Chopwell Primary Healthcare Centre

POLICY FOR RESPONDING TO DOMESTIC VIOLENCE AND ABUSE

Date 31.07.2019

Version	1.0
Ratified by:	Partners at *Chopwell Primary Healthcare centre*
Date Ratified:	31.07.2019
Name & title of Originator/Author:	
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Consultation Process:	
Mandatory/ Statutory Standards or	Care Quality Commission Outcome 7

1. Introduction

Chopwell Primary Healthcare centre is committed to improving the health and well-being of all patients and as such recognises that domestic abuse adversely affects the health of individuals, vulnerable adults, families and communities. The practice acknowledges that domestic abuse knows no boundaries and occurs equally across all social strata and recognises that this will have a huge additional negative impact on the health and well-being of victims. This policy should be read in conjunction with associated policies particularly the Safeguarding Children and Safeguarding Adults (Adults at Risk) policies.

2. Policy Scope

This policy document explains the role of the practice in identifying domestic abuse and supporting service users who experience it. The policy confirms the practice's commitment to relevant guidance and identifies actions the practice will undertake to support staff and service users in identifying, preventing and supporting victims and their children.

3. Aim of Policy

The aim of the policy is to guide staff in the management of patients/service users who are at risk of/ or have experienced domestic abuse. The practice will address the issue of domestic abuse and promote support for those who have experienced it.

4. Duties (Roles and Responsibilities)

The practice is committed to protecting adults at risk (previously known as "vulnerable adults") and children. Where someone who is defined as an adult at risk is experiencing domestic violence then adult safeguarding procedures must be followed. Where the abuse of a child or children under 18 is identified or suspected, this must be defined as child abuse in line with the practice's Child Protection Policies and Procedures. Where the victim or perpetrator of domestic violence is identified as having children, a referral to Children's Social Care will be made if the child is considered to be at potential risk.

The practice lead for Safeguarding Children is Dr M S Hassan

The practice lead for Safeguarding Adults is Dr M S Hassan

The practice Safeguarding leads are responsible for ensuring the practice response to domestic violence and abuse. They will

- implement ***Chopwell Primary Healthcare centre*** domestic violence and abuse policy
- ensure that the practice meets contractual guidance
- ensure safe recruitment procedures
- support reporting and complaints procedures
- advise practice members about any concerns that they have
- ensure that practice members receive adequate support when dealing with domestic violence and abuse
- lead on analysis of relevant significant events
- determine training needs and ensuring they are met
- make recommendations for change or improvements in practice procedural policy
- act as a focus for external contacts
- have regular meetings with others in the Primary Healthcare Team to discuss particular concerns

All members of the practice

- Have a responsibility to acknowledge domestic abuse and take action to respond to their patients' wishes and follow local domestic abuse procedures. (see Appendix: Flowchart for Responding to Domestic Abuse)

- Should respect the wishes of patients who do not want to take further actions at the time of disclosure, must respect the need for patient's confidentiality but understand when it is necessary to disclose information

- Have an awareness of and understand the indicators which may lead to domestic abuse and that this issue features highly in cases of child protection

- Undertake training that raises awareness about Domestic Abuse and of the MARAC (Multi Agency Risk Assessment Conferences) process

- Record positive disclosures of abuse in line with current guidance.

- Should use appropriate codes to highlight domestic violence and abuse in line with current guidance

5. Definitions

The 2013 definition of domestic violence and abuse (referred to within this policy as domestic abuse)

"Any incident or pattern of incidents of controlling, coercive or 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 .This can encompass but not limited to the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

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

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

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

Home Office March 2013.

There is a new draft Domestic abuse bill passing through parliament (January 2019) which will provide a legal definition of domestic violence and extend enhanced legal protection for victims.

A stalking law came into force under the Protection from Harassment Act PHA) (amended by the Protection of Freedoms Act 2012) in November 2012.

Whilst there is no strict legal definition of 'stalking', section 2A (3) of the PHA 1997 sets out examples of acts or omissions which, in particular circumstances, are ones associated with stalking. For example, following a person, watching or spying on them or forcing contact with the victim through any means, including social media.

This covers conduct that amounts to harassment, stalking or fear of violence , which causes distress, which has a substantial effect on the victims' usual day to day activities, which the perpetrator knows or ought to know amounts to stalking or fear of violence, a course of conduct that occurs on at least two occasions. There are two new offences in relation to this Law. It is known that stalking can last months and years and many victims endure serious psychological harm over a prolonged period.

Research suggests 1 in 4 women and 1 in 6 men will experience domestic violence at sometime in their lives, with women at greater risk of repeat victimisation and more serious injuries (Home Office 2004)

Domestic violence / abuse is not specific to any strand of society.

