

Dalli



THE DALLI TOOLKIT

Enhancing the identification and response
to domestic abuse for people living with a
life-limiting illness

Acknowledgements

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<https://ageingbetter.resourcespace.com/pages/home.php>

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Glossary of terms

ACP: Advance Care Plans help people to think how they wished to be cared for and the treatments they might or might not want in the final months of life.

ADRT: Advance Decision to Refuse Treatment, also known as a living will lets others know any wishes for refusing certain treatments in the future.

BAME/BAMER: Black, and Minority Ethnic or Black, Asian, Minority, Ethnic and Refugee.

Domestic Abuse: also known as domestic violence or intimate partner violence, is a pattern of behaviour within a relationship that is used to gain power and control. It encompasses physical, sexual, emotional, financial, or psychological actions. Anyone can be a victim of domestic abuse regardless of their background.

Domestic Abuse Champion: a lead for domestic abuse within an organisation who acts as a point of contact for staff to provide advice and emotional support.

HRDA: High Risk Domestic Abuse meetings

IDVA: Independent Domestic Violence Advisor (or Advocate).

IMCA: Independent Mental Capacity Advocate.

LGBTQ+: Lesbian, Gay, Transgender and Queer or questioning their sexual identity (the + stands for intersex and other).

Life-limiting illness (LLI): condition where life expectancy is shortened as a direct consequence of the illness.

LPA: Lasting Power of Attorney is a legal document in which someone gives another person the right to make decisions. There are two types, one is for health and welfare and the other for property and financial affairs.

MARAC: Multi Agency Risk Assessment Conference is a meeting where information is shared on high-risk cases of domestic abuse including representatives from the police, housing, Independent Domestic Violence Advisors, health, child and adult protection. The MARAC aims to produce a safeguarding plan.

MASH: Multi Agency Safeguarding Hubs.

MCA: Mental Capacity Act is designed to protect and empower people who are unable to make their own decisions about their care and treatment.

MDT: Multi-disciplinary team of health and care practitioners working together to plan and implement care.

Multi-agency: professionals from a range of organisations work together.

Perpetrator: a person who carries out a harmful act or acts which are defined as domestic abuse under the Domestic Abuse Act (2021).

Practitioner: those working in a professional capacity with those with life-limiting illnesses.

Safeguarding: a process in place within organisations to protect individuals' health, wellbeing and human rights and right to live free from harm.

Trauma-informed practice: is an approach that recognises when someone may be affected by trauma, and taking this into account, responds to it in such a way that supports recovery, does not cause further harm, and is sensitive to its dynamics in all aspects of service delivery.

Section 1: Toolkit Introduction

About this Toolkit

What is this Toolkit?

This Toolkit has been developed as a resource for health and social care practitioners working in hospice and palliative care and third sector organisations to inform and support them to identify and respond to domestic abuse experienced by those with life-limiting illnesses. The toolkit is designed to offer helpful information and practical suggestions that can be used flexibly in practice.

The Toolkit aims to improve knowledge and understanding of domestic abuse and provide practical guidance for those working in hospice and palliative care and third sector organisations to help them feel confident to respond to domestic abuse for those with a life-limiting illness (LLI) who are experiencing or at risk of abuse. The Toolkit offers suggestions that can be adapted by health and social care practitioners to better support people with a LLI. The Toolkit also aims to inform third sector and voluntary organisations about the specific challenges of domestic abuse and LLI combined.

“At the moment there isn’t a resource, so professionals could have anxiety ... There isn’t something that tells me what to do.”

(Healthcare practitioner)

While there are resources available to screen for domestic abuse and provide support¹, these are not always appropriate for meeting the particular needs of people with a LLI. Our research has not found an existing resource that addresses the specific and complex needs of people with a LLI affected by domestic abuse or that helps practitioners to feel more confident in dealing with domestic abuse.

Who is this Toolkit for?

The Toolkit is aimed at those providing care and support to adults with a LLI from any background who may be affected by domestic abuse. This includes:

- Health and social care practitioners
- Managers and administrative staff
- Local authority teams
- Allied healthcare professionals
- Third sector organisations
- Volunteers

¹ Dewis Choice Resources available at: <https://dewischoice.org.uk/information-and-advice/resources-3/> (Accessed 4th August 2022)

How has the Toolkit been developed?

We undertook research as part of the Domestic Abuse and Life-Limiting Illness (DALLI) study to find out more about domestic abuse in the context of LLI and look into ways we could best support practitioners to care for those affected. We looked at existing domestic abuse research and found little had been carried out in the context of LLI. We also talked with practitioners to understand their priorities and what would help them to identify where domestic abuse may be happening for people with LLIs and how they can best manage the needs of this group. The practitioners suggested a Toolkit would be helpful to act as a guide to aid them to confidently ask about and respond to domestic abuse. To produce this Toolkit, we have worked with relevant stakeholders and organisations to help meet the particular and complex needs of people living with a LLI. We have tested and evaluated the Toolkit to help ensure that the resource will improve patient experience, health, and safety when it is used in practice.

How should I use this Toolkit?

This Toolkit is designed to comprehensively cover how to identify and respond to domestic abuse in the LLI context. It is designed to be used flexibly to meet differing needs and each section can stand alone or be used in conjunction with the others. For example, certain sections could be dipped into as needed or the Toolkit could help facilitate learning events or discussions within a team. Purple summary boxes are used to highlight key points for quick reference. The Toolkit also contains information on additional resources for further reading and information. The appendices contain useful guidance on risk assessments, referral pathways, enquiring about domestic abuse and what to do if you suspect domestic abuse.

The content of the Toolkit is correct at the time of writing.

How to use the Toolkit

The Toolkit is designed as an educational resource that will sit alongside, rather than replacing, existing organisational policies and procedures. Any queries or concerns about domestic abuse should be raised with your organisations safeguarding team.

Section 2: Domestic Abuse and Life-Limiting Illness

What is a life-limiting illness?

Life-limiting illness (LLI) is a term used to describe a condition that is not curable and expected to shorten a person's life and eventually result in their death. However, someone living with a LLI may continue to have an active life for many years before it progresses to the final or terminal stage, typically defined as the last 12 months of life². There are a wide range of LLIs and people who are living with these may have a single or number of conditions. These include:

- Incurable cancer
- Advanced heart disease
- Motor Neurone Disease (MND)
- Chronic Obstructive Pulmonary Disease (COPD)
- Neurological conditions (e.g., Parkinson's Disease, Multiple Sclerosis)
- Dementia (including Alzheimer's)
- End-stage organ failure such as renal and heart

Current evidence suggests that one person in the UK dies every minute and that over the next 25 years, this number will increase with around 100,000 more deaths per year. In 2020, 607,922 deaths were recorded in England and Wales³. Excluding those from COVID-19 which was the overall leading cause of death in this year, other causes of death included LLIs including dementia and Alzheimer's disease, ischaemic heart diseases, and chronic respiratory diseases⁴.

What is domestic abuse?

Domestic abuse is a significant worldwide health and societal issue⁵. Domestic abuse can affect anyone regardless of age, gender, ethnicity, culture, sexual orientation and socio-economic status. In England and Wales, it is estimated that for the year 2020, 2.3 million adults aged 16-74, experienced domestic abuse⁶. The majority of these are female, with women more likely than men to experience repeated and severe forms of abuse, or violence which results in injury or death by male perpetrators⁷.

In England and Wales, the Domestic Abuse Act (2021)⁸ defines domestic abuse as:

“a single incident or course of conduct perpetrated towards another person aged 16 or over who are, or have been, personally connected to each other through marriage, civil partnership, an intimate relationship, parental relationship to the same child; or are family members”.

² Department of Health (2008) End of life care strategy: promoting high quality care for all adults at the end of life. London: Department of Health, 2008.

³ Office for National Statistics. UK deaths for 2019 and 2020 (2021). Available at: <https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/ukdeathsfor2019and2020> (Accessed 4th August 2022)

⁴ Office for National Statistics. Leading causes of death (2021). Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationsummarytables/2020#leading-causes-of-death> (Accessed 4th August 2022)

⁵ World Health Organisation (2021). Available at: <http://www.who.int/mediacentre/factsheets/fs239/en/> (Accessed 4th August 2022)

⁶ Office for National Statistics. Domestic abuse in England and Wales overview: November 2021 (2021) Available at: www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2021 (Accessed 4th August 2022)

⁷ Bates L. et al. (2022) Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1013128/Domestic_homicides_and_suspected_victim_suicides_during_the_Covid-19_Pandemic_2020-2021.pdf (Accessed 4th August 2022)

⁸ Domestic Abuse Act 2021. Available at: <https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted> (Accessed 4th August 2022)

Domestic abuse is rarely a single incident and behaviours include:

- **Physical abuse**
- **Sexual abuse**
- **Psychological abuse**
- **Emotional abuse**
- **Economic/financial abuse**
- **Coercive or controlling behaviour**

This Toolkit focuses on adults with LLI who are at risk of or experiencing domestic abuse. However, it is important to note that under the Domestic Abuse Act (2021) children are automatically treated as victims in their own right regardless of whether they were present during abusive incidents. This enables them to access support like mental health and safeguarding services.

Domestic abuse and the co-existence of life-limiting illness

While domestic abuse is consistent across individuals and groups in society, some experience additional vulnerabilities and increased risk factors. This includes people living with a LLI. This is because they are often frail, isolated and dependent on others and more likely to spend long periods of time at home with the perpetrator who may also be their carer. This has intensified during COVID-19 where social restrictions and lockdown measures have led to increasing isolation, particularly the clinically vulnerable who were shielding thus trapped at home with the perpetrator and cut off from the respite typically available to them, such as the abuser going out to work. In addition, those experiencing abuse were less able to access specialist support services and their routes of escape to safety closed.

Having a LLI can change relationship dynamics and can worsen existing abuse. Perpetrators may feel jealous of the increased attention that the person with a LLI may receive and may no longer feel in control of a situation. A perpetrator may use the person's illness to increase power and control in the relationship and prevent them from accessing and seeking support from service providers, families and friends. Perpetrators may seek to increase the person's dependency on them and manipulate them, so they are reluctant or unable to escape the abusive situation. Real or perceived dependency on their carer may prevent a person living with a LLI from telling anyone about the abuse, or they may not recognise the behaviour as constituting abuse, or feel embarrassment, shame or self-blame. They may also worry about the repercussions of disclosing to someone such as the fear of moving into residential care.

Living with a LLI can result in someone becoming less able to care for themselves, increase their care needs and the person may not have capacity in relation to some decisions which can result in more demands on the person caring for them. This can lead to carer stress. However, domestic abuse should not be confused, or incorrectly identified as carer stress ([see Section 6 for further information on Mitigating Carer Stress](#)).



