under the legislation as described in the Adult Support and Protection (Scotland) Act 2007.

The Act defines adults at risk as individuals, aged 16 years and over who:

- Are unable to safeguard themselves, their property, rights or other interests
- Are at risk of harm and
- Because they are affected by disability, mental disorder, illness or physical or mental infirmity are more vulnerable to being harmed than others who are not so affected

This should be considered after disclosure of domestic abuse and the procedures laid out locally to comply with the Act for each council area must be followed:

Highland

<http://www.fhcommunities.org/userfiles/file/Adult%20Support%20and%20Protection/Inter%20Agency%20ASP%20Procedures.pdf>

Argyll and Bute

<http://www.argyll-bute.gov.uk/sites/default/files/social-care-and-health/Adult%20Protection%20Procedures.pdf>

In conclusion, no single agency is solely responsible for protecting vulnerable children and adults it is the responsibility of all. The correlation between domestic abuse and child abuse must always be considered, together with childhood sexual abuse as a form of gender-based violence itself.

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Appendix 1

Asking the Domestic Abuse Question Good Practice Points for Midwives: (Revised Protocol Domestic Abuse: Pregnancy and the Early Years)

Introduction

Midwives should initiate a discussion about domestic abuse at the time of booking with **all** women providing she is alone. If the woman is never alone at clinic visits the midwife must discuss this with the GP or Health Visitor to determine if there are any concerns. Sharing information and record keeping is essential to keep track of whether discussion has taken place.

Training is available for staff through the Violence Against Women Partnership and it is recommended that they attend this regularly. It is mandatory that midwives attend the following courses:

- Understanding Violence Against Women
- Asking the Questions about Violence Against Women
- Multi-Agency Risk Assessment Conferences (MARAC)

Before Discussing Domestic Abuse

Prior to routine enquiry of domestic abuse, midwives must:

- Ensure the woman is alone
- Emphasise the role of maternity services in both the woman and the unborn child's health
- Explain that domestic abuse is primarily emotional, but can include physical and/or sexual violence and financial abuse
- Explain that pregnancy is a high risk time for domestic abuse to begin, or to escalate
- Tell her that all women are asked about domestic abuse by maternity services
- Ask about her relationship with her partner, in general terms first

It is not always helpful to use the term "domestic abuse" as many women will not recognise their experiences as abusive.

Asking about Domestic Abuse

The following questions may be helpful to determine if someone is experiencing domestic abuse:

- Does your (ex) partner make you feel frightened?
- Does your (ex) partner stop you from seeing your friends and your family?
- Do you feel that your (ex) partner controls aspects of your life?
- Does your (ex) partner ever hurt, threaten or humiliate you?

A 'yes' answer to any of these questions may indicate that a woman is experiencing domestic abuse. You can then say to a woman that it sounds like she "is experiencing domestic abuse".

