

# Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively

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## Introduction

### *What is this guidance about?*

This guidance aims to help identify, prevent and reduce [domestic violence and abuse](#). Violence and abuse perpetrated on children by adults ('child abuse') is not dealt with in this guidance, but it does include support for [children who are affected by domestic violence and abuse](#).

Domestic violence and abuse is a complex issue that needs sensitive handling by a range of health and social care professionals. The cost, in both human and economic terms, is so significant that even marginally effective interventions are cost effective.

Women and men can experience this type of violence in heterosexual and same-sex relationships. The prevalence of physical assaults from a partner or adult family member is higher among heterosexual women than among men. Moreover, heterosexual women experience more repeated physical violence, more severe violence, much more sexual violence, more coercive control, more injuries and more fear of their partner.

The recommendations cover the broad spectrum of domestic violence and abuse, including violence perpetrated on men, on those in same-sex relationships and on young people.

Working in a multi-agency partnership is the most effective way to approach the issue at both an operational and strategic level. Initial and ongoing training and organisational support is also needed.

There was not sufficient evidence to make recommendations on primary prevention programmes. Most of the evidence about this relates to interventions in educational settings and these are outside the scope of this guidance unless they are delivered by a health or social care professional. Prevention is an important area for future research (see [Recommendations for research](#)).

The guidance is for health and social care commissioners, specialist domestic violence and abuse staff and others whose work may bring them into contact with people who experience or perpetrate domestic violence and abuse. (For details, see [Who should take action?](#)) In addition it may be of interest to members of the public.

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See [About this guidance](#) for details of how the guidance was developed and its current status.

## 1 Recommendations

### ***Recommendation 1 Plan services based on an assessment of need and service mapping***

- Strategic partnerships (see [Who should take action?](#)) should assess the need for domestic violence and abuse services as part of the joint strategic needs assessment. Consult with women, men and young people who have experienced domestic violence and abuse as part of this assessment. Commissioners of domestic violence and abuse services and related services should be aware of the importance of consulting communities that are rarely heard on this matter.
- Local commissioners of domestic violence and abuse services and related services should undertake a comprehensive mapping exercise to identify all local services and partnerships that work in domestic violence and abuse. (For example, this could include: ambulance services, housing, the police, health, criminal justice, education, probation, safeguarding and social care services. It could also include other specialist statutory, community and voluntary services, such as drug and alcohol services.) Map services against the Home Office-endorsed [Coordinated Community Response Model](#) and identify any gaps.
- Local commissioners (see above) should use the results of the needs assessment and mapping exercise to inform commissioning. They should develop referral pathways that aim to meet the health and social care needs of all those affected by domestic violence and abuse. This includes people with [protected characteristics](#) and those who face particular barriers trying to access domestic violence and abuse support services (see recommendations [4](#) and [9](#)).
- Regional and national commissioners of domestic violence and abuse services and related services should work with local commissioners to ensure service support extends across local authority boundaries, where necessary, for services such as prisons that cover broader geographical areas.
- Regional and national commissioners (see above) should work with local commissioners to provide specialist services across local authority boundaries where there is not enough local need to justify setting them up within a particular local authority area. (This could include services to help prevent [forced marriages](#), to help men, and lesbian, gay, bisexual or [trans](#)



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people affected by domestic violence, or for people subjected to 'honour' violence or stalking.)

- Strategic partnerships should use the results of mapping in the joint strategic needs assessment and other strategic planning tools. They should also make the results widely available to all relevant services and the general public – for example, by publishing a directory of local and national services.

## ***Recommendation 2 Participate in a local strategic multi-agency partnership to prevent domestic violence and abuse***

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

- Ensure senior officers from the following services participate in a local strategic partnership to prevent domestic violence and abuse, along with representatives of frontline practitioners and service users or their representatives:
  - health services and the local authority (including the chairs of local safeguarding boards for adults and children)
  - public health
  - sexual violence services
  - housing
  - schools and colleges
  - police and crime commissioners
  - community safety partnerships
  - criminal justice agencies (including probation)
  - the Children and Family Court Advisory and Support Service
  - specialist voluntary, community and private sector organisations.

- Ensure health and social care practitioners are actively involved in both operational and strategic multi-agency initiatives (for example, [multi-agency risk assessment conferences](#)).
- Regularly review membership of the partnership to ensure it is relevant and inclusive.

### ***Recommendation 3 Develop an integrated commissioning strategy***

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

- Establish an integrated commissioning strategy. This should include input from domestic violence and abuse services, other relevant services and from people who have experienced domestic violence and abuse. The strategy should:
  - meet the health and social care needs of those who experience domestic violence and abuse (including young people)
  - meet the needs of children and young people who are affected by domestic violence and abuse
  - address the perpetrator's behaviour and health needs
  - meet the needs of all local communities.
- Ensure the strategy is based on the following principles:
  - aligned or, where possible, integrated budgets and other resources
  - one partner takes the strategic lead and oversees delivery on behalf of the local strategic partnership
  - services address all levels of risk and all degrees of severity of domestic violence and abuse
  - services are based on evidence-based commissioning principles and the local needs assessment and mapping exercise (see recommendation [1](#)).
  - agencies work together to deliver services.

- Monitor implementation of the strategy and evaluate its effectiveness for different groups. Include both quantitative data on outcomes and qualitative data (such as feedback from service users).

## ***Recommendation 4 Commission integrated care pathways***

Commissioners of health and social care services should:

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

## ***Recommendation 5 Create an environment for disclosing domestic violence and abuse***

Health and social care service managers and managers of specialist domestic violence and abuse services and related services (see [Who should take action?](#)) should:

- Clearly display information in waiting areas and other suitable places about the support on offer for those affected by domestic violence and abuse. This includes contact details of relevant local and national helplines. It could also include information for groups who may find it more difficult to disclose that they are experiencing violence and abuse (see recommendation 9).
- Ensure the information on where to get support is available in a range of formats and locally used languages. The former could include braille and audio versions and the use of large font sizes. There may also be more discreet ways of conveying information, for example, by providing pens or key rings with a helpline number.

- Take steps to ensure people who use the service are given maximum privacy, for example, by arranging the reception area so that people cannot be overheard.
- Establish a referral pathway to specialist domestic violence and abuse agencies (or the equivalent in a health or social care setting). This should include age-appropriate options and options for groups that may have difficulties accessing services, or are reluctant to do so (see recommendation 9).
- Ensure frontline staff know about the services, policies and procedures of relevant local agencies in relation to domestic violence and abuse.
- Provide ongoing training and regular supervision for staff who may be asking people about domestic violence and abuse. This should aim to sustain and monitor good practice.
- Establish clear policies and procedures for staff who have been affected by domestic violence and abuse. Ensure staff have the opportunity to address issues relating to their own personal experiences, as well as those that may arise after contact with patients or service users.

## ***Recommendation 6 Ensure trained staff ask people about domestic violence and abuse***

Health and social care service managers and professionals should:

- Ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse. The enquiry should be made in private on a one-to-one basis in an environment where the person feels safe, and in a kind, sensitive manner.
- Ensure people who may be experiencing domestic violence and abuse can be seen on their own (a person may have multiple abusers and friends or family members may be colluding in the abuse).
- Ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.

- Ensure staff know, or have access to, information about the services, policies and procedures of all relevant local agencies for people who experience or perpetrate domestic violence and abuse.
- Ensure all services have formal referral pathways in place for domestic violence and abuse. These should support: people who disclose that they have been subjected to it; the perpetrators; and children who have been affected by it (see recommendation 4).

## ***Recommendation 7 Adopt clear protocols and methods for information sharing***

Commissioners and service providers involved with those who experience or perpetrate domestic violence and abuse (see [Who should take action?](#)) should:

- Take note of the Data Protection Act and professional guidelines that address confidentiality and information sharing in health services. This includes guidelines on how to apply the Caldicott guardian principles to domestic violence, see [Caldicott guidelines](#). It also includes guidelines on: seeking consent from people to share their information, letting them know when, and with whom, information is being shared, and knowing when information can be shared without consent.
- Develop or adapt clear protocols and methods for sharing information, both within and between agencies, about people at risk of, experiencing, or perpetrating domestic violence and abuse. Clearly define the range of information that can be shared and with whom (this includes sharing information with health or children's services on a perpetrator's criminal history.)
- Ensure protocols and methods encourage staff to:
  - Remember their professional duty of confidentiality.
  - Determine when the duty of confidentiality might have to be breached: information should be shared only with the person's consent unless they are at serious risk, and within agreed multi-agency information-sharing protocols.
  - Note that information sharing without consent risks losing trust and may endanger a person's safety.