In many cases domestic abuse will have been present in the relationship before the person became ill. However, with the onset or progression of their illness it may be difficult for them to employ or remember the safety measures and coping mechanisms used in the past, such as confiding in others, or working longer hours to avoid returning home.

Risk factors for abuse in a person living with a LLI:

- Increased dependence on a carer who may also be a perpetrator.
- A person with a LLI may go out less and have fewer social interactions increasing their isolation.
- A LLI can change relationship dynamics and can worsen existing abuse.

What does domestic abuse look like in the context of life-limiting illness?

Domestic abuse can take place at any time in someone's life, regardless of age or health status. Research undertaken to develop this Toolkit demonstrates that domestic abuse perpetrated against those living with a LLI is often targeted directly at the person's illness and rarely an isolated incident, with the co-existence of one or more behaviours. The most frequent types of abuse we have identified as being experienced are:

Coercion and control	Emotional Abuse	Neglect	Financial Abuse	Verbal Abuse	Physical Abuse	Sexual Abuse
<ul style="list-style-type: none"> - Making or carrying out threats - Humiliation - Frightening the person to make them subordinate or dependent on abuser - Preventing or denying access to medical care/treatment - Control over/ negative comments about personal appearance - Control over relationships and restricting access to support networks, family and friends - Forced changes to Lasting Powers of Attorney 	<ul style="list-style-type: none"> - Criticising the person - Minimising seriousness of illness - Dismissing illness/person - Emotional detachment/with holding attention - Telling the person they are going to die - Telling the person they are a burden and/or threatening to place them in institutional care - Telling the person they are taking too long to die - Using carer stress as an excuse for the abuse - Making threats to harm pets or re-home them 	<ul style="list-style-type: none"> - Refusal to provide care or call for medical assistance - Withholding food and liquids, or putting them out of reach - Dismissing symptoms leading to treatment delay - Refusal to acknowledge fatigue and need for rest - Poor hygiene care or poorly managed continence 	<ul style="list-style-type: none"> - Controlling access to money - Misuse of direct payments from state benefits - Limiting access to joint bank accounts - Forcing person to make purchases against their will or using their credit cards without them knowing - Removing cash or selling valuables without permission - Forcing the person to change their will to change the inheritance of money or possessions 	<ul style="list-style-type: none"> - Swearing or insults - Making jokes or insensitive comments - Using intimidating language or tone 	<ul style="list-style-type: none"> - Broken bones - Bruises resulting from abuse to surgical sites - Strangulation - Kicking and/or shoving - Deliberate placing of obstacles to cause trips and falls - Abuse of medication 	<ul style="list-style-type: none"> - Rape - Forced or unwanted sexual activity - Rough treatment during sex which had not previously manifest in the relationship

Who can be a perpetrator?

Domestic abuse can be carried out by a partner or other family member such as:

- Partner/spouse
- Siblings
- Parent
- Child
- Grandparent
- Grandchild
- Other family members

It is also important to consider that more than one person may be involved in the abuse. During our research we have heard of some cases where someone with a LLI has left an abusive relationship and moved to live with other family members who have gone on to be abusive. This demonstrates the continued need to conduct risk assessments to consider the home environment and relationship dynamics.

Indicators and signs of domestic abuse in the life-limiting illness context

Identifying domestic abuse within this population can be challenging as it is often hidden or even covered up by those experiencing the abuse. Our research suggests that people living with a LLI may be subject to more subtle forms of abuse, such as coercive and controlling behaviour, emotional and financial abuse which can make them harder to detect than physical abuse⁹. In addition, practitioners may assume that controlling behaviours are due to gender stereotypes with a male partner taking the lead in a relationship rather than consider domestic abuse as a possibility.

*“Somebody was describing what was clearly a lifetime of coercive control from her partner and when I kind of named it and said this to me sounds like you were abused throughout your marriage. That was quite distressing for her to recognize that as abuse.”
(Healthcare practitioner)*

*“This was a gentleman who was very much controlling and actually it developed to the point that it was being detrimental to his wife’s care in the manner that he was controlling her.”
(Healthcare practitioner)*

Warnings signs to look out for in the person living with a LLI who may be experiencing abuse can include:

- Hesitancy to speak openly though they are capable.
- Offering implausible stories and explanations for physical injuries.
- No or limited access to finances or their own bank account.
- Isolation from friends and family.

⁹ Myall M, Taylor, S, Wheelwright S & Lund S (2022) Domestic abuse in the context of life-limiting illness: a scoping review. Health and Social Care in the Community.

The vignette below is a collation of different examples of domestic abuse that were shared by members of the DALLI Community of Practice during workshops to develop this Toolkit.

“Esther”

Esther and Barry have been married for 40 years. Esther is 65 and Barry is 68. Esther is living with stage IV lung cancer. She finds it hard to carry out day-to-day physical tasks and has become increasingly dependent on Barry for aspects of personal care, assisting her to move around the house, and attending medical appointments. Esther attends day services once a week at the local hospice. Hospice staff have noticed a ‘volatile’ relationship between Esther and Barry. On one occasion Barry was observed dragging Esther out of the car when she was having difficulty getting out, shouting and swearing at her and berating her for being slow. On several occasions Esther had told a staff member that she didn’t want to go home and on her last visit had become upset when Barry came to collect her.

On her next visit to day services one of the nursing staff, who knows Esther well, asks her how things are at home. She says she feels quite anxious a lot of the time, worries about saying the ‘wrong’ thing which might trigger an outburst and how Barry refuses to open the windows on hot days as it creates more dust that he will have to clean up, and sometimes does not give her pain medications. She mentions that Barry had been abusive to her ‘on and off’ throughout their married life but it had become more frequent since her illness. Esther is also upset that she has not spoken to her sister, Miriam for a few months, and twice when Miriam was due to visit, Barry had cancelled telling Miriam that Esther wasn’t well enough for visitors. She said Barry doesn’t like her telling others about “their business”. However, she insists that she wants to stay living at home with Barry and does not want him to get into trouble.

The nurse reassures Esther that her wishes will be respected but wants to ensure she is safe and that her needs are being met. A risk assessment is undertaken with Esther and her case is discussed at the next multi-disciplinary team (MDT) meeting. It is agreed that the community palliative care team will discuss with Barry her increasing support needs and will support her pain, symptom control and medication needs. With her permission, the palliative care social worker contacts Esther’s sister and nephews to inform them of Esther’s situation. A safety plan is developed with Esther and her ‘safe’ family members and friends develop an informal network who are advised that Barry is using hostile tactics to isolate her. The network includes neighbours and Esther’s hairdresser. They have regular contact with Esther and keep in touch with each other to share information. A ‘code word’ is also agreed with Esther to slip into a conversation if she feels unsafe or in danger.

Esther's situation highlights the types of abuse that people with a LLI can experience. It demonstrates the importance of hospice and palliative care practitioners enquiring about relationships when they sense things are not right. Practitioners who were involved in this study emphasised the importance of 'gut instinct' to prompt further investigations when they suspected abuse might be taking place.

However, as the vignette shows, such conversations need to ideally be undertaken by someone who has built a trusted relationship with the person and knows the right time to ask. It also requires the practitioner to feel comfortable and confident to enquire ([see Section 3: Enquiring about domestic abuse](#)).

Esther's case further highlights the importance of MDT meetings as valuable opportunities for the team to highlight concerns and share their different insights into the person and their family and social situation. MDTs can help to put different pieces of the puzzle together to help get a complete picture of the person and any possible abuse they may be experiencing. However, MDT working is complex, and it can be challenging to get different sectors and organisations to work together, especially when it comes to documenting abuse where different recording systems are in place.

Domestic abuse and the co-existence of life-limiting illness

People living with a life-limiting illness have additional vulnerabilities and increased risk factors for domestic abuse. Our research suggests that people living with a life-limiting illness may be more likely to suffer from more subtle forms of abuse, such as coercive and controlling behaviour, emotional and financial abuse that can be harder to detect than physical abuse.

Section 3: Enquiring about domestic abuse

Health services are considered a priority setting in which to enquire about domestic abuse and National Institute for Health and Care Excellence (NICE) guidelines recommend services have a focused approach when asking about abuse¹⁰. However, health and social care practitioners, who have little or no previous experience or knowledge of asking about domestic abuse, may feel concerned about how to start a conversation with a person who may be experiencing or at risk of abuse and knowing when to ask. In addition, practitioners can feel hesitant about asking about domestic abuse if they are unsure how they should respond to a disclosure.

“I think there's some fear and anxiety for professionals around raising it and getting it wrong, and particularly in end of life when people haven't got a lot of time.”

(Healthcare practitioner)

During our research, practitioners told us they feel uncomfortable enquiring about domestic abuse and causing upset if their suspicions are incorrect. Even those who have experience and received training may lack confidence when it comes to engaging with a patient or client about domestic abuse. This section provides guidance on how to enquire about abuse and specific considerations before starting a conversation.

Take a trauma-informed approach

A trauma-informed approach recognises that domestic abuse can impact someone in many ways¹¹. Domestic abuse is a complex trauma because of where it takes place, often the home, which is where the greatest sense of stability and safety should be. The intimate relationship with the person perpetrating the abuse, which enables them to exert influence and control, affects the recipient's emotional wellbeing and access to support. Abusive acts occurring over time, rather than a single “event”, and historic abuse has a cumulative impact.

The key principles underpinning a trauma-informed approach are **safety**, **collaboration**, **trust**, **empowerment** and **choice**.

Therefore, when enquiring about domestic abuse using a trauma-informed approach it is essential to:

- Approach the conversation recognising that the persons' experiences are likely to be traumatic.
- Think how best to make a person feel safe and consider the right time and place to ask sensitive questions.
- Consider how best to support them and ensure they feel involved in the processes and decision making.
- Support them to feel in control of their choices to ensure power imbalances that they experience with their abuser are not recreated.
- Treat the person with dignity and respect.

¹⁰ National Institute for Health and Care Excellence (2016) Domestic Violence and Abuse. Available at: <https://www.nice.org.uk/guidance/gs116> (Accessed 4th August 2022)

¹¹ Wilson, J.M., Fauci, J.E. and Goodman, L.A., 2015. Bringing trauma-informed practice to domestic violence programs: A qualitative analysis of current approaches. *American journal of orthopsychiatry*, 85(6), p.586.

- Be sensitive when labelling abusive behaviour. For some this might be the first time they realise that what they have experienced is abuse and will need to be supported to come to terms with this.

Create a safe space

When you are asking about domestic abuse it should be carried out in a safe environment which is as private and confidential as possible and where you will not be interrupted. Speak to the person on their own and remember to never use friends or family members as interpreters as this may affect whether someone feels comfortable to disclose abuse. Enquiring about abuse should not take place if children are present, unless they are unable to repeat what is being said, as this can increase the risk to the person.