Policies on Domestic Abuse

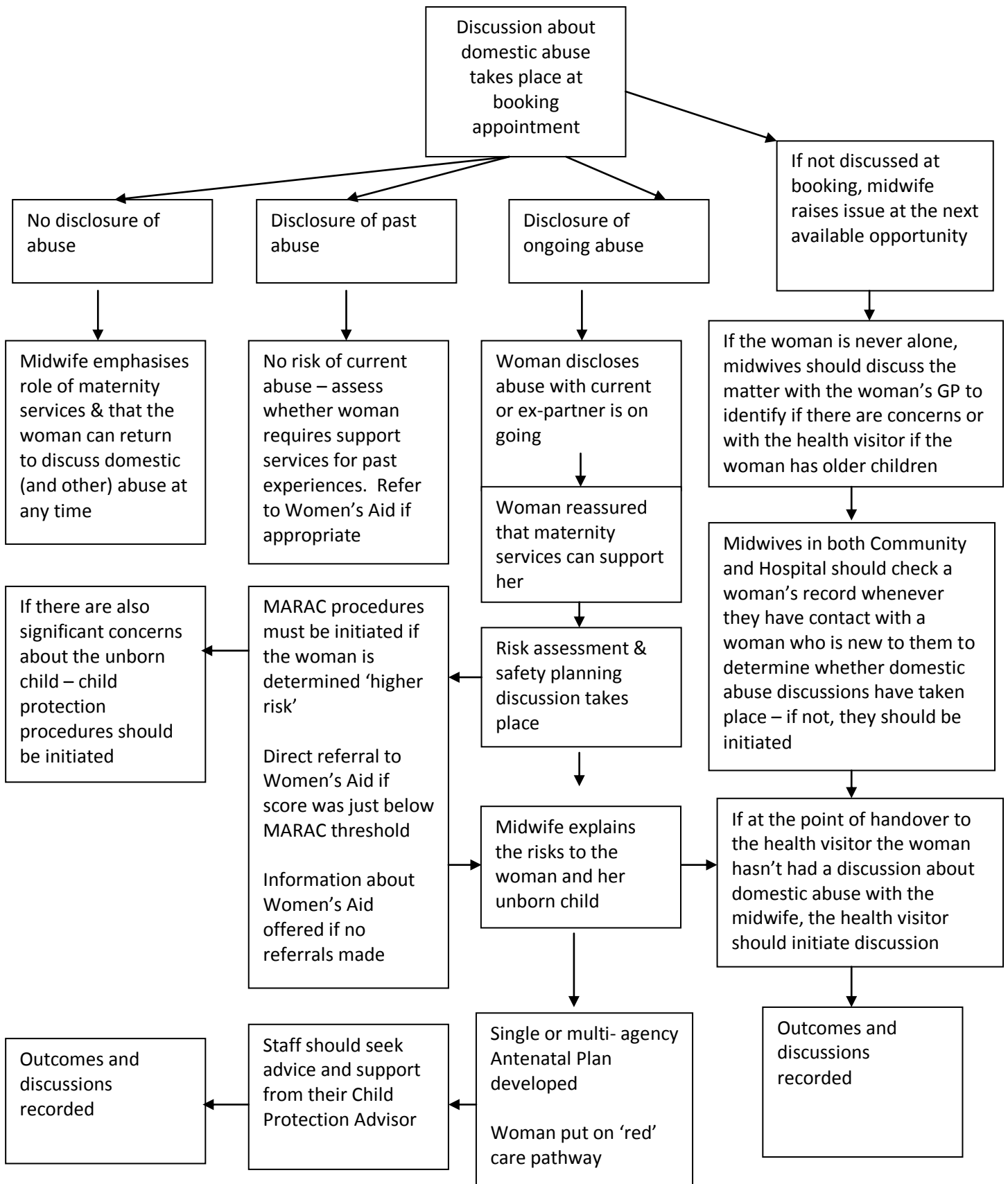
All midwives should be aware of the following policies and guidance in relation to domestic abuse and Violence against Women:

- Protocol Domestic Abuse: Pregnancy and the Early Years
- Multi-Agency Violence Against Women Guidance
- Support Services for Women