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- Weigh the risks of sharing information or not by determining whether you are sharing with the aim of protecting someone. It is acceptable to share information if that is the case and you are not sharing data just to alert another agency to a problem.
  - Distinguish between anonymised data and personal data: the former does not need individual consent, but there should be a protocol in place for sharing such data.
  - Distinguish between situations that involve only adults and those where children are involved: information sharing without consent, or where consent is not given, is necessary when children's safety is at risk.
- Ensure information-sharing methods are secure and will not put anyone involved at risk.
  - Ensure the protocols and methods are regularly monitored.
  - Identify and train key contacts responsible for advising on the safe sharing of domestic violence and abuse-related information.
  - Ensure all staff who need to share information are trained to use the protocols so that they do not decline to cooperate because of being overcautious or for fear of reprisal.
  - Ensure any information shared is acknowledged by a person, rather than by an automatically generated response.

## ***Recommendation 8 Tailor support to meet people's needs***

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

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

- Think about referring someone to floating or outreach advocacy support or to a skill-building programme if they need longer-term support. Also explore whether they would like to be referred to a local support group.
- If there are indications that someone has alcohol or drug misuse or mental health problems, also refer them to the relevant alcohol or drug misuse or mental health services (see recommendation [13](#)).

## ***Recommendation 9 Help people who find it difficult to access services***

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

- Help people who may find domestic violence and abuse services inaccessible or difficult to use. This includes: people from black and minority ethnic groups or with disabilities, older people, [trans people](#) and lesbian, gay or bisexual people. It also includes people with [no recourse to public funds](#).
- Identify any barriers people from these groups may face when trying to get help. Do this in consultation with local groups that have an equality remit (including organisations representing the interests of specific groups), and in line with statutory requirements.
- Introduce a strategy to overcome these barriers.
- Train staff in direct contact with people affected by domestic violence and abuse to understand equality and diversity issues. This includes those working with people who perpetrate this type of violence and abuse. Specifically:
  - Ensure assumptions about people's beliefs and values (for example, in relation to ['honour'](#)) do not stop staff identifying and responding to domestic violence and abuse.
  - Ensure staff know where to seek specialist advice, for example, for people with no recourse to public funds or for people with HIV.
  - Ensure staff are aware that lesbian, gay, bisexual and trans people are also at risk of forced marriage and that 'honour'-based violence might be triggered by someone's gender identity or sexuality.

- Ensure interpreting services are confidential (often a concern in small communities where a minority language is spoken).
- Ensure professional interpreters are used. Do not use family members or friends. In some areas this will mean using a national interpreting service or one based in another locality.

## ***Recommendation 10 Identify and, where necessary, refer children and young people affected by domestic violence and abuse***

Providers of services where children and young people affected by domestic violence and abuse may be identified and those responsible for safeguarding children (see [Who should take action?](#)) should:

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



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## ***Recommendation 11 Provide specialist domestic violence and abuse services for children and young people***

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

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

## ***Recommendation 12 Provide specialist advice, advocacy and support as part of a comprehensive referral pathway***

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

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

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

### ***Recommendation 13 Provide people who experience domestic violence and abuse and have a mental health condition with evidence-based treatment for that condition***

Health, police and crime commissioners, health and social care providers and practitioners in primary, mental health and related care services (see [Who should take action?](#)) should:

- Where people who experience domestic violence and abuse have a mental health condition (either pre-existing or as a consequence of the violence and abuse), provide evidence-based treatment for the condition.
- Ensure mental health interventions are provided by professionals trained in how to address domestic violence and abuse. Interventions may include psychological therapy (for example, trauma-focused cognitive behavioural therapy), medication and support, in accordance with national guidelines.
- Ensure any treatment programme includes an ongoing assessment of the risk of further domestic violence and abuse, collaborative [safety planning](#) and the offer of a referral to specialist domestic violence and abuse support services. It must also take into account the person's preferences and whether the violence and abuse is ongoing or historic.

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## ***Recommendation 14 Commission and evaluate tailored interventions for people who perpetrate domestic violence and abuse***

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

- Commission robust evaluations of the interventions to inform future commissioning.
- Identify, and link with, existing initiatives that work with people who perpetrate domestic violence and abuse.
- Commission tailored interventions for people who perpetrate domestic violence and abuse, in accordance with national standards and based on the local needs assessment (see recommendation [1](#)).
- Ensure interventions primarily aim to increase the safety of the perpetrator's partner and children (if they have any). Ensure this is monitored and reported. In addition, staff should report on the perpetrators' attitudinal change, their understanding of violence and accountability, and their ability and willingness to seek help.
- Link perpetrator services with services providing specialist support for those experiencing domestic violence and abuse (including children and young people). For example, link ongoing risk assessments of the perpetrator with safety planning and support provided by specialist services.

See also recommendations [2–4](#).

## ***Recommendation 15 Provide specific training for health and social care professionals in how to respond to domestic violence and abuse***

Organisations responsible for training and registration standards and providers of health and social care training (see [Who should take action?](#)) should provide different levels of training for different groups of professionals, as follows.

- Training to provide a **universal response** should give staff a basic understanding of the dynamics of domestic violence and abuse and its links to mental health and alcohol and drug misuse, along with their legal duties. In addition, it should cover the concept of shame that is associated with 'honour'-based violence and an awareness of diversity and equality issues. It should also ensure staff know what to do next:
  - **Level 1** Staff should be trained to respond to a disclosure of domestic violence and abuse sensitively and in a way that ensures people's safety. They should also be able to direct people to specialist services. This level of training is for: physiotherapists, speech therapists, dentists, youth workers, care assistants, receptionists, interpreters and non-specialist voluntary and community sector workers.
  - **Level 2** Staff should be trained to ask about domestic violence and abuse in a way that makes it easier for people to disclose it. This involves an understanding of the epidemiology of domestic violence and abuse, how it affects people's lives and the role of professionals in intervening safely. Staff should also be able to respond with empathy and understanding, assess someone's immediate safety and offer referral to specialist services. Typically this level of training is for: nurses, accident and emergency doctors, adult social care staff, ambulance staff, children's centre staff, children and family social care staff, GPs, mental health professionals, midwives, health visitors, paediatricians, health and social care professionals in education (including school nurses), prison staff and alcohol and drug misuse workers. In some cases, it will also be relevant for youth workers.
- Training to provide a **specialist response** should equip staff with a more detailed understanding of domestic violence and abuse and more specialist skills:
  - **Level 3** Staff should be trained to provide an initial response that includes risk identification and assessment, safety planning and continued liaison with specialist support services. Typically this is for: child safeguarding social workers, safeguarding nurses, midwives and health visitors with additional domestic violence and abuse training, multi-agency risk assessment conference representatives and adult safeguarding staff.
  - **Level 4** Staff should be trained to give expert advice and support to people experiencing domestic violence and abuse. This is for specialists in domestic violence and abuse. For example, domestic violence advocates or support workers, independent domestic violence advisers or independent sexual violence advisers,

refuge staff, domestic violence and abuse and sexual violence counsellors and therapists, and children's workers.

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

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

- The higher levels of training include increasing amounts of face-to-face interaction, although level 1 training can be delivered mostly online or by distance learning.
- Face-to-face training covers the practicalities of enabling someone to disclose that they are affected by domestic violence and abuse and how to respond.

### ***Recommendation 16 GP practices and other agencies should include training on, and a referral pathway for, domestic violence and abuse***

- NHS England, commissioners and GPs should commission integrated training and referral pathways for domestic violence and abuse. This should include education for clinicians and administrative staff in GP practices on how to make it easier for people to disclose domestic violence and abuse. It should also include education for clinicians on how to provide immediate support after a disclosure and how to make referrals to specialist agencies.
- Managers of specialist domestic violence and abuse services, clinical commissioning groups and public health departments should work in partnership with voluntary and community agencies to develop training and referral pathways for domestic violence and abuse.