Creating a safe space

- Private and confidential
- Where an interpreter is needed do not use friends or family
- Speak to the person alone
- Telephone calls - could the perpetrator be present?
- Consider your own personal safety



If it is difficult to speak to the person alone organise a follow-up visit or appointment which makes it clear that part of this will be between the practitioner and person only, for example requesting a urine sample or physical examination which requires privacy. This may involve building a relationship with the abuser so that they trust you to speak with the person alone. Alternatively, it may be possible to speak to the person at a day centre/outpatient appointment.

If undertaking home visits, it is essential to consider your own safety. Risk assess and put appropriate safety mechanisms in place such as joint visits ([See Section 5 Working with perpetrators for further information on looking after yourself](#)). A colleague can also assist trying to get the person on their own. For example, ask to be shown something in the home that requires them to leave the room.

Consider any impairments that may affect their ability to communicate and try to find solutions. For example, if there are hearing difficulties ensure that any hearing aids are worn and speak clearly. Someone with fluctuating capacity may struggle to accurately recall events but their accounts should be listened to, and other sources of information explored, e.g., talking to care agencies and district nurses, to get as much information as possible if abuse is suspected. ([See Section 7: Safeguarding for further information on mental capacity](#)).

*“If we only ever go in and focus on how somebody’s nausea is and never open-up a conversation about anything else, we’re never going to find out information if it’s there.”
(Healthcare practitioner)*

If you are talking to the person on the phone or online remember that the perpetrator may be able to hear the conversation so it may not be appropriate to continue until you are alone with the person.

Trust your instincts

The complex emotions generated within the context of life-limiting illness (LLI) can sometimes make it challenging for practitioners to assess relationship dynamics (see [APPENDIX 2](#)). Be alert to signs and use your own instinct to judge when something does not feel right and how best to enquire about domestic abuse. Stay neutral, calm and respectful.

If you suspect abuse or it is disclosed, be open and honest, including about your own professional (in)experience in this area.

“I do think you have a bit of a sixth sense when it comes to these sorts of things, where you think... “that’s not quite right.””

(Healthcare practitioner)

Develop a trusted relationship to initiate a conversation

Remember, it can take time to build a rapport with someone for them to feel comfortable discussing sensitive issues such as domestic abuse. To begin, establish a supportive and trusting relationship, start by getting to know the person and undertaking a holistic assessment, perhaps including mapping out a family tree or completing a life review, including questions about family dynamics, coping strategies the person may have used in the past and support networks.

Staged enquiry¹²

Start with a gentle introduction ensuring you have introduced yourself, explained your role and your reason for contact. Use the right language – words are very important, mirror their words. Avoid the use of jargon.

Invitation

Begin by using simple open questions such as:

- How are things at home?
- Who else lives at home?
- What is important to you?
- You seem worried about something, and I wondered whether you’d like to talk about it?
- How does your carer care for you? How is your carer coping?
- Are things stressed at the moment?
- Do you have any financial concerns? Who manages the finances?
- Who supports you other than your carer? Is there someone else?
- Do you feel supported?
- What do I need to know to support you?



¹² Mannix, K. 2021 *Listen How to find words for Tender Conversations*. Harper Collins Publishers.

Pace

Do not try and cover everything in one go. Offer to talk again and continue to build your relationship with the person so they feel comfortable to disclose concerns including domestic abuse. Allow the person to talk in their own time.

- We can talk about this whenever you would like to.
- We can talk about this again if you would like?
- We can always come back to this.

Listen to understand

Gently probe further with open questions. Ensure you get your facts straight and do not make assumptions. Check your understanding by repeating what you heard with empathy, starting with something like:

- Have I got this right?
- Can I just check?
- You are saying...?

Be curious

It is important to remember that anyone can experience domestic abuse, whatever their age or background, so remain open minded as to what a perpetrator or victim might look like. Be aware of your own assumptions; class, gender, sexual orientation, relationship, culture are not barriers to abuse or being abused. Some people may have disclosed abuse previously to practitioners and may not have felt heard or taken seriously. Some may have even felt responsible for the abuse. So, it is vital that conversations are handled sensitively, and assumptions avoided. It is also important to consider who else is at home or may be affected by abuse, particularly children (including grandchildren or children from the wider family).

“Rather than asking direct questions and going through a checklist, we are asking, ‘What is important to you today? What matters to you?’.”
(Healthcare practitioner)

During conversations around domestic abuse, it is important to consider how they see the situation and how they are feeling. Example questions you might like to ask are:

- Do you feel safe?
- Tell me more about ...
- How do you feel about?
- What is important to you at this time?
- What do you think about that now?
- What if you challenge their behaviour? What are the consequences?
- Who do you trust/can confide in?
- Could we be missing anything here?

Sit with distress

You should acknowledge someone’s distress and allow them to talk in their own time. Some examples of this include:

- I’m sorry this is so upsetting.
- I’m glad you can talk about this with me.

Don't interrupt silence

Have open body language and ensure that your facial expressions match what you are saying. For example, you may normally smile to encourage someone to talk but this may be misinterpreted. Example statements to use include:

- Take your time.
- This needs some thought.

Validate

It is important to acknowledge any disclosure of abuse ([See Section 4: Responding to domestic abuse for further information on validation](#)). Validating statements should be delivered confidently and not be scripted, however, some examples of appropriate validating statements are:

- Thank you for telling me.
- It takes huge strength to share what you have today.
- I believe you.
- It is not OK to be treated like that.
- This is not your fault; you are not to blame.
- I am concerned about your safety and well-being but there are options and resources available to you.



Support don't fix

Ask what solutions they have considered or what they would advise someone else in their situation to do. Not everyone will want support or further action to be taken and where appropriate this should be respected. Example phrases that can be used:

- What would you like to happen?
- Is there anything you would like me to do?
- Have you had any ideas about what to do next?
- Who else can support you?
- Is there something about this that could be easily changed?
- Have you ever dealt with a problem like this in the past? What did you do? Can you apply any of that experience here?
- If a friend had a problem like this, what would you advise them?

Staged Enquiry

- Invitation
- Pace
- Listen
- Be curious
- Sit with distress
- Don't interrupt silence
- Support
- End on a positive note

End on a positive note

At the end of the discussion, you should make a plan even if that is just that you are there for them.

Key Stages for Enquiring about Domestic Abuse

Definition of Domestic Abuse

An incident or pattern of behaviour within a relationship that is used to gain power and control. It encompasses physical, sexual, emotional, financial, or psychological actions. Anyone can experience domestic abuse regardless of their background.

Creating a safe space

- Privacy
- Independent interpreter
- Personal safety

Opening Questions

Create a safe space to ask about domestic abuse. Example opening questions include:

- How are things at home?
- You seem worried about something, and I wondered if there is anything you would like to talk about?
- What do I need to know to support you?

Further Questions

Gently probe further with open questions:

- Do you feel safe
- Tell me more about...
- What if you challenge the behaviour? What are the consequences?
- Who do you trust/can confide in?
- What is important to you at this time?

Dealing with Disclosure

It is important to acknowledge disclosures of domestic abuse:

- Thank you for telling me
- It is not OK to be treated like that
- This is not your fault; you are not to blame

Support Following Disclosure

Ask the person what they would like to happen next:

- What would you like to happen?
- Is there anything you would like me to do?
- Who else can support you?

Section 4: Responding to domestic abuse

Disclosure

Health and social care practitioners have unique opportunities to respond to those experiencing domestic abuse, especially those with a life-limiting illness (LLI), who might not feel comfortable, willing or able to disclose abuse to the police.

All practitioners should remember the impact of trauma and consider how to ask and respond in a way that takes into account and acknowledges this.

It is imperative that, following disclosure, the persons' usual care continues, with a holistic approach taken so that the experience of abuse is seen as an additional need, not a need that replaces another. People who experience domestic abuse can fear that disclosure of abuse may lead to the removal of services for health issues, based on an assumption that helping them escape the abusive situation means that the presenting indicators of their illness will disappear. Therefore, the person should be reassured that help for domestic abuse will not affect continued treatment and care needs.

"I try to form an open therapeutic relationship in terms of trying to give patients the sense that they can discuss anything, that someone is prepared to listen to them".

(Healthcare practitioner)

Risk of Harm

Be aware that someone is at **increased risk of harm after a disclosure of domestic abuse**. People can feel more confident after talking about their experiences leading to behaviour changes that may be picked up by the perpetrator. This risk should be considered in the Safety Plan.

Validation

It is important to believe and respond to all disclosures of domestic abuse. After a person discloses, take a moment to recognise how difficult it may have been for them to trust you and let you in on what they have been experiencing. It may be the first time they have told anyone about the abuse. You should reassure them that you believe them and that the abuse is not their fault ([See Section 3: Enquiring about domestic abuse for example responses](#)).

"I would like to think that you would continue to support and be there with that person however difficult it may feel because hopefully you can help to improve their quality of life."

(Healthcare practitioner)

It may also be important to label abusive behaviour. Some people may not realise what they have been experiencing is abuse and they will need to be supported to come to terms with this.

Dealing with disclosure

How you respond to a disclosure is as key as the questions you ask. It is important to try to stay calm and composed when listening to a disclosure. However, you should be honest in acknowledging your own

concerns and reactions to what you have heard. You should also be clear about who you may have to tell and any information that may be shared with other organisations, gaining consent if possible.

Support the person in whatever decision they make. In some cases, the person might request they want no further action to be taken. Sometimes talking about their experiences of abuse is enough although sometimes further action will be required. ([See Section 7: Safeguarding for further information](#)).

Do not dismiss your professional judgement

Even if abuse has not been disclosed, a practitioner may still be concerned for the person but challenging them on their answer is unlikely to lead to a disclosure and may increase their anxiety. A person should always have choice about what they choose to disclose as they may not be ready to share information.

There will be cases where someone does not disclose but where a practitioner remains concerned for their safety and wellbeing. Use your intuition and look for signs that support why you feel concerned. Your concerns should be raised with your manager and the immediate care team to consider whether the concern would satisfy legal criteria to share information with the safeguarding team and what actions can be taken to safeguard the client. Your concerns and opinions should be recorded in the notes with the reasons for them.

The multi-disciplinary team (MDT) can be key in making decisions. Everyone's professional opinions on suspected cases of domestic abuse and relationship dynamics are important and all viewpoints should be considered. Use the expertise in the team, however, also trust your instincts. Much abuse is not obvious especially controlling and coercive behaviour. This combined with the heightened emotions involved in life-limiting care may mean different practitioners have different perspectives. Practitioners should be supported and respected in discussing these challenging situations.

Whole Family Approach

Family members and their vulnerabilities interconnect, and people do not operate in silos. A whole family approach aims to engage all family members- mothers, fathers, and children- living with domestic abuse. Appropriate support should be considered for all members of the family. For families who do not meet the threshold for social care input, universal or non-statutory services should be considered. People need to access support at the right time to keep them safe and help them to recover.