According to the Crime Survey for England and Wales (CSEW) year ending March 2018, an estimated 7.9% of women (1.3 million) and 4.2% of men (695,000) experienced domestic abuse in the last year.

- Women were four times as likely as men to have experienced sexual assault by a partner (including attempts) in the last year.
- Female victims of partner abuse were more likely than male victims to experience non-physical abuse (emotional, financial) and sexual assault by rape or penetration(including attempts); male victims of partner abuse reported a higher level of force than female victims.

Domestic violence includes, but is not limited to:

• **Physical Violence:**

Slapping, pushing, kicking, stabbing, damage to property or items of sentimental value, attempted murder or murder

• **Sexual Violence:**

ANY non-consensual activity, including rape, sexual assault, coercive sexual activity or refusing safer sex

• **Emotional/Psychological Abuse**

Intimidation, social isolation, verbal abuse, humiliation, constant criticism, enforced trivial routines and online abuse

• **Financial Abuse**

Stealing, depriving or taking control of money, running up debts, withholding benefits books and bank cards

Perpetrators may use different forms of violence at different times. This policy and guidance applies equally to men and women who require advice or help whatever form it takes. Domestic violence is rarely a one off incident. More usually it is a pattern of abusive and controlling behaviour where the abuser exerts power over the victim. It occurs across society, regardless of age, gender, race, sexuality, wealth and geography.

6. Domestic Violence and Abuse Process

Practice Name is committed to improving the health and well-being of all patients by:

- Promoting the message that domestic abuse is unacceptable

- Domestic abuse has a hugely negative impact in the health and well -being of those that experience it. All staff working within the practice have a responsibility to respond appropriately to domestic abuse victims and perpetrators

- Commitment to work in partnership with other agencies to support victims of domestic abuse by using appropriate referral systems and to ensure perpetrators are held accountable

- The practice is committed to supporting the Multi-Agency Risk Assessment Conferences (MARAC) procedures by

    - The collection and sharing of relevant health information

    - Carrying out an assessment of risk within the practice or making a referral / encouraging engagement with an organisation such as Women's Aid or Victim Support who will undertake such assessments

    - The identification and referral of patients at significant risk of serious or life threatening harm into the MARAC procedures, sometimes without express consent of the victim. Staff are advised if considering referral to MARAC to discuss the situation with one of the Safeguarding teams

    - Re-referring to MARAC if the situation changes or they have new information

    - Storing reports from MARAC in medical records and highlighting the records of victims and alleged perpetrators

Selective Enquiry

The practice will implement and promote the use of Selective Enquiry, identification and signposting to other support agencies.

Selective Enquiry forms the basis for providing those who are experiencing abuse with information about the local specialised services available to them.

These specialist services include those provided by a variety of voluntary

sector organisations, in particular by Women's Aid affiliated organisations and

in some instances by Victim Support Independent Domestic Violence

Advocates (IDVAs), Specialist Domestic Violence Units and Domestic

Violence Officers within the Police Protecting Vulnerable Persons Unit.

These agencies will carry out a risk assessment. If a victim fails to engage with a specialist agency the practice will take steps to assess the level of risk using the CAADA-DASH checklist as a guide.

Selective Enquiry refers to asking direct questions in the presence of signs and symptoms which may indicate abuse has taken place.

It is recognised that all staff within the practice should have an awareness of domestic abuse issues and be aware of reporting system. All health professionals should be able to carry out Selective Enquiries. The victim should be seen alone to ask about domestic abuse.

Assessment Technique/Process

- Staff must display a non-judgmental approach that is supportive to the abused person and use open questions

- Staff must be aware of their own prejudices/feelings/experiences and ensure that they do not act in a discriminatory way

- Questions should be asked in as quiet, private and safe environment as possible

- The abused person should be seen on their own if possible. However, some individuals will require another person present (Offer choice of gender if possible) either as an interpreter for language differences, sign language interpreters or as an advocate, particularly for people with learning disabilities. Family members/friends must not be used in these roles.

- The abused person must understand the issue of confidentiality and staff should clarify for the person the limits of confidentiality with particular regard to Child Protection and adult at risk concerns.

- Staff with any concerns about how to respond to a disclosure should discuss the issues with the practice safeguarding lead for children or adults and take advice regarding the need to disclose information

- All staff should document what has been disclosed in the medical records using appropriate codes.

- The victim will be given appropriate and timely information, advice leaflets about options e.g. signposting to support services including Women's Aid, IDVA or other agencies

- The issue of domestic violence/abuse should be reviewed in subsequent consultations to assess whether the situation has changed and to judge whether any further action is now needed.