### ***Recommendation 17 Pre-qualifying training and continuing professional development for health and social care professionals should include domestic violence and abuse***

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

- 
- Ensure training about domestic violence and abuse is part of the undergraduate or pre-qualifying curriculum, and part of the continuing professional development, for health and social care professionals who come into contact with service users. It should be delivered in partnership with local specialist domestic violence and abuse services and include face-to-face contact, even if it is mainly delivered online.
  - Implement a rolling training programme that recognises the turnover of staff and the need for follow-up. The training strategy should:
    - be clear about the level of competency needed for each role (see recommendation [15](#))
    - refer to existing accredited materials from specialist organisations working in domestic violence and abuse, if they are suitable
    - ensure the content on domestic violence and abuse is linked to child welfare, safeguarding and adult protection services, and vice versa
    - follow the recommended content for each level (see recommendation [15](#)).

## 2 Who should take action?

### *Introduction*

The guidance is for everyone working in health and social care whose work brings them into contact with people who experience or perpetrate domestic violence and abuse.

This includes: people working in criminal justice settings and detention centres, health and social care commissioners, including clinical commissioning groups and local authorities, and staff working for specialist domestic violence and abuse services. The latter could be working in local authorities, the NHS and other organisations in the public, private, voluntary and community sectors. The guidance is also aimed at local strategic partnerships and health and wellbeing boards.

In addition, it will be of interest to people affected by domestic violence and abuse, including those who perpetrate it, those who experience it, their families or carers and other members of the public.

### *Who should do what at a glance*

<b>Who should take action</b>	<b>Recommendation</b>
NHS England	16
Organisations that coordinate or offer training, or that register and set standards for professionals	15, 17
Health services, local authorities and strategic partnerships (including health and wellbeing boards)	1, 2, 3, 12, 13, 14
Local safeguarding children boards and other local partnerships with a responsibility for safeguarding children	10, 11
Commissioners	1, 3, 4, 7, 9, 11, 12, 13, 14, 15, 16, 17
Heads and managers of health and social care services	5, 6, 15, 17

Service providers	5, 7, 8, 9, 10, 11, 13, 16
Health and social care staff	6, 8, 12, 13

## ***Who should take action in detail***

### **Recommendation 1**

Local, regional and national commissioners of domestic violence and abuse services and related services; strategic partnerships, for example, health and wellbeing boards, local domestic violence partnerships; community safety partnerships

### **Recommendation 2**

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

### **Recommendation 3**

Local strategic partnerships on domestic violence and abuse; commissioners, including clinical commissioning groups and local authorities

### **Recommendation 4**

Commissioners of health and social care services

### **Recommendation 5**

Health and social care service managers in the statutory, voluntary, community and private sectors; specialist domestic violence and abuse services and related services. The latter includes: criminal justice, early years and youth services, housing, the police, prison and probation services, schools and colleges, and services for older people

### **Recommendation 6**

Health and social care service managers and professionals



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## Recommendation 7

Health, social care, education, criminal justice, probation and voluntary and community sector commissioners and service providers involved with those who experience or perpetrate domestic violence and abuse

## Recommendation 8

Managers of domestic violence and abuse services; staff in all health and social care settings, including the public, voluntary and community sectors, and those they work with. The latter includes: criminal justice, including prisons, early years and youth services, housing, the police, schools and colleges, and services for older people

## Recommendation 9

Health and social care commissioners and service providers in the public, voluntary and community sector; managers and commissioners of interpreting services

## Recommendation 10

Local safeguarding children boards and other local partnerships with a responsibility for safeguarding children; providers of services where children and young people who are affected by domestic violence and abuse may be identified in the public, community and voluntary sectors. The latter includes: accident and emergency departments, child and adolescent mental health services, dental services, GP practices, health visiting, maternity services, sexual health services and other health services; early years services, schools and colleges, school nursing services; social care; specialist paediatric services for child safeguarding and looked after children; alcohol and drug misuse services; youth services; youth justice services

## Recommendation 11

Local safeguarding children boards and other local partnerships with a responsibility for safeguarding children; commissioners and providers of specialist services for children and young people who are affected by domestic violence and abuse in the public, community and voluntary sectors. The latter includes: child and adolescent mental health, health visiting, sexual health, social care and specialist paediatric services for child safeguarding and looked after children, and youth services

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## Recommendation 12

Health and social care commissioners (including clinical commissioning groups, local authority commissioners and police and crime commissioners); health and wellbeing boards; frontline practitioners in specialist domestic and sexual violence services (for example, domestic violence and abuse advisers, people working in refuges or outreach services)

## Recommendation 13

Clinical commissioning groups and specialist commissioners; police and crime commissioners; health and wellbeing boards; providers of primary care and mental health care services in the private, voluntary and community sectors. The latter includes: health and social care professionals working in alcohol and drug misuse services, detention centres and criminal justice settings

## Recommendation 14

Health and wellbeing boards; commissioners of tailored interventions for people who perpetrate domestic violence and abuse

## Recommendation 15

Royal colleges and professional organisations responsible for setting training and registration standards for clinical, social workers and social care staff; commissioners; Health Education England; heads of health, social care and related services; universities and other providers of health and social care training, including interpreting

## Recommendation 16

NHS England, commissioners and service managers working in specialist domestic violence and abuse services, GPs

## Recommendation 17

Royal colleges and professional organisations responsible for setting training and registration standards for relevant clinical, social workers and social care staff; heads of health, social care and related services; universities and other providers of health and social care training for professionals who come into contact with service users, including interpreters

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## 3 Context

### *Introduction*

- 3.1 At least 1.2 million women and 784,000 men aged 16 to 59 in England and Wales experienced domestic abuse in 2010/11 – 7.4% of women and 4.8% of men. (Domestic violence and abuse here is defined as: physical abuse, threats, non-physical abuse, sexual assault or stalking perpetrated by a partner, ex-partner or family member.) At least 29.9% of women and 17.0% of men in England and Wales have, at some point, experienced it (Smith et al. 2012).
- 3.2 These figures are likely to be an underestimate, because all types of domestic violence and abuse are under-reported in health and social research, to the police and other services.
- 3.3 Both men and women may perpetrate or experience domestic violence and abuse. However, it is more commonly inflicted on women by men. This is particularly true for severe and repeated violence and sexual assault.
- 3.4 Lesbian and bisexual women experience domestic violence and abuse at a similar rate to women in general (1 in 4), although a third of this is associated with male perpetrators (Hunt and Fish. 2008). Compared with 17% of men in general, 49% of gay and bisexual men have experienced at least 1 incident of domestic violence and abuse since the age of 16. This includes domestic violence and abuse within same-sex relationships ([Stonewall Gay and Bisexual Men's Health Survey 2012](#)). A focus on specific incidents and episodes is of limited value in understanding the experience of domestic abuse.

### *Associated risk factors*

- 3.5 The risk of experiencing domestic violence or abuse is increased if someone:
- is female

- is aged 16–24 (women) or 16–19 (men) (Smith et al. 2011)
- has a long-term illness or disability – this almost doubles the risk (Smith et al. 2011)
- has a mental health problem (Trevillion et al. 2012)
- is a woman who is separated (Smith et al. 2011) – there is an elevated risk of abuse around the time of separation (Richards 2004).

The risk is also increased if a woman is pregnant or has recently given birth. Although pregnancy appears to offer protection for some women (Bowen et al. 2005) for others it increases the risk (Harrykissoon et al. 2002). In addition, there is a strong correlation between postnatal depression and domestic violence and abuse.

- 3.6 The majority of [trans people](#) (80%) experience emotional, physical or sexual abuse from a partner or ex-partner (Roch et al. 2010).
- 3.7 Just under 40% (38.4%) of bisexual, gay and lesbian people class themselves as having experienced domestic violence and abuse. However, many more respondents reported behaviours that could be classed as domestic violence and abuse (Donovan et al. 2006).
- 3.8 The role played by alcohol or drug misuse in domestic violence and abuse is poorly understood. Research has indicated that 21% of people experiencing partner abuse in the past year thought the perpetrator was under the influence of alcohol and 8% under the influence of illicit drugs (Smith et al. 2012). People are thought to be at increased risk of substance dependency as a consequence of being the victim of domestic violence (Humphreys et al. 2005).

## ***Partner abuse among adults***

- 3.9 Partner abuse is the most prevalent form of domestic abuse. At least 26.6% of women and 14% of men have, at some point, experienced this since they were 16 (Smith et al. 2012). The prevalence is consistently higher among people in healthcare settings (Feder et al 2009).