Referral

You should ask the person what they would like to happen next including any support they would like. It is important to explain what is possible, outline anyone you will need to inform, and how they will be involved.

[See Section 7: Safeguarding and Section 10: Resources](#) for further information.

*"A lot of people who are experiencing domestic abuse sometimes don't even realize it's abusive, so you have to see the person first, not the condition."
(Third sector professional)*

*"I suppose the clear point is partly asking that person what they would like from us to not destroy any trust there is."
(Healthcare practitioner)*

Documentation

All practitioners should accurately record the questions they asked the person about issues related to domestic abuse and their relationships, and the responses in the person's own words in relevant case notes or files. People have a general right of access to their own personal data under the Data Protection Act 2018¹³ so it's vital that the records are relevant and accurate.

As with all records, documentation relating to domestic abuse should be:

- **Contemporaneous**; written at the time the conversation is held or as soon afterwards as possible to ensure an accurate record of events.
- **Concise** yet detailed enough for it to be useful to manage and progress the case. They may also be required in the future if court proceedings occur.
- **Legible** so others within your team can access them in your absence or in emergencies.
- **Accurate** - distinguishing between fact and opinion.
- Indication of **information provided** on local sources of help.
- Indication of **action taken** (for example, direct referrals).

Your professional opinion can be recorded in the clinical notes, particularly if you suspect domestic abuse or if you think someone is withholding information. It should be made clear in the notes the difference between opinion and fact. Any opinions recorded in the notes should be supported with the reasons why. It is also particularly important that decisions made following a person's disclosure are recorded, principally where a decision to share their information without their consent is deemed necessary in ensuring their safety.

Assessing and Managing Risk of Domestic Abuse

Any signs or indication of domestic abuse should prompt safeguarding concerns for adults with a LLI. Living with a LLI increases someone's vulnerability to domestic abuse and therefore puts them at higher risk of harm. Therefore, practitioners and members of the public should report all concerns of domestic abuse in those with a LLI by making a referral to the Local Authority Adult Safeguarding (details can be found on your local authority website).

Children

Practitioners should consider whether children or other vulnerable adults live in or have regular access to the household where the abuse is suspected or experienced. Where children are at risk the local child protection services must be contacted (contact details can be found on the website for the local authority the child lives in).

Assessing Risk

A risk assessment should take place in all situations where an adult with care and support needs, such as those with a LLI, is experiencing domestic abuse. A thorough, personalised risk assessment should be carried out with the person at risk. **A practitioner must have received specific training before completing a risk assessment.** ([See APPENDIX 2: Domestic Violence and Abuse Tool for further information on categorising concern](#))

¹³ <https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted>

Risk assessment tools are used in many adult safeguarding processes and can help to support judgements and decision making about the level of risk for individuals and their families. It is important to remember that risk and situations can change quickly, and a person should have a safety plan in place in case things change or they do not wish to act on disclosure.

One tool that is widely used is the **Domestic Abuse, Stalking and Honour Based Violence Risk Identification Checklist (DASH)**¹⁴ ([See Section 11: APPENDIX 1 for a copy of the DASH](#)).

The DASH is a list of 24 questions that ask about factors present in a case of domestic abuse. A 'yes' answer to 14 or more questions indicates a

serious risk of injury or harm. However, 'yes' responses to certain questions, such as strangling, indicate higher risk of imminent harm, including death, and should prompt immediate action.

This tool is used by practitioners to refer high risk cases to the local Multi Agency Risk Assessment Conference (MARAC). Practitioner judgement is essential when using the DASH. This is especially the case for those with a lower score than expected particularly as some may not feel comfortable or able to disclose all aspects of their abuse. In addition, the DASH is acknowledged as having limitations for risk factors experienced by disabled and older people. Therefore, practitioners should be aware of its limitations and understand that determining the level of risk may be more difficult when using it with those with in the LLI context.

Involving the person affected, and/or an advocate or Independent Mental Capacity Advocate or IMCA (if the person lacks capacity) in the risk assessment is best practice. All risk assessments are also likely to benefit from information from other agencies. Adults with capacity should be asked to consent to information from other agencies to be collected. A consent form should be used to document their decision. For adults assessed as lacking capacity an advocate should be involved. Where the person is at evidenced high risk, the person concerned must be informed that the information will be shared.

An assessment carried out in this way is more likely to:

- Create an accurate and comprehensive risk assessment.
- Provide the person an opportunity and support to identify, explain and understand the risks for themselves, keeping their needs at the forefront of the safeguarding process.

Practitioner Judgement

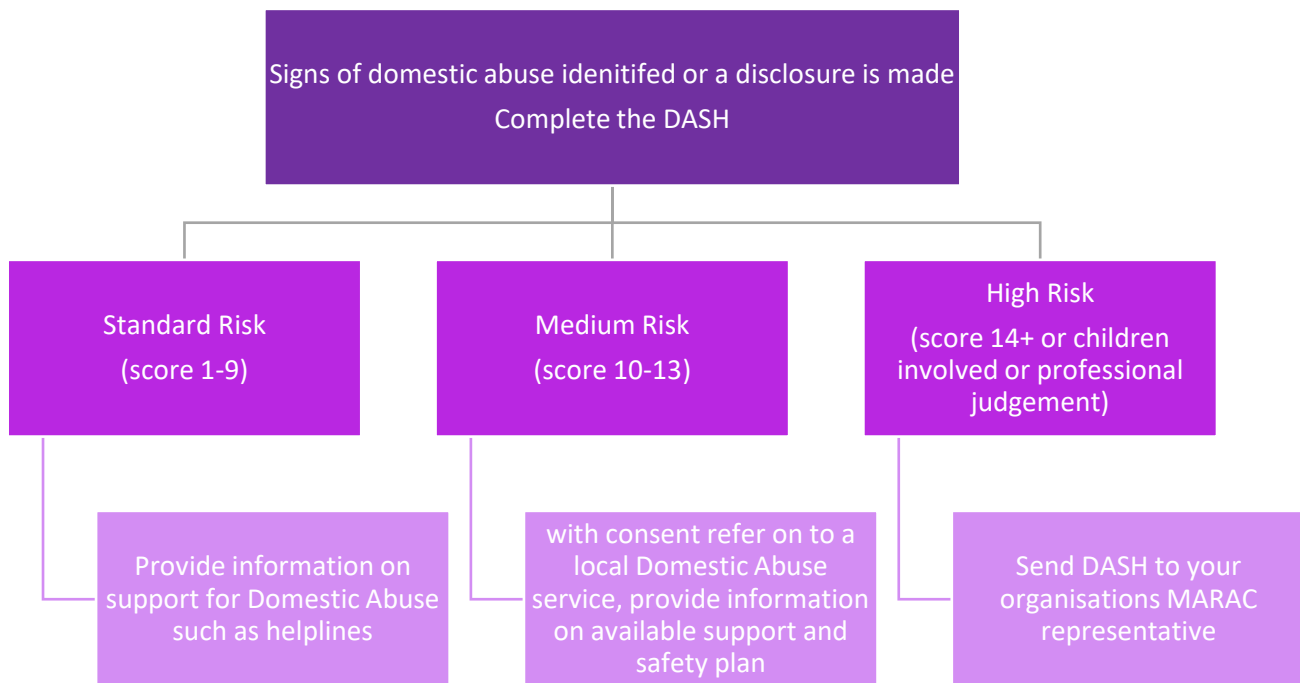
Personal judgement is important when completing risk assessments particularly when scores are lower-than-expected.

If a practitioner feels that someone is withholding information, this should be documented in the notes. For example, the practitioner should record in the notes: "although the score is X, in my opinion the risk might be higher as they were reluctant to answer certain questions".

¹⁴ Safe Lives Dash Risk Assessment (2014). Available at:

<https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf> (Accessed 4th August 2022)

Referral Pathway¹⁵



Remember

If you have **immediate** concerns over someone's physical safety, please call the **Police on 999**.

Be guided by the risk assessment score and personal judgement. If there is immediate risk to a vulnerable adult, initiate your organisations safeguarding adult procedures.

All risk assessments should be completed **promptly** and sent within 2 working days of identifying the risk to the appropriate agency.

Risk assessments should be conducted **regularly** to identify any changes to the risk of harm.

There are three possible responses where domestic abuse is suspected or identified. **However, cases of experienced or suspected domestic abuse in those with a LLI are high risk.**

1. Risk identification indicates high risk to an adult or child.

In high-risk cases of domestic abuse, the first step is to deal with any **immediate requirements for medical or police involvement by calling 999**.

It is important to ask the person what they would like to happen. People experiencing domestic abuse have the rights of autonomy and to make their own decisions. It is important that this right is respected unless there is a threat to life or serious harm, or a child is involved. As such, it is best practice to share information

¹⁵ Somerset Safeguarding Adults Board. Guidance for Safeguarding Adults in Somerset. Available at: <https://ssab.safeguardingsomerset.org.uk/adult-safeguarding-procedures-intro/domestic-abuse-and-maracs/> (Accessed 4th August 2014)

with consent if possible. It is important to be open and honest, unless this puts you or others at risk. Below is an example of how to discuss sharing information when someone does not consent:

“I understand you don’t want me to share this information, but I need to do this to support you and get you access to help. Please continue to talk to me and I will support you through this process.”

After dealing with any immediate risks, a practitioner should:

- Alert appropriate practitioners and involve an advocate for those who need support in decision making.
- Share information that is relevant, timely, proportionate and on a need-to-know basis.
- Record exactly what has been shared, with whom and the reasons why. If information is not shared, then this should be recorded in the notes and the reasons for this documented.
- Discuss with the person, if appropriate and safe.
- Record when and whether the person was informed and reasons why if not.
- Consider proactive ways to assist the person to access help from other agencies and make a safety plan.
- Continue to support and safeguard the individual at risk and inform them of the actions you are taking and who else is involved.
- Continue to assess needs and risks as situations can change quickly.

2. Risk identification does not indicate high risk and the person consents to their information being shared.

Where someone provides explicit, informed consent to share their information it is important a record of this is kept on file, stating which information is to be shared, with whom and for what purpose. Regular risk assessments should continue to be conducted to identify any changes to the level of risk.

Risk Assessments

- Risk assessments should be conducted regularly to identify any changes to the risk of harm.
- Always consider children or other vulnerable adults in the household.

3. Risk identification does not indicate high risk and the person does not consent to their information being shared or consent cannot be obtained for their information being shared.

Where there is no clear and legitimate purpose for sharing a persons’ information this information should not be shared. In such cases the practitioner should:

- Record the assessment of risk and actions on file.
- Reassure the person of ongoing support and signpost to available services. Regular risk assessments should be conducted as domestic abuse is a dynamic situation that can change quickly.
- Mark/flag the persons’ file to ensure a sensitive, heightened response is provided, should the person return to the service for any purpose.