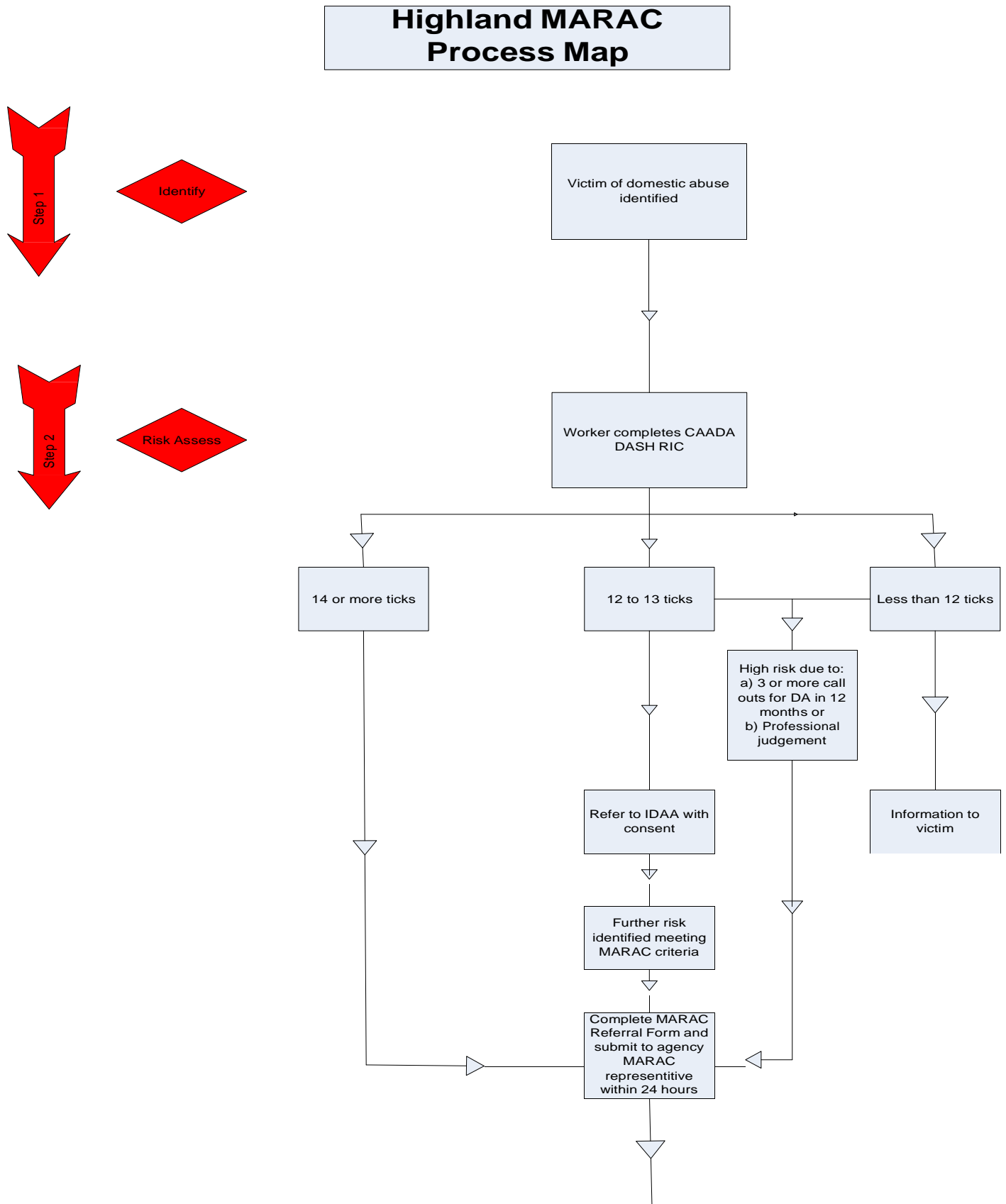
All are available on the NHS Highland intranet in the Gender Based Violence section.

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Summary Flowchart for midwives Protocol on Domestic Abuse: Pregnancy & the Early Years