- 3.10 Women are more likely than men to experience repeated partner abuse, partner abuse over a longer period of time, violence and more severe abuse (Smith et al. 2010). Women's reports of partner abuse are also more likely to indicate that it is part of a system of fear and coercive control (Hester and Westmarland 2005; Hester 2013).
- 3.11 Men are less likely to report abuse to the police, and more likely to say this is because they consider it too trivial or not worth reporting (Smith et al. 2010).
- 3.12 Each year since 1995, approximately half of all women aged 16 or older murdered in England and Wales were killed by their partner or ex-partner. Around 12% of men murdered each year from 1995 were killed by their partner or ex-partner (Smith et al. 2012; Thompson 2010).

### ***Partner abuse among young people***

- 3.13 Partner violence is also prevalent in young people's relationships. In the UK in 2009, 72% of girls and 51% of boys aged 13 to 16 reported experiencing emotional violence in an intimate partner relationship, 31% of girls and 16% of boys reported sexual violence, and 25% of girls and 18% of boys experienced physical violence (Meltzer et al. 2009). Some form of severe domestic violence and abuse inflicted on them by a partner (Barter et al. 2009) was reported by 1 in 6 girls.
- 3.14 In line with research among adults, girls described more abuse, and more severe abuse, more direct intimidation and control, and more negative impacts.
- 3.15 Young people in same sex relationships were at greater risk than those in heterosexual relationships.

### ***Domestic violence and abuse between parents***

- 3.16 Domestic violence and abuse between parents is the most frequently reported form of trauma for children (Meltzer et al. 2009). In the UK, 24.8% of those aged 18 to 24 reported that they experienced domestic violence and abuse

during their childhood. Around 3% of those aged under 17 reported exposure to it in the past 12 months (Radford et al. 2011).

- 3.17 The impact of living in a household where there is a regime of intimidation, control and violence differs by children's developmental age. However, whatever their age, it has an impact on their mental, emotional and psychological health and their social and educational development. It also affects their likelihood of experiencing or becoming a perpetrator of domestic violence and abuse as an adult, as well as exposing them directly to physical harm (Stanley 2011; Holt et al. 2008).
- 3.18 There is a strong association between domestic violence and abuse and other forms of child maltreatment: it was a feature of family life in 63% of the serious case reviews carried out between 2009 and 2011 (Brandon et al. 2012).

### ***'Honour'-based violence and forced marriage***

- 3.19 It is difficult to estimate the prevalence of so-called 'honour'-based violence and forced marriage, but we do know that the incidences of both are under-reported. Both can occur in Christian, Jewish, Sikh, Hindu, Muslim and other communities. They are probably more common in some groups, for example, some Pakistani, Kurdish, and Gypsy and Traveller communities, reflecting a more oppressive patriarchal ideology. (Home Affairs Select Committee 2008; Brandon and Hafez 2008).
- 3.20 Both often involve wider family members and affect men, as well as women: 22% of the 1468 cases looked at by the Forced Marriage Unit involved a male being forced to marry. It is estimated that between 5000 and 8000 cases of forced marriage were reported to local and national organisations in England in 2008. In 41% of cases reported to local organisations the person forced to marry was younger than 18 (Kazmirski et al. 2009).

### ***Abuse of older people***

- 3.21 More than 250,000 older people (aged 66 and older) living in England in private households reported experiencing maltreatment from a family member,

close friend or care workers in the past year (O'Keefe et al. 2007). Maltreatment included neglect and psychological, physical, sexual and financial abuse.

- 3.22 Of those experiencing maltreatment, 51% experienced it from a partner, 49% from another family member, 5% from a close friend and 13% from a care worker. Women were more likely to experience maltreatment than men (3.8% of women and 1.1% of men in the past year), and men were more often the perpetrators.

## ***Abuse of parents by children***

- 3.23 The prevalence of abuse of parents by their children is very difficult to ascertain and 'still lies in a veil of secrecy' (Kennair and Mellor 2007). It is 'a pattern of behaviour that uses verbal, financial, physical or emotional means to practise power and exert control over a parent' (Holt 2012). It is more commonly experienced by mothers than fathers – and is more common among single parents.
- 3.24 It can bring stress, fear, shame and guilt, as well as physical, emotional and psychological harm to the person who experiences it. Those inflicting the abuse may feel inadequate, hopeless and alone (Holt 2012; Kennair and Mellor 2007). A large proportion of those inflicting the abuse will themselves have been physically or sexually abused or have witnessed abuse.

## ***Public sector costs***

- 3.25 The public service burden of domestic abuse is considerable. A high proportion of women attending accident and emergency departments, primary care, family planning, reproductive and sexual health settings are likely to have experienced domestic violence and abuse at some point (Alhabib et al. 2010; Feder et al. 2009). In addition, between 25 and 56% of female psychiatric patients report experiencing domestic violence and abuse in their lifetime (Oram et al. 2013).

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3.26 Domestic violence and abuse cost the UK an estimated £15.7 billion in 2008 (Walby 2009). This included:

- just over £9.9 billion in 'human and emotional' costs
- more than £3.8 billion for the criminal justice system, civil legal services, healthcare, social services, housing and refuges
- more than £1.9 billion for the economy (based on time off work for injuries).



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## 4 Considerations

The Programme Development Group (PDG) took account of a number of factors and issues when developing the recommendations, as follows. Please note: this section does **not** contain recommendations (see [Recommendations](#).)

### *General*

- 4.1 The PDG agreed that domestic violence and abuse occurs in all communities.
- 4.2 The PDG was clear that both women and men can experience domestic violence in heterosexual and same sex relationships. The likelihood of ever experiencing a physical assault from a partner or adult family member is higher among heterosexual women than men. Moreover, heterosexual women experience more repeated physical violence, more severe violence, much more sexual violence, more coercive control, more injuries and more fear of their partner than heterosexual men.
- 4.3 Although domestic violence and abuse research and services mainly focus on intimate partners, this type of violence and abuse takes many forms. Examples include: [forced marriage](#), violence connected to '[honour](#)', violence against adults by their children, abuse of older people and other intra-familial abuse. However, evidence of effective interventions in these areas is lacking.
- 4.4 The PDG recognised the important role that the experiences, views and preferences of those who have experienced domestic violence should have in the development of policy and services. However, it did not hear evidence from them directly; this was largely outside the scope of the evidence reviews due to a focus on evaluation of interventions and the quality appraisal system used. However, the PDG did receive very helpful expert evidence and reports from people working in the specialist domestic violence sector and directly with service users. Such organisations were also represented by PDG members.
- 4.5 The PDG agreed that, rather than use the terms 'victim' or 'survivor', the Group would refer to 'people who have experienced domestic violence and abuse'.

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- 4.6 The PDG thought it likely that domestic violence and abuse services could also benefit the extended family and friends of people who directly experience domestic violence and abuse. However, these effects have not been studied.
- 4.7 The PDG was aware that much of the expertise and support for people who experience domestic violence and abuse lies in the voluntary and community sector, where funding and capacity is generally limited.
- 4.8 The PDG was aware that domestic violence and abuse is often one of several problems that a couple or family may face. For example, it may be combined with poverty, drug and alcohol misuse or mental health problems. Most of the evidence relates to male violence against women and children in heterosexual relationships. However, the PDG noted that domestic violence and abuse affects: bisexual, gay, lesbian and trans relationships, and reconstituted (or step) and more complex families. In such cases, the Group noted that people may face particular barriers to accessing support and may have specific needs.

### ***Children who are affected by domestic violence and abuse***

- 4.9 The PDG recognised the wide range of ill-effects that exposure to domestic violence and abuse can have on children and young people, including the effect on their social, emotional, psychological and educational wellbeing and development. It also recognised that providing effective interventions and support may reduce the likelihood of them being affected by, or perpetrating, domestic violence and abuse in adulthood.
- 4.10 The PDG noted the importance of working concurrently with both the non-abusive parent or carer and child, rather than just focusing on the parent. Research on the effectiveness of parent/carer-child interventions has focused exclusively on mothers. Given the profile of domestic violence and abuse, that is where the biggest need for services is likely to be, but provision is needed for all families. The PDG agreed that evaluation of programmes where the father is the non-abusive carer will be especially important in light of the current lack of evidence about effective interventions.

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- 4.11 The PDG noted that domestic violence and abuse – and children's exposure to it – often continues beyond the end of the adults' relationship.
- 4.12 The evidence linking effectiveness to the length of interventions for children is unclear. But it appears that longer interventions are more effective. This may be particularly true in complex cases.
- 4.13 The PDG did not consider evidence on the timeliness of interventions for children, but the Group was aware of a developing body of literature in this area.
- 4.14 The PDG noted the importance of ensuring services are appropriate to the age, gender and developmental stage of the child or young person. For example, teenagers may not want to be seen at the same time as their non-abusive parent or carer.