Professional Responsibilities

It is best practice to seek consent before sharing information. However, all cases of abuse in someone with a LLI should be considered high risk and concerns raised with the safeguarding team. It is essential that events are documented accurately.

Managing Risk

Safety Planning

The safety plan is usually developed through safeguarding as part of a multi-agency approach including social workers, domestic abuse specialists and clinicians. The safety plan and its actions must not put anyone at risk. How the safety plan is developed will be dependent on the outcome of the risk assessment. For those who are not categorised as high risk it is essential to work with the individual to put in place agreed safety measures with which they feel comfortable. The person affected needs to feel supported and empowered to discuss their experiences. **Once agreed, the safety plan should be monitored closely and reviewed regularly for any exacerbations in the person's condition and escalation in abuse.**



Key actions that might be included in a safety plan¹⁶:

- Advance plans for responses to different scenarios including crisis situations.
- Identifying a trusted person who can be called upon for help and establishing how to call for help.
- Creating a code word that can help the person notify others that they require further support and assistance.
- Keeping an emergency bag that is hidden somewhere safe that may include medication, money, bank cards, important documents, items of personal significance e.g., photos, and other essentials such as toiletries and clothing. The bag should be kept somewhere the perpetrator will not find it such as a trusted friend or relative or even a healthcare team. If a healthcare professional is asked to look after an emergency bag this should be accommodated wherever possible. A refusal to look after the bag may prohibit someone from leaving an abusive relationship.
- If the person has children/visiting grandchildren, the safety plan should include ways to keep them safe if violence or abuse occurs and details to remember if preparing to leave. For example, teaching children when, how, and who to contact in an emergency or agree a code word for when to leave the house in an emergency.
- If the person has a pet, the safety plan should include who can look after them if they cannot take them to their place of safety. Some charities, such as the RSPCA and Dogs Trust, offer pet fostering for those fleeing domestic abuse.
- Temporary admission to a hospice or other institution to allow time to formulate a long-term plan.
- Consider different support options that are available.
- Regular risk assessments should be conducted to assess the level of harm as situations can change quickly.
- Recognise that there are times when someone's risk of harm from domestic abuse may be higher. This includes after making a disclosure and around the time that someone leaves an abusive relationship. Additional support will be required around these times.

¹⁶ Women's Aid. Available at: [Home - Women's Aid \(womensaid.org.uk\)](https://www.womensaid.org.uk) (Accessed 4th August 2022)

Barriers and Challenges to Leaving Abusive Relationships

There are many barriers that may prevent someone from seeking help to leave an abusive relationship. To provide the best care and support to those experiencing domestic abuse it is important to understand why some people remain in abusive relationships and may not seek help. These barriers may include¹⁷:

- Fear of what the perpetrator will do.
- Lack of knowledge or experience of what support is available.
- Lack of resources.
- Victim blaming and feelings of shame or failure.
- Fears that they may not be believed.
- Pressure from others including family, friends, and the wider community.
- Religious beliefs.
- The long-term impact of domestic abuse such as self-neglect and mental health problems.
- Fear of losing contact with family and friends.
- Not being asked about domestic abuse by practitioners.

Additional Barriers

There are also additional barriers to reporting and seeking help for domestic abuse for certain groups who may experience domestic abuse.

Adults with care and support needs

Adults with care and support needs such as those with a life-limiting illness (LLI) or disability are twice as likely to experience domestic abuse than men and non-disabled women^{18,19}. Adults with care and support needs are more likely to be physically vulnerable. Threats to withhold care or remove mobility or sensory devices required for independence limit people's ability to disclose, and they may need more support to remove themselves from an abusive situation. They may also be so affected by their illness that they do not have the energy to consider leaving the situation.

People with care and support needs may experience barriers to accessing services such as:

- Lack of accessible information about domestic abuse, legal rights, and services to meet their care and support needs.
- Assumptions that physical and sensory disabilities may prevent people from making decisions.
- Increased feelings of dependency on the perpetrator based on their health and care needs particularly if the perpetrator is also their carer.
- Being more physically vulnerable, socially isolated and have less means of escape.
- Lack of specialist refuges for the people with specialist or complex needs.
- Fear of being placed in a care home or other institution.

¹⁷ Adult safeguarding and domestic abuse. A Guide to support practitioners and managers (2015). Available at: <https://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-and-do-cfe.pdf> (Accessed 4th August 2022)

¹⁸ Balderston, S. (2013) Victimized again? Intersectionality and Injustice in disabled women's lives after hate crime and rape. In Texler Segal, M., Demos, V. (Eds.) *Advances in Gender Research Volume 18a – Gendered Violence*. Cambridge MA: Emerald Publishing.

¹⁹ Khalifeh, H., Howard, L. M., Osborn, D., Moran, P., & Johnson, S. (2013). Violence against people with disability in England and Wales: findings from a national cross-sectional survey. *PLoS One*, 8(2), e55952.

Older people

It is important that practitioners are particularly alert to potential abuse from wider family members to older people. Older people may find it particularly difficult to disclose given a traditional notion people should hide their problems, particularly if they involve family members.

The choices and options available to those experiencing violence against women, domestic abuse and sexual violence in the past were limited in comparison to the spectrum of services available currently. Older people may have limited knowledge and expectations of the help available to them and be less likely to seek help as a result.

Older people are, however, more likely to be involved with care services and reliant on these for support. Their reliance on these services and the carers who provide them may increase their risk of abuse and make them less likely to disclose abuse of any form.

Older people may experience additional barriers such as:

- Traditional attitudes towards marriage and gender roles.
- Ageism in our culture and society- including fears of being a burden on society.
- Fear, shame and wishing to keep things private.
- Impact of health conditions.
- Fear of being moved from their own home if they disclose abuse.



Black, Asian, Minority Ethnic and Refugee (BAMER) communities

BAMER communities may experience additional barriers such as:

- Language barriers.
- Fear that interpreters may not maintain confidentiality.
- Family honour, shame or stigma and fear of honour-based violence.
- Racism.
- Immigration status and no recourse to public funding.
- Fear of rejection by their community.

LGBTQ+ community

For the LGBTQ+ community barriers can include:

- Fear of or experiences of homophobia.
- Assumptions may be made about the nature of relationships.
- Lack of specialist refuges for the LGBTQ+ community.
- Threats to 'out' them to family, friends and the community.
- Potential loss of support network.

The fictional case study below demonstrates how a safety plan can be designed and created by the person experiencing domestic abuse to plan for their safety.

“Reggie”

Joseph, 60, and Reggie, 55, have been in a civil partnership for 10 years. Joseph has always been critical of Reggie and can easily lose his temper. Since Reggie was diagnosed with Motor Neurone Disease (MND) a year ago the abuse has escalated. Joseph now controls who Reggie sees, and who comes to the house, sometimes places his meals and drinks out of reach, and berates him for being slow and clumsy when he tries to get to them. During an admission to hospital for a respiratory tract infection, Reggie confided in Mary, a MND Nurse Specialist, about Joseph’s behaviour and how he feels increasingly unsafe and worried about what will happen as his condition progresses and he becomes more dependent on Joseph for his care. He tells Mary that he is thinking of leaving Joseph but is worried that he might have to move into a care home as he may not be able to live independently.

Mary thanks Reggie for telling her and validates that the abuse is not his fault and is not something he should have to put up with. She informs him that help is available. Mary conducts a risk assessment, offers to speak to the safeguarding team and make a referral to the local domestic abuse support services. Reggie agrees to the referral and together they create a safety plan together. A ‘code word’ is agreed that will be shared with the clinical team, both in the community and hospital. Reggie can say this ‘code word’ any time to indicate that he feels unsafe and requires further support. If Reggie needs help when he is discharged from hospital, he decides to use his mobile phone to contact a friend. Mary suggests that Reggie should also pack an emergency bag in case he decides to leave their home at short notice. The bag can include things like money, medication, clothing, toiletries, and forms of identification. Reggie decides to leave the bag with a close friend.

Mary also discusses his care package with the clinical team to see if any further support can be offered when he is discharged. The team arrange for the community team to visit Reggie regularly. Mary also explains that if Reggie decides to leave the relationship, housing can be applied for from the local authority.

Reggie feels reassured by having a safety plan in place. Mary thanks Reggie again for confiding in her and arranges to see Reggie the next day on the ward.

Domestic Abuse Support²⁰

There are a range of specialist services available for those experiencing domestic abuse.

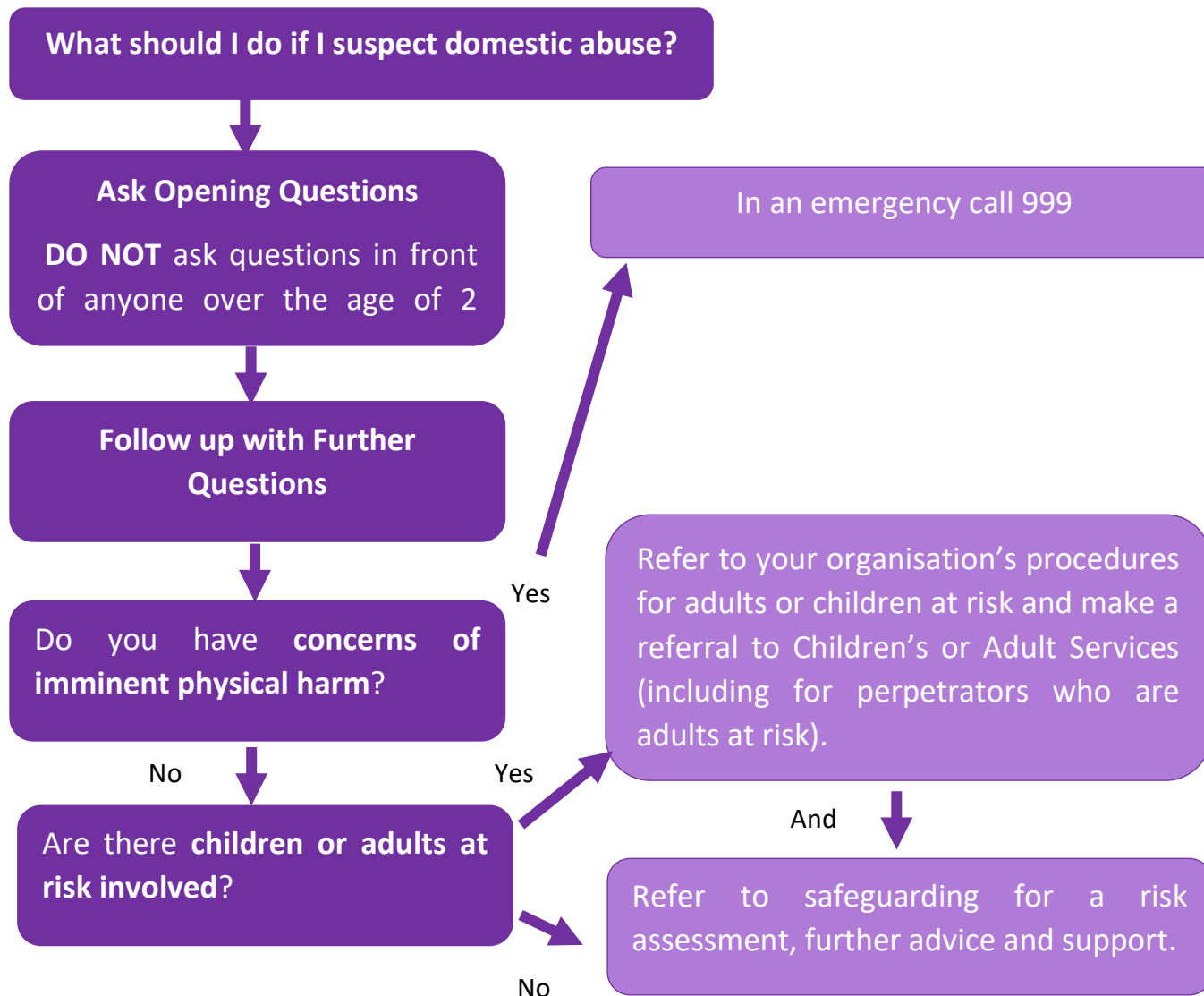
- **MARACs** are regular local meetings where statutory and voluntary sector organisations work together. MARACs consider high risk cases of domestic abuse that are identified through the use of DASH and a coordinated safety plan is developed to protect the victim. A referral to MARAC is usually