- If there are any concerns regarding the mental capacity of the victim a Mental Capacity Act assessment must be performed to inform decision making.

7. Information Sharing

There are legitimate concerns about sharing information however GMC guidance on this is clear in **Ethical Guidance for Doctors: confidentiality** https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality/disclosures-for-the-protection-of-patients-and-others. (Accessed 27.1.19 12:29)

"Disclosing information to protect patients

50 All patients have the right to a confidential medical service. Challenging situations can however arise when confidentiality rights must be balanced against duties to protect and promote the health and welfare of patients who may be unable to protect themselves

Disclosing information about adults who may be at risk of harm

52 As a rule, you should make decisions about how best to support and protect adult patients in partnership with them, and should focus on empowering patients to make decisions in their own interests. You must support and encourage patients to be involved, as far as they want and are able, in decisions about disclosing their personal information.

Disclosing information in the public interest

63 Confidential medical care is recognised in law as being in the public interest. The fact that people are encouraged to seek advice and treatment benefits society as a whole as well as the individual. But there can be a public interest in disclosing information to protect individuals or society from risks of serious harm, such as from serious communicable diseases or serious crime.23

64 If it is not practicable or appropriate to seek consent, and in exceptional cases where a patient has refused consent, disclosing personal information may be justified in the public interest if failure to do so may expose others to a risk of death or serious harm. The benefits to an individual or to society of the disclosure must outweigh both the patient's and the public interest in keeping the information confidential.

65 Such a situation might arise, for example, if a disclosure would be likely to be necessary for the prevention, detection or prosecution of serious crime, especially crimes against the person. When victims of violence refuse police assistance, disclosure may still be justified if others remain at risk, for example from someone who is prepared to use weapons, or from domestic violence when children or others may be at risk.

67 Before deciding whether disclosure would be justified in the public interest you should consider whether it is practicable or appropriate to seek consent (see paragraph 14). You should not ask for consent if you have already decided to disclose information in the public interest but you should tell the patient about your intention to disclose personal information, unless it is not safe or practicable to do so. If the patient objects to the disclosure you should consider any reasons they give for objecting.

68 When deciding whether the public interest in disclosing information outweighs the patient's and the public interest in keeping the information confidential, you must consider:

a. *the potential harm or distress to the patient arising from the disclosure – for example, in terms of their future engagement with treatment and their overall health*
b. *the potential harm to trust in doctors generally – for example, if it is widely perceived that doctors will readily disclose information about patients without consent*
c. *the potential harm to others (whether to a specific person or people, or to the public more broadly) if the information is not disclosed*
d. *the potential benefits to an individual or to society arising from the release of the information*
e. *the nature of the information to be disclosed, and any views expressed by the patient*
f. *whether the harms can be avoided or benefits gained without breaching the patient's privacy or, if not, what is the minimum intrusion.*

If you consider that failure to disclose the information would leave individuals or society exposed to a risk so serious that it outweighs the patient's and the public interest in maintaining confidentiality, you should disclose relevant information promptly to an appropriate person or authority.

69 You must document in the patient's record your reasons for disclosing information with or without consent. You must also document any steps you have taken to seek the patient's consent, to inform them about the disclosure, or your reasons for not doing so.

70 Decisions about whether or not disclosure without consent can be justified in the public interest can be complex. Where practicable, you should seek advice from a Caldicott or data guardian or similar expert adviser who is not directly connected with the use for which disclosure is being considered. If possible, you should do this without revealing the identity of the patient."

In terms of domestic violence key points are:

- The best interests of the child are of paramount concern. This is reflected in judgements from the courts and in professional advice from the GMC. The duty to those with parental responsibility is a secondary consideration and should not divert the clinician from his/her prime concern for the child – clinicians should be reassured of the professional and legal framework that supports disclosures without consent even if concerns prove unfounded.
- Seek consent if it is appropriate to do so but consider the risks of seeking consent.
- Information may be shared without consent even when children are not involved if there is a risk to a vulnerable adult or when a serious crime has been committed or may be committed.
- The level of risk needs to be considered on a case by case basis with a consideration of the potential benefits and risks of sharing information.
- Only relevant information needs to be shared.
- Document in the records reasons for sharing or not sharing information.

8. Training

Chopwell Primary Healthcare centre is committed to ensuring that all staff meet minimum requirements for Safeguarding Adults and Safeguarding Children training.

In addition clinical staff are encouraged to undertake specific training in domestic violence and abuse.

Declaration

In law, the responsibility for ensuring that this policy is reviewed belongs to the partners of the practice. The checklist has been completed on behalf of the practice.