### ***Identifying domestic violence or abuse***

- 4.15 The PDG was aware that there is an ongoing debate about the effectiveness and desirability of screening, routine and targeted enquiries to identify people who are experiencing domestic violence and abuse. Currently there is insufficient evidence to recommend screening or routine enquiry in healthcare settings. Nevertheless, the PDG recognised that asking patients routinely about abuse in some specialised health care settings was considered good practice by professionals in those fields. The PDG acknowledged that people experiencing domestic violence and abuse may choose not to disclose it when asked by a healthcare or other professional. Or, if they do disclose, they do not want to be pressurised to give more details of the abuse or take a specific course of action (Feder 2006).
- 4.16 The PDG noted that healthcare professionals not trained to identify domestic violence and abuse may mislabel and misdiagnose people's problems, leading to inappropriate plans or ineffective remedies. (For example, specialists may be ordering unnecessary and expensive investigations and GPs may be prescribing inappropriate anxiolytics and antidepressants.)

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## ***Specialist support, advocacy, advice and skill building***

- 4.17 There is no universally accepted understanding of what 'advocacy' means in the context of domestic violence and abuse. The PDG kept the term because it has been applied to a range of interventions that have been evaluated in research studies. A definition of advocacy was agreed for the purposes of this guidance.
- 4.18 The PDG noted that skill-building approaches might be of particular use in refuge settings, although they are also an intrinsic part of the advocacy and support role.

## ***Programmes for people who perpetrate domestic violence and abuse***

- 4.19 There is a lack of consistent evidence on the effectiveness of programmes for people who perpetrate domestic violence and abuse. The PDG noted that some evaluations take account of the partner's health and wellbeing and include their perception of any changes in the perpetrator's behaviour. However, these tend to be small-scale, uncontrolled studies.
- 4.20 The cost effectiveness analyses concluded that interventions with people who have experienced domestic violence and abuse are likely to be cost effective. However, this conclusion could not be extrapolated to interventions with perpetrators and the PDG was split on whether interventions with perpetrators should be recommended. However, members agreed that such interventions are an important part of domestic violence and abuse services and, provided they are supported by robust evaluation to inform future commissioning decisions, should be recommended.
- 4.21 The PDG noted that national programmes dealing with behaviour-change among perpetrators are aimed at heterosexuals. Members were unclear whether or not these programmes would also be effective for other groups.

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## **Prevention**

- 4.22 Members of the PDG (and stakeholders) were disappointed that the review did not find sufficient evidence to make recommendations on primary prevention programmes. This was partly because it looked only at health and social care – and currently most primary prevention interventions are delivered in education settings. However, the PDG agreed that prevention is an important area for future research (see [Recommendations for research](#)).

## **Training**

- 4.23 The PDG discussed the relationship between training to support people affected by domestic violence and abuse and child safeguarding training. Overall, members agreed that there were obvious links between them. However, they did not necessarily think they should be combined. Members recommended that this question should be addressed in future research (see [Recommendations for research](#)).

## **Health economics**

- 4.24 The economic modelling showed that effectiveness and cost-effectiveness in the medium to long term was less certain than in the shorter term. This was partly due to the short follow-up period applied to the studies used as the basis of the model. It was also due to the lack of longitudinal studies. However, even using conservative assumptions, it seems likely that the interventions will be cost-effective in the long term by stopping the violence and improving the mental health of all those involved.
- 4.25 The PDG was aware that lack of evidence about the medium- and long-term consequence of interventions meant the economic models would underestimate their cost effectiveness. For example, a reduction in the incidence of post-trauma-related stress disorder is likely to lead to additional benefits, such as being less depressed or having improved self-esteem. However, limited data on these benefits meant they could not be estimated in the model.

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- 4.26 Although the systematic review of cost-effectiveness studies only found one analysis (Devine 2012) and the [economic modelling](#) focused on 2 interventions, the findings are also relevant for interventions with similar benefits and similar (or lower) costs. The PDG noted that the potential health and non-health benefits of these interventions would outweigh the costs when the positive impacts on people experiencing the violence and abuse, their families and wider society were considered.

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## 5 Recommendations for research

The Programme Development Group (PDG) recommends that the following research questions should be addressed. It notes that 'effectiveness' in this context relates not only to the size of the effect, but also to cost effectiveness and duration of effect. It also takes into account any harmful or negative side effects.

- 5.1 How effective are programmes that aim to prevent domestic violence and abuse from ever happening in the first place? This includes media-based public health awareness campaigns. It also includes social movements to establish people's rights, and community-building and primary prevention activities that tackle underlying assumptions in society. (Examples of the latter might include the role and status of women.)
- 5.2 How effective are combinations of interventions to deal with domestic violence and abuse in the short, medium and long term? Are the outcomes sustainable and do they have a beneficial effect on quality of life and health in the longer term?
- 5.3 How effective are the following interventions in the short, medium and long term, across various levels of risk and including diverse and marginalised groups:
  - [advocacy](#)
  - domestic abuse recovery programmes
  - perpetrator programmes
  - psychological or social interventions modified for domestic violence and abuse, including programmes for those who have suffered multiple forms of abuse and those who are still experiencing it
  - interventions for primary carers apart from mothers (for example, fathers, grandparents)
  - interventions for other family members?

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- 5.4 What are the most appropriate ways to collect and manage data about domestic violence and abuse across the health, social care and criminal justice sectors? Is there value in collecting anonymised aggregate data, or is there a more useful method of data capture?
- 5.5 What type of interventions (including training and referral pathways), in diverse health care settings, provide the most effective support for practitioners working with people who are experiencing, or have experienced, domestic violence and abuse?

More detail identified during development of this guidance is provided in [Gaps in the evidence](#).



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## 6 Related NICE guidance

- [Common mental health disorders](#). NICE clinical guideline 123 (2011)
- [Depression in adults \(update\)](#). NICE clinical guideline 90 (2009)
- [Alcohol dependence and harmful alcohol use](#). NICE clinical guideline 115 (2011)
- [Pregnancy and complex social factors](#). NICE clinical guideline 110 (2010)
- [Looked-after children and young people](#). NICE public health guidance 28 (2010)
- [Alcohol-use disorders: preventing harmful drinking](#). NICE public health guidance 24 (2010)
- [When to suspect child maltreatment](#). NICE clinical guideline 89 (2009)
- [Antisocial personality disorder](#). NICE clinical guideline 77 (2009)
- [Antenatal care](#). NICE clinical guideline 62 (2008)
- [Antenatal and postnatal mental health](#). NICE clinical guideline 45 (2007)
- [Postnatal care](#). NICE clinical guideline 37 (2006)
- [Post-traumatic stress disorder \(PTSD\)](#). NICE clinical guideline 26 (2005)

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## 7 Glossary

### ***Advocacy***

In general, advocacy for people who have experienced domestic violence includes:

- legal, housing and financial advice
- access to and use of community resources such as [refuges](#), emergency housing and psychological interventions
- [safety planning](#) advice.

The activities may differ according to the level of risk facing the person. Crisis advocacy involves working with the person for a limited period of time (they may then be referred on to more specialised agencies).

Practitioners providing advocacy can also provide ongoing support and informal counselling. The intensity of the advocacy provided may vary. It may last for a year – or longer, if the person is particularly vulnerable.

### ***Coercive behaviour***

Coercive behaviour is an act, or a pattern of acts, involving assault, threats, humiliation and intimidation or other abuse, to harm, punish or frighten someone. This includes so-called 'honour'-based violence and forced marriage. People who experience domestic violence can be male or female and from any ethnic group. (Home Office [2012] [Ending violence against women and girls in the UK](#) [accessed 6 November 2012].)

### ***Controlling behaviour***

Controlling behaviour involves a range of acts designed to make a person subordinate or dependent. This could range from isolating them from sources of support to exploiting them for personal gain. It can also involve depriving them of the means to be independent, including stopping them from leaving and regulating their everyday behaviour. (Home Office [2012] [New definition of domestic violence](#), 18 September 2012).

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## ***Children and young people affected by domestic violence and abuse***

Children (aged under 16) and young people (aged 16 to 18) can experience domestic violence and abuse:

- when they are affected by it; this includes fearing, hearing or seeing it within their families, or worrying about its effects on someone else
- within their own intimate relationships.

Young people may also perpetrate domestic violence and abuse in their own intimate relationships and on their parents or carers.