²⁰ Adult safeguarding and domestic abuse. A Guide to support practitioners and managers (2015). Available at: <https://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-and-do-cfe.pdf> (Accessed 4th August 2022)

carried out following consent. However, if this is not possible or forthcoming, high-risk cases are still considered to prevent serious harm.

- **High Risk Domestic Abuse (HRDA)** meetings consider the highest risk domestic abuse incidents and occur more regularly than MARACs to receive a more immediate response. The meetings can be chaired by the police or safeguarding lead.
- **Multi-Agency Safeguarding Hub (MASH)** decides if a case of domestic abuse will be heard at MARAC or HRDA.
- **Independent Domestic Violence Advisers/Advocate (IDVAs)** usually provide support to high-risk cases that have been referred to the MARAC. IDVAs offer independent specialist support and help organise resources from local agencies to best protect and support someone. IDVAs can provide key information and advice for healthcare practitioners caring for people at risk of or experiencing domestic abuse.
- **Accommodation** and physical accessibility can be barriers to those with LLI seeking help for domestic abuse. Some may believe that their health needs could not be accommodated if they leave an abusive relationship particularly if their home has been specifically adapted. However, all accommodation options should be explored including providing a support plan in a refuge, or rehousing / supported living / residential care home options.
- **Other domestic abuse organisations-** [see Section 10: Resources](#) for further information.

What to do if you suspect Domestic Abuse?



Top Tips

- Be compassionate and non-judgemental.
- Make sure you are in a safe and private environment.
- Do not use family or friends as interpreters.
- Be aware of who else might be present when having conversations over the phone.

In all cases, undertake the following actions:

- Talk to the person about safety planning.
- Consider what your organisation should do to help them and keep them safe, and which other agencies should be contacted.
- Ask if they want further support or information.

Section 5: Working with the Perpetrator²¹

Who can be a perpetrator?

Domestic abuse can be carried out by a partner or other family member such as:

- Partner/spouse
- Sibling
- Parent
- Child
- Grandparent
- Grandchild
- Other family members

Warning signs of a perpetrator can include:

- Speaking for the person or advocates for them when the person has capacity.
- Reluctant or refuses for the person to be seen alone without them.
- Overly protective or dominant.
- Unreasonably critical of health and care workers or displays intimidating behaviour towards them. They may submit complaints about staff.
- Critical or humiliates person in front of others.
- Exhibits controlling behaviour such as leaving drinks out of reach or limiting access to medication.
- Isolates the person from other family members and friends.

It can be challenging for practitioners who come in to contact with perpetrators of domestic abuse. There are two key principles that should inform your practice:

1. **Safety**- whilst working with a perpetrator you should always aim to increase the safety and wellbeing of the person affected by domestic abuse and consider the risk to yourself and others.
2. **Do no harm**- take all appropriate actions to ensure the support you provide does not increase or create additional risks

When the person living with a life-limiting illness is a perpetrator

In some cases, domestic abuse may be perpetrated by the person living with a life-limiting illness (LLI) and may have been present in the relationship with their carer prior to the person becoming ill. It is important

²¹ Respect Phonenumber. Guideline for working with perpetrators of domestic abuse. Available at: <https://respectphonenumber.org.uk/resources/frontline-workers/guidelines-for-working-with-perpetrators-of-domestic-abuse/> (Accessed 4th August 2022)

that those working in hospice and palliative care services recognise this and are aware of potential situations where this can occur. Key things to look out for include:

- Lacks consideration for the needs of their carer.
- Treats the carer with a lack of respect or courtesy.
- Rejects help and support from others, including external agencies.
- Controls carer's finances, including bank accounts and cards, property and living arrangements.
- Displays aggressive and controlling behaviours, is verbally and/or physically abusive.
- Blames the carer for their illness and their situation.

Supporting carers experiencing domestic abuse

A person living with a LLI should not be assumed to pose less risk to their carer, even if they are frail and dependent. For example, a carer for a perpetrator may be at increased risk of physical harm, when providing personal care which places them at close proximity to the abuser. Additionally, safety and coping mechanisms that may have been implemented by the carer before the abuser became ill, such as spending time away from the home, may no longer be possible if they are the sole carer. Below are some key points to consider in your practice if a carer is being abused by a person with a LLI:

- The person may still choose, or feel they have no option, to provide care to the perpetrator and it is essential that safety assessments are undertaken, and plans put into place that take abusive behaviours into account.
- Explore the aspects of care that the person feels safe to provide. For example, they may not feel happy to carry out personal care but willing to provide meals.
- Do not assume that the carer wants to stay in the relationship with the perpetrator and provide them with the same information about their rights and choices as you would a person with a LLI experiencing abuse.
- They may be worried about the response of family members, practitioners and their community if they decide to leave the relationship so it is important to be empathetic and provide a validating response about their concerns and assure them that their safety is as important as anyone else's.
- Provide information and offer referral to other services who may be able to provide care.

Working with perpetrators

There are six key steps to guide your work with perpetrators:

1. **Look and listen.** Perpetrators may present in numerous ways including insisting on attending appointments, talking on behalf of someone else or present with other related problems such as depression or substance misuse. It is important to consider domestic abuse for any situations where you feel something doesn't feel right.
2. **Enquire.** Direct enquires about abuse may be denied by the perpetrator. However, in some cases the perpetrator may disclose their abusive behaviour. Your response to this disclosure could help encourage them to take responsibility for their actions and motivate a perpetrator to change. Below are some example questions that may help your conversation:
 - What worries you most about your behaviour?
 - When you feel like that, what do you do?
 - It sounds like you wish to make changes to help your partner. How might you do this? What help would you like to assist you?
3. **Risk assessment-** specialist training is required before assessing perpetrators of domestic abuse. Practitioners without this skill set or who lack confidence in dealing with perpetrators should discuss

the case with their manager and the multidisciplinary team. The main focus should be to conduct a risk assessment on the person affected by abuse. However, information that is disclosed by the perpetrator, should be listened to carefully to help assess the severity and risk of abuse. **There are some circumstances where the risk of serious harm is heightened:**

- a. Recent or imminent separation
- b. Recent increase in frequency or severity of abuse
- c. Recent disclosure of abuse
- d. Current substance misuse by the perpetrator
- e. Use of weapons
- f. Death threats

On completion of a risk assessment local safeguarding policies should be followed.

4. **Respond-** during interactions with a perpetrator the following good practice guidance should be followed:
 - a. Be clear that abuse is unacceptable.
 - b. Acknowledge that their disclosure is the first step in ending the abuse.
 - c. Confirm any accountability for their behaviour that they show.
 - d. Be respectful, empathetic, non-judgemental but do not buy-in to their version of events without clarifying with colleagues and/or the multi-disciplinary team (MDT).
 - e. Do not pressure the perpetrator to make a full disclosure of domestic abuse. Allow the perpetrator to share what they feel comfortable with. This may be the first time they have discussed their abusive behaviour with someone, and they may not feel ready to discuss everything. Disclosure may be made over a number of conversations.
 - f. Inform the perpetrator that domestic abuse encompasses a variety of behaviour and is not just physical abuse.
 - g. Ask a colleague to accompany you to appointments and visits with perpetrators. Working with a colleague not only offers you protection but working together can also help to separate the perpetrator and the person at risk of or experiencing domestic abuse to enable private conversations.
 - h. Always see partners on their own away from the perpetrator when discussing domestic abuse.
 - i. Inform the perpetrator that safeguarding policies and processes must be followed, and confidentiality cannot always be maintained.
5. **Record and document-** all disclosures of abusive behaviour by the perpetrator should be accurately recorded in the notes or file. Disclosures should be written down verbatim in the notes using quotation marks. These records could provide help in any future legal proceedings. Inform the perpetrator that you will document the discussion and that the information may be shared and consider ways to support them.
6. **Signpost-** provide information on appropriate and relevant services for the perpetrator. Examples may include perpetrator programmes, and drug, alcohol and mental health services. You may also wish to seek support from your local safeguarding team.

Looking after yourself and personal safety

Working with a perpetrator can be challenging and can affect you. Things to look out for include:

- Invasive thoughts about someone's distress
- Frustration/fear/anxiety

- Disturbed sleep
- Difficulty leaving work at the end of the day

It is recommended to talk to a trusted colleague for support and find ways to rest and disconnect from work. Other ways to look after yourself include:

- Always work with a colleague where a perpetrator might be present as they may see you as a threat. For example, home visits where a perpetrator might be present should always be conducted jointly with a colleague.
- Use clinical supervision or other forms of professional support to discuss all cases of domestic abuse for emotional support and guidance on safeguarding procedures.
- Take up opportunities for debriefing and other therapeutic support.
- Regularly report to your manager and colleagues to feedback on the situation and discuss any concerns you may have.
- Ensure you have sufficient training for your work.
- Accept support and positive feedback when offered.
- Take regular breaks from work.

Collusion

Interactions with perpetrators of domestic abuse should be guided by a non-judgmental, empathic approach, with recognition of the capacity for a perpetrator to change.

It should also be noted, however, that many perpetrators of domestic abuse have the capacity to be very manipulative. When working with perpetrators, practitioners will need to be careful to avoid using language that colludes with the perpetrator's abuse or to buy in to their version of events without clarifying details with other members of the team or partner agencies.