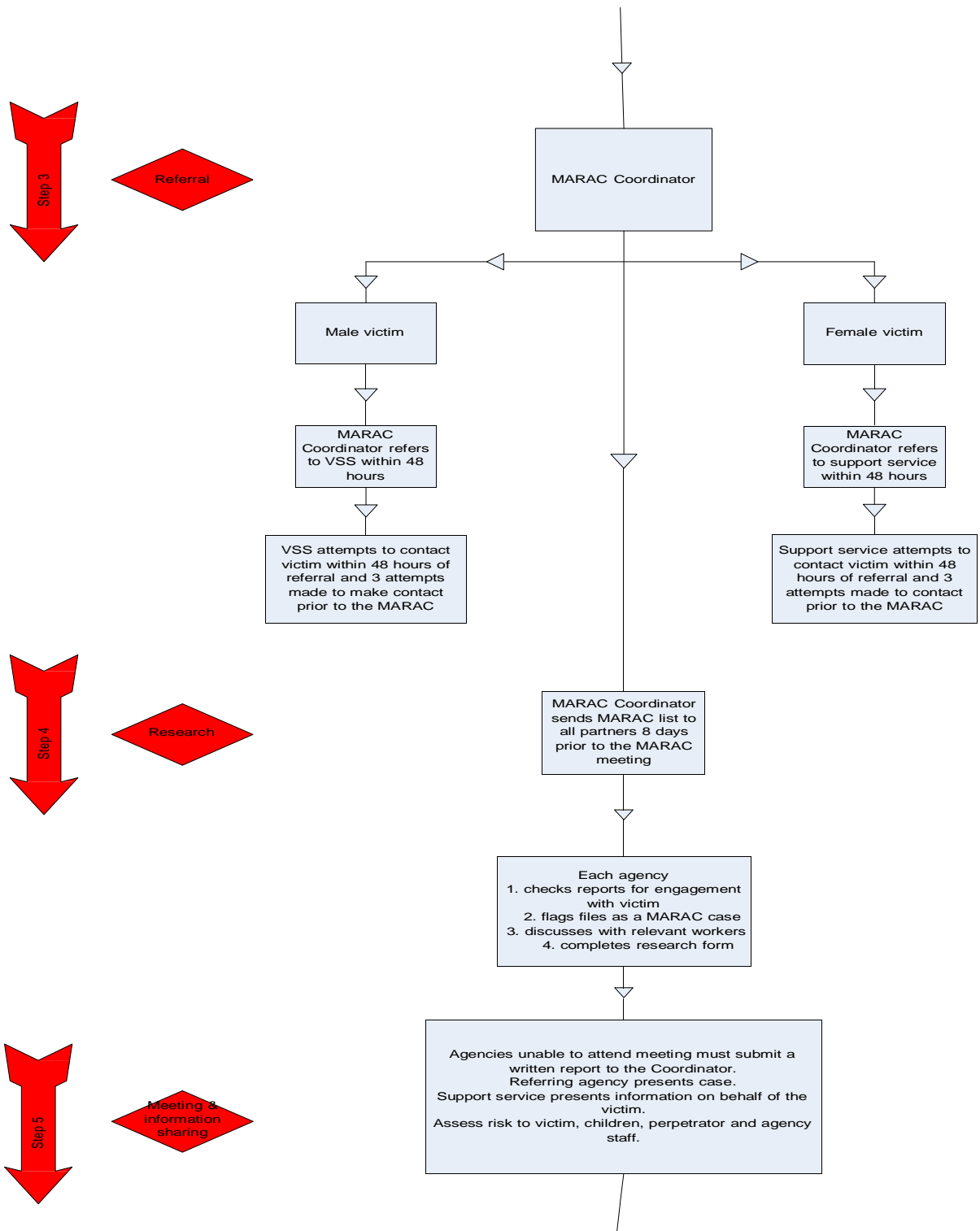


Appendix 2



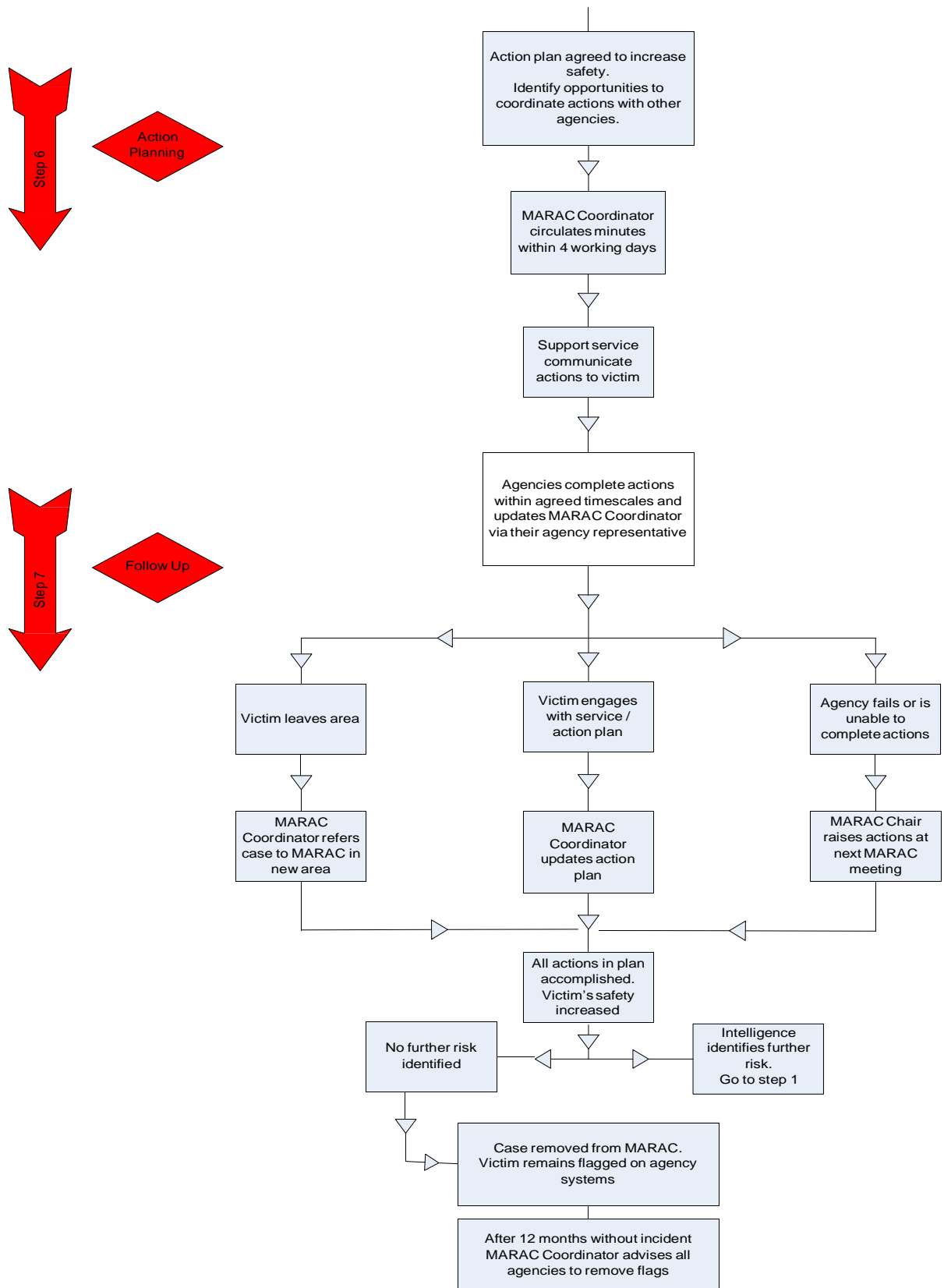
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Appendix 3



CAADA-DASH Risk Identification Checklist (RIC)ⁱ for MARAC Agencies

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 MARAC¹ 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 Frequently Asked Questions and Answers². These can be downloaded from http://www.caada.org.uk/marac/RIC_for_MARAC.html. Risk is dynamic and can change very quickly. It is good practice to review the checklist after a new incident.

Recommended Referral Criteria to MARAC

1. **Professional judgement:** if a professional has serious concerns about a victim's situation, they should refer the case to MARAC. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. *This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers particularly in cases of 'honour'-based violence.* This judgement would be based on the professional's experience and/or the victim's perception of their risk even if they do not meet criteria 2 and/or 3 below.
2. **'Visible High Risk':** the number of 'ticks' on this checklist. If you have ticked 14 or more 'yes' boxes the case would normally meet the MARAC referral criteria.
3. **Potential Escalation:** the number of police callouts to the victim as a result of domestic violence in the past 12 months. This criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at MARAC. It is common practice to start with 3 or more police callouts in a 12 month period but this will need to be reviewed depending on your local volume and your level of police reporting.

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

¹ For further information about MARAC please refer to the 10 Principles of an Effective MARAC:

http://www.caada.org.uk/marac/10_Principles_Oct_2011_full.doc

² For enquiries about training in the use of the form, please email training@caada.org.uk or call 0117 317 8750.

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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. Name of victim: Date: Restricted when completed

Name of victim :Date: Restricted when completed

CAADA-DASH Risk Identification Checklist for use by IDVAs and other non-police agencies³ 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 <input checked="" type="checkbox"/> . Please use the comment box at the end of the form to Tick expand on any answer. It is assumed that your main source of information is the victim. If this is not the case please indicate in the right hand column	Yes (tick)	No	Don't Know	State source of info if not the victim e.g. police officer
1. Has the current incident resulted in injury? (Please state what and whether this is the first injury.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Are you very frightened? Comment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Do you feel isolated from family/friends i.e. does (name of abuser(s)) try to stop you from seeing friends/family/doctor or others? Comment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Are you feeling depressed or having suicidal thoughts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Have you separated or tried to separate from (name of abuser(s)....) within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Is there conflict over child contact?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Does (.....) 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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Are you pregnant or have you recently had a baby (within the last 18 months)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Is the abuse happening more often?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Is the abuse getting worse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Does (.....) try to control everything you do and/or are they excessively jealous? (In terms of relationships, who you see, being 'policed at home', telling you what to wear for example. Consider 'honour'-based violence and specify behaviour.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

³Note: This checklist is consistent with the ACPO endorsed risk assessment model DASH 2009 for the police service.