### ***Disclosure***

For the purpose of this guidance, disclosure is defined as any occasion when an adult or child who has experienced or perpetrated domestic violence or abuse informs a health or social care worker or any other third party.

### ***Domestic violence and abuse***

The term 'domestic violence and abuse' is used to mean: 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 are family members. This includes: psychological, physical, sexual, financial and emotional abuse. It also includes 'honour'-based violence and forced marriage. For the purposes of this document, it does not include female genital mutilation, which may be referred to NICE as a future topic.

### ***Elder abuse or maltreatment***

Action or neglect, within a relationship in which there is an expectation of trust, that causes harm or distress to a person older than 60. The abuse can take various forms: physical, verbal, psychological, sexual and financial.

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## ***Floating support***

In the context of this guidance, floating support is a housing service designed to prevent tenancy breakdowns. Floating support can also provide help with:

- keeping safe and security measures
- accessing legal advice and options
- welfare benefits
- budgeting and debts
- life skills
- resettlement or re-housing
- accessing community services
- form filling
- pre-tenancy support
- training, education and employment

## ***Forced marriage***

A forced marriage is one in which one or both spouses do not (or, in the case of some adults with learning or physical disabilities, cannot) consent to the marriage but are forced into it using physical, psychological, financial, sexual or emotional pressure. ('Handling cases of forced marriage', HM Government 2008). It is distinct from an arranged marriage that both partners enter into freely.

## ***'Honour'-based violence or 'honour' violence***

A crime or incident committed (or possibly committed) to protect or defend the perceived 'honour' of a family or community. Often this term is enclosed in quote marks, or prefaced with 'so-called', to emphasise that the concept of honour in these cases is contested and that it is generally invoked as a means of power and control.

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## ***Independent domestic violence advisers (IDVAs)***

Also known as independent domestic violence advocates, IDVAs work primarily with people at high risk of domestic violence and abuse, independently of any one agency, to secure their safety and the safety of their children. Serving as the primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the options and develop plans that address their immediate safety, as well as longer-term solutions. In many areas they are funded by the local community safety partnership, in some areas they are funded by the police or local authorities.

### ***Indicators***

Indicators are presenting problems or conditions that are associated with domestic violence and abuse. They can include:

- symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders
- suicidal tendencies or self-harming
- alcohol or other substance use
- unexplained chronic gastrointestinal symptoms
- unexplained reproductive symptoms, including pelvic pain and sexual dysfunction
- adverse reproductive outcomes, including multiple unintended pregnancies or terminations, delayed pregnancy care, miscarriage, premature labour and stillbirth
- unexplained genitourinary symptoms, including frequent bladder or kidney infections
- vaginal bleeding or sexually transmitted infections
- chronic pain (unexplained)
- traumatic injury, particularly if repeated and with vague or implausible explanations
- problems with the central nervous system – headaches, cognitive problems, hearing loss
- repeated health consultations with no clear diagnosis

- intrusive 'other person' in consultations including partner or husband, parent, grandparent or an adult child (for elder abuse).

(Adapted from Black 2011.)

## ***Multi-agency risk assessment conferences (MARACs)***

Regular meetings at which information about people experiencing domestic violence or abuse and who are at high risk (those at risk of homicide or serious harm) is shared between local agencies. Whenever possible, the person who experiences the violence is represented by an independent domestic violence adviser or advocate (IDVA). Participants aim to draw up a coordinated safety plan to support the person. In many areas they are funded by the local community safety partnership, in some areas they are funded by the police or local authorities.

## ***No recourse to public funds***

'No recourse to public funds' is a term used for people who are not entitled to welfare benefits, home office asylum support, public housing and other public funds and services. The term derives from the 'no recourse to public funds' condition applied to certain immigration statuses. 'Public funds' refers to a range of benefits including housing support, carer's allowance, child benefit, disability living allowance, housing benefit, income support and social fund payments.

## ***Parenting support***

Interventions that aim to improve parents' understanding of how domestic violence and abuse affects children and how to protect them. Most of the interventions found to be effective focus on non-abusive mothers and on strengthening the mother–child bond.

## ***People who experience domestic violence and abuse***

Throughout this guidance, 'people who experience domestic violence and abuse' refers to those who are victims or survivors of the violence and abuse.

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## ***Protected characteristics***

The Equality Act (2010) makes it illegal to discriminate against anyone because of:

- age
- being or becoming a transsexual person
- being married or in a civil partnership
- being pregnant or having a child
- disability
- race including colour, nationality, ethnic or national origin
- religion, belief or lack of religion/belief
- sex
- sexual orientation.

These are called 'protected characteristics'.

## ***Refuge or shelter***

Residential service – a safe house – provided for adults (usually women) and children who are experiencing domestic violence and abuse.

## ***Risk identification and assessment***

This process is undertaken with people who have disclosed that they are the victims of domestic violence and abuse. The aim is to evaluate their risk of further harm. Practitioners with level 2 training assess their immediate safety, for example, whether it is safe for the person to go home. Practitioners with level 3 training identify the risks faced in more detail to inform safety planning, referrals to specialist support services and to aid any police investigation. Almost all police forces in England and Wales use the [DASH](#) (domestic abuse, stalking and harassment and 'honour'-based violence) risk identification tool and guidance. A multi-sectoral version, [CAADA-DASH](#), is used by independent domestic violence advisers, some domestic violence advocates and

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support workers, other specialist domestic abuse services and some health and social care practitioners.

## ***Safety planning***

An intervention to help people judge their risk of violence, identify the warning signs and develop plans on what to do when violence is imminent or is happening.

## ***Skill building***

Training and education to improve the skills of people who have experienced domestic violence and abuse. Typically it covers: problem solving and decision making, resilience and coping, financial skills, and understanding the dynamics of domestic violence and abuse. Sometimes it also includes other components; for example, relaxation and parenting skills.

## ***Therapy***

A structured psychological or psychiatric treatment delivered by professional clinicians, such as psychologists. Therapeutic interventions may be delivered in an individual or group format.

## ***Trans people***

Trans is an umbrella term. It includes cross-dressers, transgender and transsexual people as well as anyone else who is in any way gender-variant.



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## 9 Summary of the methods used to develop this guidance

### *Introduction*

The review and economic modelling report include full details of the methods used to select the evidence (including search strategies), assess its quality and summarise it.

The minutes of the Programme Development Group (PDG) meetings provide further detail about the Committee's interpretation of the evidence and development of the recommendations.

All supporting documents are listed in [About this guidance](#).

### *Guidance development*

The stages involved in developing public health guidance are outlined in the box below.

1. Draft scope released for consultation
2. Stakeholder meeting about the draft scope
3. Stakeholder comments used to revise the scope
4. Final scope and responses to comments published on website
5. Evidence reviews and economic modelling undertaken and submitted to PDG
6. PDG produces draft recommendations
7. Draft guidance (and evidence) released for consultation and for field testing
8. PDG amends recommendations
9. Final guidance published on website
10. Responses to comments published on website

### *Key questions*

The key questions were established as part of the scope. They formed the starting point for the reviews of evidence and were used by the PDG to help develop the recommendations. The overarching questions were:

1. What types of intervention or approach are effective and cost effective in preventing domestic violence from ever happening in the first place (that is, primary prevention)?
2. What types of intervention or approach are effective and cost effective in helping all those working in health and social care to safely identify and, if appropriate, intervene to prevent domestic violence? Examples may include collaborative partnerships, advice and information-sharing protocols and specialised training, both on-the-job and pre-entry.
3. What types of intervention or approach are effective and cost effective in helping all those working in health and social care to respond to domestic violence? This may include interventions and approaches to assess and improve someone's safety, reduce the risk of harm, support their recovery and prevent a perpetrator reoffending. It may also include collaborative partnerships and advice and information-sharing protocols.
4. What types of intervention and approach are effective and cost effective in identifying and responding to children who are exposed to domestic violence in the various settings identified? (That is, the violence is not perpetrated on them directly but they witness or experience it.) Interventions could include collaborative partnerships and advice and information-sharing protocols.
5. What are the most effective and cost-effective types of partnership and partnership approaches for assessing and responding to domestic violence?

These questions were made more specific for the review (see [review](#) for further details).

## ***Reviewing the evidence***

### **Effectiveness reviews**

One review of effectiveness was conducted.

### **Identifying the evidence**

A number of databases were searched in May 2012 for randomised controlled trials (RCT), case-control studies, interrupted time series, cohort studies, cross-sectional studies, observational studies, systematic reviews and qualitative studies. See the [review](#) for details of the databases searched.