Practitioners will need to be able to make a clear distinction between a perpetrator's co-operation and engagement with the service provided and their capacity for causing harm. Domestic abuse perpetrators are often capable and compliant individuals who would not ordinarily give a cause for concern.

Managing dual or counter allegations

It is common for perpetrators of domestic abuse to make counter allegations of violence or abuse against the person who has experienced the abuse. Such allegations can make it difficult for practitioners to involve appropriate services, understand risk and meet the needs of all family members.

In addition to counter allegations, the perpetrator may also submit complaints about staff. This can be intimidating for practitioners, but it is important to continue to deliver the care and support required by the person with a LLI and seek the advice of your manager.

*“He put in a complaint about most people after an incident of safeguarding was reported. He complained about the nurse who made that call. He complained about the social worker and the police officer that turned up at the house.”
(Healthcare practitioner)*

The fictitious vignette below is an example of a conversation with a perpetrator.

“Clive”

Clive 45, and Jane 38 are siblings and have been living together for a year. Jane has cystic fibrosis and over the last few months has been in and out of hospital with several respiratory tract infections. Her lung function has reduced, and she struggles with getting up the stairs. Clive has struggled with Jane’s worsening health and gets angry when she sees friends and other family members. As a result, she rarely leaves the house and hasn’t seen her friends or other family for several months. In recent months Clive has also begun making negative comments about her appearance, particularly about her weight loss, and he has also started to drink heavily.

During an outpatient appointment, a cystic fibrosis nurse specialist, Sanjeev, asks about their support network and Jane explains that she doesn’t go out very often. Before Sanjeev can ask any follow up questions the conversation is shut down by Clive who says Jane is happy at home. Sanjeev senses that something isn’t right between Clive and Jane. Sanjeev asks to examine Jane on her own and after asking how things are at home, Jane admits Clive can get angry with her and she would like to see her friends more often.

When Jane goes off for a chest x-ray, Sanjeev takes the opportunity to ask Clive how things are. Clive admits that he is struggling to cope with Jane’s declining health over the last few months and has started to have the occasional drink to try and relax. Sanjeev asks Clive what worries him most about his behaviour. Clive explains that he can sometimes lose his temper and finds it difficult if Jane wants to spend time with others. He would like help to control his anger. Sanjeev says that it must be challenging seeing Jane suffer in recent months, thanks him for confiding in him but that controlling behaviour is not acceptable. Sanjeev explains that accepting there is a problem is the first step to changing the behaviour. It is important for them both that they maintain their social networks to help their wellbeing. Sanjeev signposts Clive to go to his GP for support with his drinking and counselling to help him process his feelings. Sanjeev also informs Clive that he will need to document and share their conversation to look at ways to best support them.

After their discussion Sanjeev accurately records the conversation with Clive in Jane’s clinical notes and uses quotation marks to write down word for word what has been disclosed. Sanjeev also discusses the case with his manager who agrees they should discuss the case in the multi-disciplinary team (MDT) meeting the next day, the GP is informed of the outcome of the MDT. The team decide to contact Jane weekly to assess her health, see how things are going with Clive and regularly reassess the situation. Jane is encouraged to contact the cystic fibrosis team if the situation with Clive deteriorates further.

Working with a perpetrator

There are **six key steps** to follow when **working with a perpetrator**:

1. Look and listen for signs of domestic abuse
2. Enquire
3. Conduct a risk assessment
4. Respond to any disclosures
5. Record and document any disclosures
6. Signpost to appropriate information and support

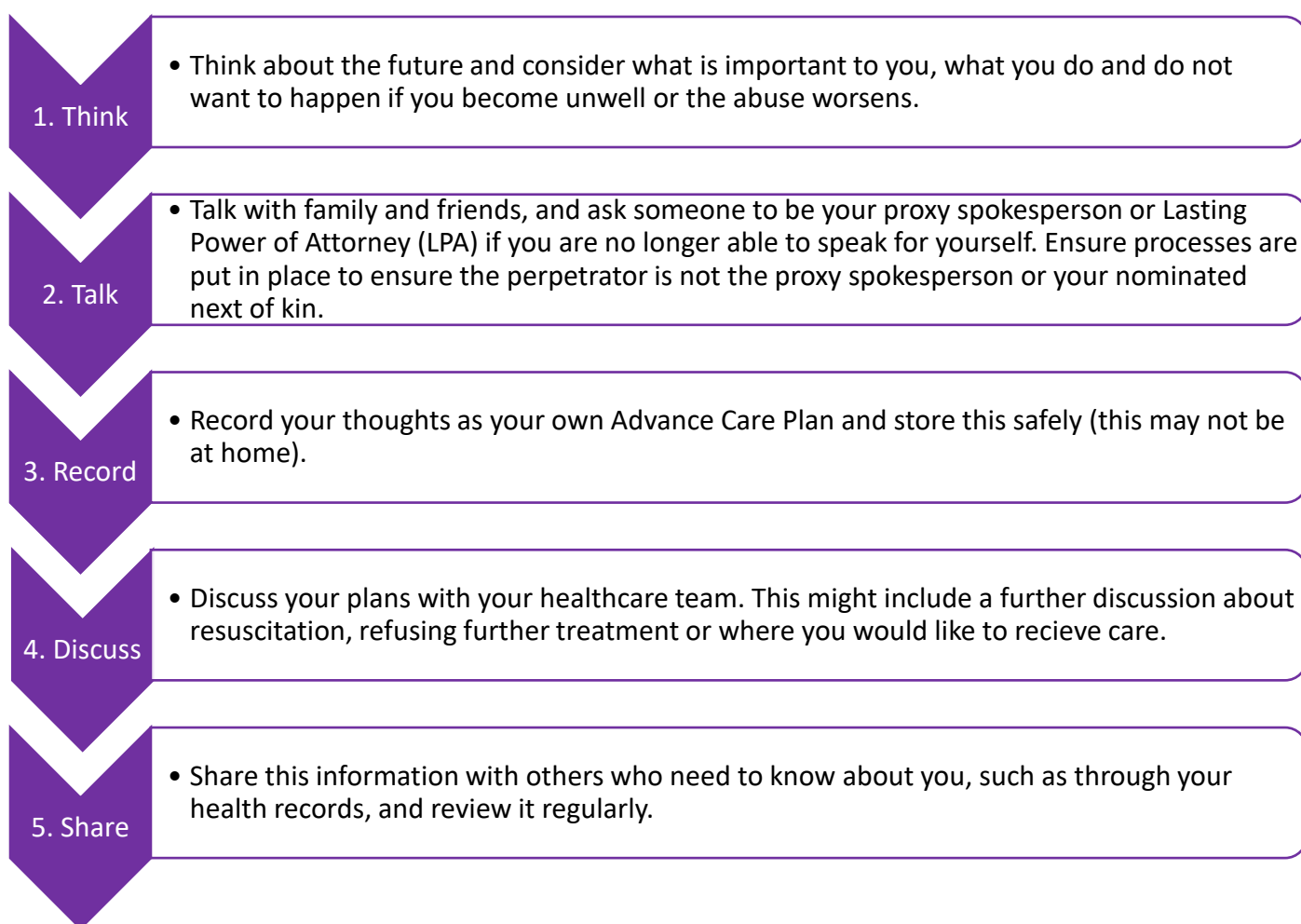
Section 6: Preventing and Reducing Risk of Domestic Abuse

In this section we explore different ways that practitioners can help prevent and reduce the risk of people with life-limiting illnesses (LLI) experiencing domestic abuse. This includes advanced care planning, mitigating carer stress, working with the perpetrator, and increasing someone's social network.

Advance Care Planning²²

Advance care plans (ACP) help people to think about how they wish to be cared for in the final months of life and what treatments they might or might not want. Many people feel more confident that they have gained more control of their own lives through doing this. Creating a plan while someone is still able can help let family members and practitioners know their care wishes. A perpetrator may specify that a person does not wish to receive certain treatments but having an ACP helps direct care in line with someone's wishes when they are no longer able to make these decisions themselves. This ensures the perpetrator does not direct care against someone's wishes. Therefore, ACPs are particularly helpful in cases of domestic abuse, especially involving coercive and controlling behaviour.

Five steps in Advance Care Planning²³



²² NHS. End of Life Care (2021). Available at: <https://www.nhs.uk/conditions/end-of-life-care/> (Accessed 4th August 2022)

²³ The gold standards framework. Advance Care Planning. Available at: [Gold Standard Framework - Advance Care Planning \(goldstandardsframework.org.uk\)](https://goldstandardsframework.org.uk/) (Accessed 4th August 2022)

There are several different ways to plan ahead:

- **Advance statement** can be written by anyone with mental capacity. An advanced statement can cover any aspect of future health or social care. It can include requirements in line with religious beliefs, where someone would like to receive care e.g., home or residential care, practical concerns and personal preferences. It is not legally binding but should be considered when care decisions are being made.
- **Advance decision to Refuse Treatment (ADRT) (living will)** lets others know any wishes for refusing certain treatments in the future including those that are life-sustaining. It is legally binding and should be signed and witnessed. It will only be used if someone is no longer able to make their own decisions.
- **Lasting power of attorney (LPA)** is a legal document that gives another person the right to make decisions about someone's care and welfare when they are unable to. The attorney could be a relative, friend or practitioner. There are two types one for health and welfare and the other for property and financial affairs. The attorney would be able to make decisions about things like medical care, life-sustaining treatment and moving into residential care. The LPA must be registered to be enacted.

Mitigating Carer Stress²⁴

Carer stress is well recognised, particularly at the end of life when care demands on those looking after someone with a LLI can increase significantly. With increasing anxiety and stress carers may feel helpless in their situation and the opportunity for abuse either intentionally or unintentionally is heightened. Sometimes domestic abuse can be wrongly labelled as carer stress particularly as perpetrators may portray a caring outward appearance. Carer stress is different to domestic abuse and is usually characterised by the carer feeling remorse and is not about having power and control over someone. Carer stress is usually experienced by the person providing the most care whereas domestic abuse can be perpetrated by any relative. Treating abuse as carer stress is dangerous for vulnerable adults as:

- Attention is directed away from the person with the LLI to the carer. Actions that are aimed to support the carer e.g., respite care, are not domestic abuse prevention programmes.
- Blame may be placed on the person needing care rather than the carer.
- The perpetrator may be given more power and control.
- The accountability of the perpetrator may be minimised, and carer stress can be used to explain and justify abusive behaviour.

²⁴ Brandl, B. and Raymond, J., 2012. Policy implications of recognizing that caregiver stress is not the primary cause of elder abuse. *Generations*, 36(3), pp.32-39.