We have reviewed and accepted this policy

Signed by: Louise Powell Date: 31.07.2019

Signed: L Powell

on behalf of the partnership

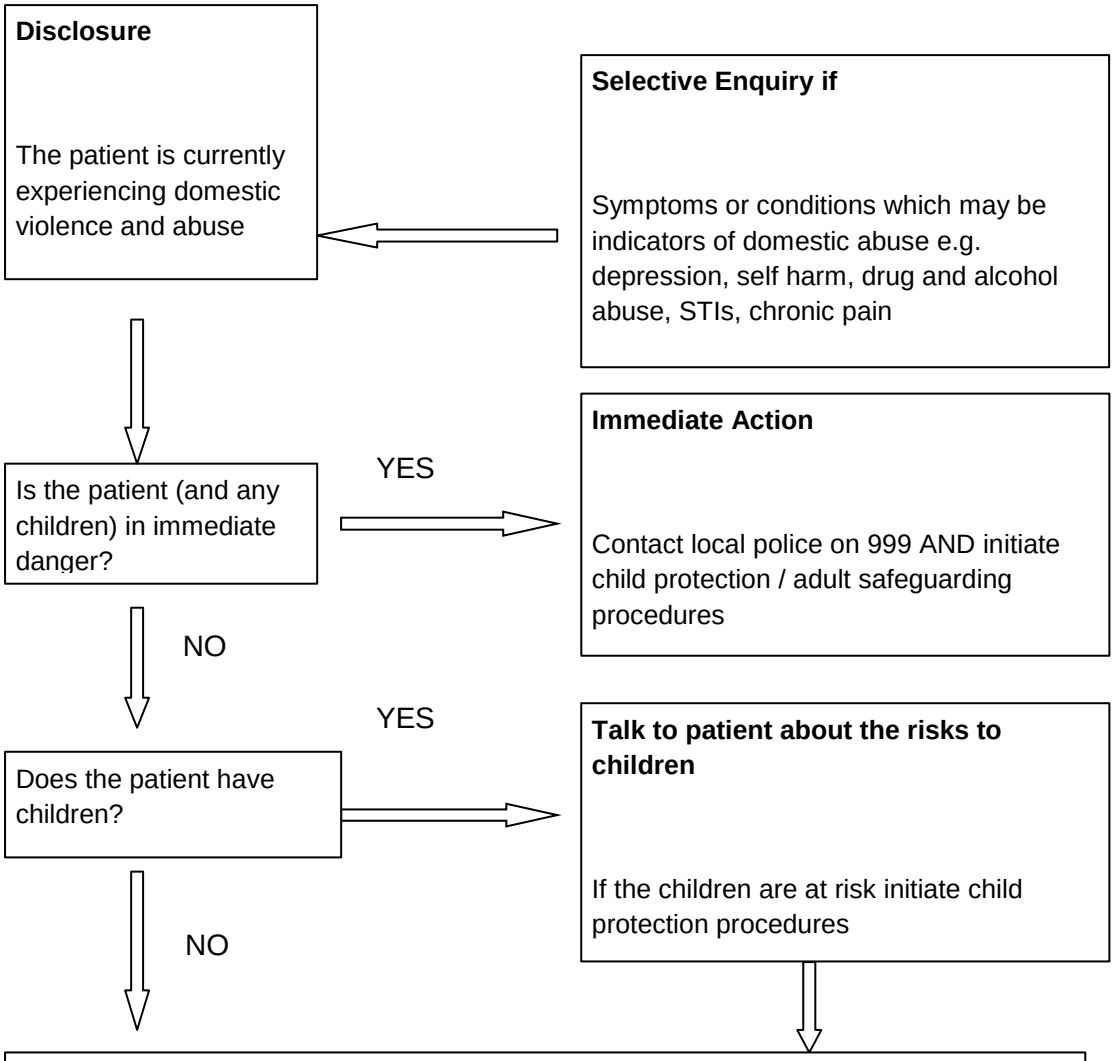
The practice team has been consulted on how we implement this policy

Signed by: Louise Powell Date: 31.07.2019

Signed: L Powell

This policy will be reviewed on DATE**: 31.07.2020**

Appendix: Flowchart for Responding to Domestic Abuse



Respond

- Refer / signpost to specialist services
- Assess level of risk
- If high risk consider MARAC referral/ DASH RIC assessment and discuss with safeguarding
- Follow up at subsequent appointments
- Undertake Mental Capacity Act assessment if concerns about Mental Capacity

Record

- Consent to share information (or not) and ensure information is shared appropriately
- Explain the need to document domestic abuse and document any injuries for purposes of evidence
- Use recommended codes for domestic violence/ MARAC and consider blocking online access to these codes.

Adapted from CAADA/RCGP guidance on responding to Domestic Abuse