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Tick box if factor is present. Please use the comment box at the end of the form to expand on any answer.	Yes (tick)	No	Don't Know	State source of info if not the victim
13. Has (.....) ever used weapons or objects to hurt you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Has (.....) ever threatened to kill you or someone else and you believed them? (If yes, tick who.) You <input type="checkbox"/> Children <input type="checkbox"/> Other (please specify) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Has (.....) ever attempted to strangle/choke/suffocate/drown you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Does (.....) 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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Do you know if (.....) has hurt anyone else? (Please specify whom including the children, siblings or elderly relatives. Consider HBV.) Children <input type="checkbox"/> Another family member <input type="checkbox"/> Someone from a previous relationship <input type="checkbox"/> Other (please specify) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Has (.....) ever mistreated an animal or the family pet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Are there any financial issues? For example, are you dependent on (.....) for money/have they recently lost their job/other financial issues?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Has (.....) 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 <input type="checkbox"/> Alcohol <input type="checkbox"/> Mental Health <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. Has (.....) ever threatened or attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23. Has (.....) 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 <input type="checkbox"/> Non Molestation/Occupation Order <input type="checkbox"/> Child Contact arrangements <input type="checkbox"/> Forced Marriage Protection Order <input type="checkbox"/> Other <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24. Do you know if (.....) has ever been in trouble with the police or has a criminal history? (If yes, please specify.) DV <input type="checkbox"/> Sexual violence <input type="checkbox"/> Other violence <input type="checkbox"/> Other <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Total 'yes' responses				

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Revised Protocol Domestic Abuse: Pregnancy and the Early Years

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: Name:	Date:

Practitioner's Notes

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¹ This checklist reflects work undertaken by CAADA in partnership with Laura Richards, Consultant Violence Adviser to ACPO. We would like to thank Advance, Blackburn with Darwen Women's Aid and Berkshire East Family Safety Unit and all the partners of the Blackpool MARAC for their contribution in piloting the revised checklist without which we could not have amended the original CAADA risk identification checklist. We are very grateful to Elizabeth Hall of Cafcass and Neil Blacklock of Respect for their advice and encouragement and for the expert input we received from Jan Pickles, Dr Amanda Robinson and Jasvinder Sanghera.

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Appendix 4

Useful Contacts

Name	Tel No
Domestic Abuse Helpline (24hr)	FREEPHONE 0800 027 1234
Argyll & Bute Women's Aid	0870 241 3548
Caithness & Sutherland Women's Aid	0845 408 0151
Inverness Women's Aid	01463 220719
Lochaber Women's Aid	01397 705734
Ross-shire Women's Aid	01349 863568
Community Violence & Abuse Support Service (Badenoch Strathspey & Nairn)	01479 812144
Rape & Abuse Line	0808 800 0123 (7pm-10pm) (answered by women most evenings) 0808 800 0122 (7pm-10pm) (answered by men most evenings)
Police Police Scotland (in emergency)	101 999
Housing Dept (Emergency out-of-hours) (Daytime)	0845 700 2005 01463 702888
Social Services Highland (Emergency out-of-hours Highland) Argyll & Bute (Emergency out-of-hours)	01463 703456 0845 769 7284 01631 563 068 0800 811 505
Advocacy Highland	01463 233460
Amina Muslim Women's Helpline	0808 801 0301
HematGryffe Women's Aid - Glasgow Asian, black minority ethnic women and children	0141 353 0859
Shakti Women's Aid - Edinburgh Asian, black minority ethnic women and children	0131 475 3299
Victim Support Highland	01463 258834
24-hour Highland Adult Protection Line	0800 9020042
Useful websites:	
www.domesticabuse.co.uk	
www.zerotolerance.org.uk	
www.amnesty.org.uk	
www.un.org	

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