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A range of websites were searched manually for relevant grey literature.

In addition, the citation lists of all studies included in the review were searched and PDG members provided and discussed key literature 'virtually' with the external contractor. NICE also issued a call for evidence.

## Selection criteria

Studies from countries in the Organisation for Economic Co-operation and Development (OECD) were included in the effectiveness review if they:

- evaluated an intervention or approach to identify, prevent, reduce or respond to domestic violence and abuse between adults and young people who were, or had been, intimate partners
- evaluated an intervention or approach to identify, prevent, reduce or respond to the abuse of older people by a family member
- focused on healthcare, social care or specialised services that deal with domestic violence and abuse.

Studies were excluded if they:

- focused on children who directly experienced domestic violence and abuse and perpetrators whose violence is directed at children
- focussed on female genital mutilation, violence perpetrated against older vulnerable people by paid carers or violence in occupational settings
- included interventions not linked to health and social care.

See the [review](#) for details of the inclusion and exclusion criteria.

## Quality appraisal

Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in [Methods for the development of NICE public health guidance](#). Each study was graded (++, +, -) to reflect the risk of potential bias arising from its design and execution. Studies graded (-) were excluded from the review.

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## Study quality

++ All or most of the checklist criteria have been fulfilled. Where they have not been fulfilled, the conclusions are very unlikely to alter.

+ Some of the checklist criteria have been fulfilled. Those criteria that have not been fulfilled, or not adequately described, are unlikely to alter the conclusions.

– Few or no checklist criteria have been fulfilled. The conclusions of the study are likely or very likely to alter.

The evidence was also assessed for its applicability to the areas (populations, settings, interventions) covered by the scope of the guidance. Each evidence statement concludes with a statement of applicability (directly applicable, partially applicable, not applicable).

## Summarising the evidence and making evidence statements

The review data were summarised in evidence tables (see [full review](#)).

The findings from the review and expert reports were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements were prepared by the external contractors (see [About this guidance](#)). The statements reflect their judgement of the strength (quality, quantity and consistency) of evidence and its applicability to the populations and settings in the scope.

## *Cost effectiveness*

There was a systematic review of economic evaluations and an economic modelling exercise.

### Review of economic evaluations

A search was undertaken using a search strategy developed by the review team. Studies were included if they focused on:

- full economic evaluations of relevant types of intervention
- high quality costing studies relevant to the UK.



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Studies were categorised according to study type, methodological rigour and quality.

## **Economic modelling**

A number of assumptions were made that could underestimate or overestimate the cost effectiveness of the interventions (see [review modelling report](#) for further details).

Economic models were constructed to incorporate data from the reviews of effectiveness and cost effectiveness. The results are reported in: [Economic analysis of interventions to reduce the incidence and harm of domestic violence and abuse](#).

## **Fieldwork**

Fieldwork was carried out to evaluate how relevant and useful NICE's recommendations are for practitioners and how feasible it would be to put them into practice.

It was conducted with commissioners and practitioners, including directors of public health and mental health and substance misuse services who are involved in domestic violence and abuse services. They included: commissioners, primary and secondary health care professionals, police officers, public health specialists, specialist domestic violence staff and other representatives from local authorities and voluntary sector groups.

The fieldwork comprised:

- 10 focus groups and 20 in-depth interviews carried out in Birmingham, Bristol, Liverpool and London by Word of Mouth.

The 10 focus groups and 20 in-depth interviews were commissioned to ensure there was ample geographical coverage. The main issues arising are set out in section 10 under [fieldwork findings](#). Or see [Field testing NICE guidance on domestic violence and abuse: how social care, health services and those they work with can identify, prevent, and reduce domestic violence](#).

## **How the PDG formulated the recommendations**

At its meetings in 2012/3 the Programme Development Group (PDG) considered the evidence, expert reports and cost effectiveness to determine:

- 
- whether there was sufficient evidence (in terms of strength and applicability) to form a judgement
  - where relevant, whether (on balance) the evidence demonstrates that the intervention or programme/activity can be effective or is inconclusive
  - where relevant, the typical size of effect (where there is one)
  - whether the evidence is applicable to the target groups and context covered by the guidance.

The PDG developed recommendations through informal consensus, based on the following criteria:

- Strength (type, quality, quantity and consistency) of the evidence.
- The applicability of the evidence to the populations/settings referred to in the scope.
- Effect size and potential impact on the target population's health.
- Impact on inequalities in health between different groups of the population.
- Equality and diversity legislation.
- Ethical issues and social value judgements.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of harms and benefits.
- Ease of implementation and any anticipated changes in practice.

Where evidence was lacking, the PDG also considered whether a recommendation should only be implemented as part of a research programme.

Where possible, recommendations were linked to an evidence statement(s) (see [The evidence](#) for details). Where a recommendation was inferred from the evidence, this was indicated by the reference 'IDE' (inference derived from the evidence).

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## 10 The evidence

The evidence statements from 1 review are provided by an external contractor (see [Evidence](#)). This section lists how the evidence statements and expert reports link to the relevant recommendations and sets out a brief summary of findings from the economic analysis and the fieldwork.

The evidence statements are short summaries of evidence, in a review, report or paper (provided by an expert in the topic area). Each statement has a short code indicating which document the evidence has come from. The letters in the code refer to the type of document the statement is from, and the numbers refer to the document number, and the number of the evidence statement in the document.

Evidence statement number 1 indicates that the linked statement is numbered 1 in the review 'Review of interventions to identify, prevent, reduce and respond to domestic violence and abuse'. Evidence statement ER1 indicates that the evidence is in the expert report 1 'Current health and social care interventions on domestic violence and abuse'.

The [review, expert reports and economic analysis](#) are available online. Where a recommendation is not directly taken from the evidence statements, but is inferred from the evidence, this is indicated by IDE (inference derived from the evidence).

- Recommendation 1: ER1
- Recommendation 2: evidence statement 30–33
- Recommendation 3: evidence statements 30–33
- Recommendation 4: evidence statements 9, 30–33
- Recommendation 5: evidence statements 3, 8, 9; ER2–5
- Recommendation 6: evidence statements 11–14
- Recommendation 7: evidence statements 3, 33
- Recommendation 8: evidence statements 8–10, 31
- Recommendation 9: evidence statement 33; ER2–5

- Recommendation 10: evidence statements 8, 9, 30–33
- Recommendation 11: evidence statements 27–29
- Recommendation 12: evidence statements 10–12, 27, 28
- Recommendation 13: evidence statements 13, 14
- Recommendation 14: evidence statements 15, 17; ER2
- Recommendation 15: evidence statements 8–10, 30
- Recommendation 16: evidence statements 8,9, 31–33
- Recommendation 17: evidence statements 8, 9, 30

## ***Review of economic evaluation***

Two papers were included in the review. These reported findings from a pilot intervention to prevent domestic violence (Norman et al. 2010) and a cluster RCT of the intervention (Devine et al. 2012). This multi-faceted intervention included: education of doctors about domestic violence and abuse; improved cross-system collaboration; use of electronic prompts for doctors to ask about intimate partner violence; use of prompts to encourage doctors to refer people who have experienced domestic violence to domestic violence and abuse advocates and to psychologists.

Moderate evidence from the UK perspective suggested that the interventions were cost effective, with an incremental cost–effectiveness ratio of £2450 when an additional quality-adjusted life year was valued at £20,000.

## ***Economic modelling***

Two interventions were modelled: the use of independent domestic violence services and cognitive trauma therapy for battered women.

Overall, the independent domestic violence adviser service intervention was found to be cost saving (that is, it both saves resources and improves quality of life) compared with no intervention. The overall message is that the cost of domestic violence and abuse is so significant that even marginally effective interventions are cost effective.

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Cognitive trauma therapy for battered women saved £15 million by reducing the harm from domestic violence, compared with no intervention.

The results are subject to uncertainty and assumptions made in both models.

The key assumptions were explored in a series of sensitivity analyses. These analyses demonstrated that the interventions are cost effective, even when the costs and effects of the interventions varied.

Full details can be found in the [Economic analysis of interventions to reduce the incidence and harm of domestic violence and abuse](#).

## ***Fieldwork findings***

Fieldwork aimed to test the relevance, usefulness and feasibility of putting the recommendations into practice. The PDG considered the findings when developing the final recommendations. For details, go to [Fieldwork](#) and [Field testing NICE guidance on domestic violence and abuse: how social care, health services and those they work with can identify, prevent, and reduce domestic violence](#).

Fieldwork participants who come into contact with people who experience, or perpetrate, domestic violence and abuse were fairly positive about the recommendations and their potential to help identify, prevent and reduce this violence and abuse.

Many welcomed the holistic (multi-agency and multi-sector) approach and the comprehensive scope of the guidance (covering everything from strategy development to service delivery). The inclusion of a key role for public health – including NHS services – was especially welcomed, because participants felt that domestic violence and abuse has not been seen as a priority by the health sector in the past.

If the recommendations are implemented, participants felt that the overall standard of domestic violence and abuse service provision was likely to improve. (According to participants, current provision varies by locality, due to the uncertain and short-term nature of funding arrangements.)

However, recent changes in the commissioning of health and social care services were reported to have created confusion, with many participants saying that it is difficult to identify the relevant

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commissioners in their area. Some suggested that the guidance should more clearly identify accountable agencies and partnerships.

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## 11 Gaps in the evidence

The Programme Development Group (PDG) identified a number of gaps in the evidence related to the programmes under examination, based on an assessment of the evidence and expert comment. These gaps are set out below.

1. There is a lack of research on:

a) working with men who experience domestic violence and abuse

b) 'honour'-based violence or forced marriage

c) interventions to prevent elder abuse

d) lesbian, gay, bisexual and trans people's experiences of domestic violence and abuse

e) the differences in outcomes of interventions for women and men

f) dating violence and intimate partner violence among adolescents

g) tailored approaches for women facing different levels of risk

h) whole-family interventions in response to domestic violence

i) violence and abuse directed at parents, carers or siblings by children and young people

j) stalking.

2. There is a lack of evidence on identifying people affected by domestic violence or abuse in social care settings and integrated approaches to identifying people across various health and social care settings. There is also a lack of evidence on integrated approaches to identifying coexisting issues, such as the links between domestic violence and substance use or mental health issues.

3. There is a lack of evidence on prevention interventions due to methodological issues including: short follow up, lack of comparisons of different interventions, lack of behavioural

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measures and reliance on self-reporting. In addition, most studies measured attitudes and knowledge, or exposure to educational materials and messages, rather than behavioural outcomes. Many included women who were already using refuge or shelter services, so the findings may not be applicable to those who are not using them.

4. There is a lack of large, robust studies of advocacy, skill development, counselling and other therapeutic approaches for people who have experienced domestic violence or abuse.

5. There is a lack of large, robust studies of interventions for people who perpetrate abuse. The majority were non-experimental (primarily before-and-after studies). Often they did not include a comparison group, had relatively small sample sizes, reported high rates of attrition and lacked follow up beyond programme completion.

6. There is a lack of high quality studies measuring the effects of multi-faceted and multi-sectorial approaches to the prevention of domestic violence. The majority were before and after, or qualitative studies providing narrative reports. Methodological weaknesses included: scant information on data collection, methods and analysis and small sample size (particularly for qualitative studies).

7. There is a lack of research on the impact of partnership working among agencies serving men or a range of subgroups of women experiencing violence. No studies discussed the effectiveness of partnership working for lesbian women who experience domestic violence.

The Committee made 4 recommendations for research into areas that it believes will be a priority for developing future guidance. These are listed in Recommendations for research.



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## 12 Membership of the Programme Development Group (PDG) and the NICE project team

### *Programme Development Group*

PDG membership is multidisciplinary. The Group comprises public health practitioners, clinicians, local authority officers, teachers, social care practitioners, representatives from the voluntary sector and the public, and academics and technical experts as follows.

**Gene Feder** (Chair)

Professor of Primary Health Care, University of Bristol

**Zlakha Ahmed**

Chief Executive, Apna Haq Ltd

**Rahila Ameen**

Integrated Domestic Abuse Programme Facilitator, London Probation Trust

**Diana Barran**

Chief Executive, Co-ordinated Action Against Domestic Abuse

**Susan Bewley**

Honorary Professor of Complex Obstetrics, King's College London (coopted to PDG in meeting 9)

**Bushara Bostan**

Health Improvement Specialist, NHS Leeds

**Adrian Boyle**

Consultant Emergency Physician, Addenbrookes Hospital and Honorary Visiting Senior Research Fellow, Cambridge University

**Lori Busch**

Charity Manager, The ManKind Initiative

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**Sarah Byford**

Professor of Health Economics, King's College London.

**Linda Davies**

Independent Domestic Abuse Training Consultant, Cheshire East and West

**Chris Green**

Executive Director, White Ribbon Campaign

**Marianne Hester**

Professor of Gender, Violence & International Policy and Head of Centre for Gender and Violence Research, University of Bristol

**Louise M Howard**

Professor in Women's Mental Health, King's College London

**Davina James-Hanman**

Director, AVA (Against Violence & Abuse)

**Jane Lewis**

Director of Implementation Support, The Colebrooke Centre for Evidence and Implementation

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Consultant and Reader in Forensic Psychiatry, St George's, University of London

**Maureen Noble**

Independent Consultant – Safeguarding and Public Protection

**Federico Podeschi**

Chief Executive, Broken Rainbow UK

**Pamela Richardson**

Chief Executive, Women's Aid Leicestershire Ltd

**Amanda Robinson**

Reader in criminology, Cardiff University

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**Hannana Siddiqui**

Policy, Research and Fundraising Manager, Southall Black Sisters (co-opted in meeting 11)

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Professor of Social Work, University of Central Lancashire

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## 13 About this guidance

### *Why has this guidance been produced?*

In 2008, the Department of Health (DH) asked the National Institute for Health and Care Excellence (NICE) to produce guidance on how to identify, prevent and reduce domestic violence and abuse. (See the [scope](#).)

The PDG felt that the review did not find sufficient evidence for them to make recommendations on primary and secondary prevention programmes. This was partly because it looked only at health and social care settings and most primary prevention interventions are delivered in education settings.

There were other measures and interventions for which no evidence, or insufficient evidence, was identified. Their absence from the recommendations is a result of this lack of evidence and should not be taken as a judgement on whether they are effective.

Violence and abuse can be perpetrated on children by adults ('child abuse'), but that is not dealt with in this guidance. NICE has produced guidance on [child maltreatment](#).

### *How was this guidance developed?*

This guidance was developed jointly by NICE and the Social Care Institute for Excellence (SCIE). SCIE provided particular input into discussions about what the guidance should cover.

The recommendations are based on the best available evidence. They were developed by the Programme Development Group (PDG).

Members of the PDG are listed in [Membership of the Programme Development Group and the NICE project team](#).

For information on how NICE public health guidance is developed, see the NICE [public health guidance process and methods guides](#).

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## ***What evidence is the guidance based on?***

The [evidence](#) the PDG considered included:

- evidence review
- review of economic evaluations and economic modelling
- expert reports
- fieldwork report.

In some cases the evidence was insufficient and the PDG has made recommendations for future research. See [Recommendations for research](#) and [Gaps in the evidence](#) respectively.

## ***Status of this guidance***

The draft guidance, including the recommendations, was released for consultation in August 2013. At its meeting in November 2013, the PDG amended the guidance in light of comments from stakeholders and experts and the fieldwork. The guidance was signed off by the NICE Guidance Executive in February 2014.

The guidance is available on NICE's website. The recommendations are also available in a [pathway](#) for professionals whose remit includes public health and for interested members of the public.

## ***Implementation***

NICE guidance can help:

- Commissioners and providers of NHS services to meet the quality requirements of the DH's [Operating framework for 2012/13](#). It can also help them to deliver against domain 1 of the [NHS outcomes framework](#) (preventing people from dying prematurely).
- Local health and wellbeing boards to deliver on their requirements within [Healthy lives, healthy people](#) (2010).

- Local authorities, NHS services and local organisations determine how to improve health outcomes and reduce health inequalities during the joint strategic needs assessment process.

NICE has developed [tools](#) to help organisations put this guidance into practice.

All healthcare professionals should ensure people have a high quality experience of the NHS by following NICE's recommendations in [Patient experience in adult NHS services](#).

All health and social care providers working with people using adult NHS mental health services should follow NICE's recommendations in [Service user experience in adult mental health](#).

## ***Updating the recommendations***

This guidance will be reviewed 3 years after publication to determine whether all or part of it should be updated. Information on the progress of any update will be posted on the [NICE website](#).

## ***Your responsibility***

This guidance represents the views of the Institute and was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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