To help prevent or reduce the risk of abuse it is important that carers receive the necessary support they require. This may include completing a fast-track pathway tool for continuing healthcare²⁵ (enables an individual to receive prompt NHS funding to meet the cost of care at end of life) or signposting them to support or benefits such as Carer's Allowance²⁶. When seeing patients and their carers it is important to look out for and ask about common signs of carer stress which can include²⁷:

- Feeling overwhelmed.
- Denial over the severity of the condition the person has been diagnosed with.
- Becoming easily irritated or angry.
- Depression and or anxiety.
- Sleep problems.
- Physical symptoms such as headaches and body pain.

²⁵ UK Government. NHS continuing healthcare fast-track pathway tool. <https://www.gov.uk/government/publications/nhs-continuing-healthcare-fast-track-pathway-tool> (Accessed 6th June 2023).

²⁶ UK Government. Carer's Allowance. <https://www.gov.uk/carers-allowance> (Accessed 6th June 2023)

²⁷ Alzheimer's Association. Caregiver Stress. Available at: <https://www.alz.org/help-support/caregiving/caregiver-health/caregiver-stress> (Accessed 4th August 2022)

The fictitious vignette below is an example of how carer stress can manifest when care demands increase. To reduce the impact of carer stress it is important to work with the person with the LLI and family:

- Family preparedness- outline the disease trajectory. It is important to describe what can be expected at each stage and what help, and support is available.
- Agree caring roles and responsibilities within the family (what is good enough care).

“Grace”

Grace, 80, and David, 82, have been married for 62 years. In their marriage they have had traditional roles with Grace caring for the home and family and David a retired bank manager. Grace was diagnosed with Parkinson’s Disease ten years ago. Prior to diagnosis Grace was very active and was solely responsible for household duties such as cooking and cleaning. In the last year Grace has been unable to look after the house and has recently needed David to help with her personal care such as washing and dressing. David has been struggling with running the house and feels overwhelmed by his wife’s increasing dependence on him. On several occasions he got angry and shouted at Grace. Each time he has lost his temper David has been extremely apologetic and promises to control his temper in future.

During a routine appointment at the Parkinson’s clinic, the registrar Dr Bennet, notices a tension between the couple. Dr Bennet asks to examine Grace on her own and enquires how things are at home. Grace admits that things have been difficult. David is struggling to look after her and do the household chores. Grace said that she would like some extra support.

Dr Bennet asks David to re-join them and during the remainder of the consultation she reviews Grace’s medication to see if any adjustments would help her symptoms. Dr Bennet also discusses how Parkinson’s Disease can progress and the importance of establishing caring roles and responsibilities. David admitted that he has found his new caring role challenging. It was agreed that the couple would talk to their two sons about the situation and see if family members could take it in turns to visit and provide help around the house and enable David to have a break and sometimes go to his bowls club. Dr Bennet also talked to them about support package options. Grace and David both agreed to a carer visiting once a day to help Grace get dressed in the morning. Dr Bennet arranges to see Grace and David in a months’ time to review how things are.



Increasing Social Networks^{28, 29}

Social networks consisting of relationships and interactions with individuals and groups are thought to be a key factor in quality of life. In cases of domestic abuse, the perpetrator may control or prevent someone from accessing their usual social network. In addition, a LLI may also prevent or limit social contact. Loss of social interaction can lead to feelings of isolation and depression and prevent access to support from their usual social network and

specialist services. Someone who is lonely may find it harder to seek help due to the stigma that loneliness can have. By reducing someone's social isolation it can help to lessen the risk of domestic abuse by providing opportunities for the person affected to seek help and to deter the perpetrator from abusive behaviour.

Practitioners should be alert to people who appear to have few social connections as this may be a result of domestic abuse and not just the impact of a LLI. Practitioners should consider:

- Speaking to people on their own in a safe environment.
- When carrying out assessments, such as the Holistic Needs Assessment³⁰, try and undertake at least part of this alone with the person to enable them to speak freely. Ask about who is in their support network and what social contact they have.
- Find out if someone wishes to spend more time with those in their social network and enquire if they need any support facilitating this. Is someone preventing them from seeing or contacting others?
- Offer support suggestions such as phoning friends or helplines such as The Silver Line helpline for older people and getting involved with local community activities or planning activities for the week ahead.
- Do not assume that social isolation is a result of someone's age or health status.
- Encourage uptake of all appropriate services and support such as, help with personal care, respite care, and visits from the district nurse or palliative care team.

²⁸ NHS. Loneliness in older people (2018). Available at: <https://www.nhs.uk/mental-health/feelings-symptoms-behaviours/feelings-and-symptoms/loneliness-in-older-people/> (Accessed 4th August 2022)

²⁹ James, E., Kennedy, A., Vassilev, I., Ellis, J., & Rogers, A. (2020). Mediating engagement in a social network intervention for people with a long-term condition: a qualitative study of the role of facilitation. *Health Expectations*, 23(3), 681-690. <https://doi.org/10.1111/hex.13048>

³⁰ Macmillan. Holistic Needs Assessments. Available at: <https://www.macmillan.org.uk/healthcare-professionals/innovation-in-cancer-care/holistic-needs-assessment> (Accessed 4th August 2022)

Preventing and reducing risk of domestic abuse

- **Advance planning**, such as advance statements, advance decisions, and lasting power of attorney, help other people to know how they wish to be cared for and minimises the risk of a perpetrator acting against their wishes.
- To **mitigate carer stress**, it is important that carers receive the necessary support they require.
- Be alert to people who have a small **social network**. This may be the result of domestic abuse rather than the impact of living with a life-limiting illness.

Section 7: Safeguarding

This section provides an overview on safeguarding and does not create or replace existing safeguarding procedures in place in your organisation. If you suspect someone is at risk, you must follow your organisations safeguarding policies and procedures.

Definition

The Statutory Guidance issued under the Care Act³¹ that was published in 2014 defines adult safeguarding as 'protecting an adult's right to live in safety, free from abuse and neglect' (Section 14.7). Local authorities in England and Wales have a responsibility to assess and meet the needs for care and support for adults and to safeguard 'adults at risk'. Safeguarding duties apply to an adult who:

- Has needs for care and support (whether or the not the authority is meeting any of those needs).
- Is experiencing, or is at risk of, abuse or neglect.
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect'. (Section 14.2)

The key principles and responsibilities of all safeguarding work, as outlined in the Care Act Guidance are:

- **Empowerment**- to support and encourage people to make their own decisions and informed consent.
- **Prevention**- raising awareness and taking action before harm occurs.
- **Proportionality**- taking an appropriate and proportional response to the risk.
- **Protection**- to provide support and representation for those in greatest need.
- **Partnership**- working with local organisations and communities to prevent, detect and report abuse.
- **Accountability**- ensuring everyone knows their role, responsibility and accountability in keeping individuals safe.

Aims of Safeguarding

Adult safeguarding uses a 'person-centred' approach that helps to support the person who has been harmed make their own decision.

The guidance outlines that the aims of adult safeguarding are to:

- Stop abuse or neglect wherever possible.
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
- Safeguard adults in a way that supports them in making choices and having control about how they want to live.
- Promote an approach that concentrates on improving quality of life for the adults concerned.
- Raise public awareness so that communities as a whole, alongside practitioners, play their part in preventing, identifying and responding to abuse and neglect.
- Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult.
- Address what has caused the abuse or neglect (Section 14.11).

³¹ Care Act 2014. Available at: <https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted> (Accessed 4th August 2022)

NHS England's 'Safeguarding Policy'³² outlines that it is the role of every healthcare practitioner working in the NHS to ensure that the principles and duties of safeguarding are applied with wellbeing at the centre of the health service.

Your role as the Person Raising Concern

The person who raises a safeguarding concern should follow their organisation's policy and procedures and make a referral to adult safeguarding services if criteria are met (See [Section 4: Responding to domestic abuse](#) for more information on assessing and managing risk of domestic abuse). This concern may result from something that you have seen, been told or heard.

Your assessment should be holistic and thorough considering the person's emotional, social, psychological and physical presentation as well as the identified clinical need. Particular attention should be paid to the persons wishes and views, signs of neglect, whether there are others at risk e.g., children or other vulnerable adults, and whether immediate protection is required. Practitioners working with adults have a key role in identifying children who need safeguarding. In situations where there is a concern an adult may be experiencing abuse and there may be children living in or regularly visiting the household, they too could be at risk and your local child protection services should be contacted³³.

Where there are safeguarding concerns, staff have a duty to share information and make a Safeguarding Adult referral. This information should be shared with consent wherever possible. (See [Section 4: Responding to domestic abuse](#) for further information on referrals to the safeguarding team).

Mental Capacity³⁴

Some people who experience domestic abuse may lack capacity to make certain decisions. The Mental Capacity Act (MCA) 2005³⁵ contains various safeguarding and legal approaches that can be used to support people affected by domestic abuse. Decisions taken with and on behalf of persons experiencing domestic abuse who need safeguarding may be serious and life changing. These may involve someone leaving home or having restricted contact with the perpetrator and other relatives. It is essential that people are involved to the maximum degree possible in making decisions about their own wellbeing, including their protection from domestic abuse.



Unwise decisions that put someone in danger, including the decision to not leave an abusive relationship require careful assessment to ensure someone has capacity to make these decisions. Everyone experiencing domestic abuse should be given information on their options to ensure they have access to all relevant information required to make an informed decision. For those who return to or do not wish to leave an abusive relationship, a safeguarding plan should include developing a safety plan with them to reduce risks and outline options for leaving should they wish to do so. Ensure decisions are fully documented and discussed within the team.

³² NHS. Safeguarding Policy (2019). Available at: <https://www.england.nhs.uk/wp-content/uploads/2019/09/safeguarding-policy.pdf> (Accessed 4th August 2022)

³³ HM Government Working Together to Safeguard Children (2018). Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf (accessed 6th June 2023)

³⁴ NHS. Mental Capacity Act (2021). Available at: <https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/> (Accessed 4th August 2022)

³⁵ Mental Capacity Act 2005. Available at: <https://www.legislation.gov.uk/ukpga/2005/9/contents> (Accessed 4th August 2022)

When someone is assessed to lack capacity and is not able to participate in decision making, the Care Act (2014) says that an independent advocate must be engaged. Independent Mental Capacity Advocate (IMCAs) are a statutory safeguard to make key decisions for those who lack capacity and do not have friends or family to represent them or if having an IMCA would benefit the person. IMCAs can be involved in decisions around housing and treatment. IMCAs and Independent domestic Violence Advisors (IDVAs) may work together to best support those affected by domestic abuse.

The **MCA's 5 core principles** state:

- Assume a person has the capacity to make a decision themselves, unless it's proved otherwise.
- Wherever possible, help people to make their own decisions.
- Do not treat a person as lacking the capacity to make a decision just because they make an unwise decision.
- If you make a decision for someone who does not have capacity, it must be in their best interests.
- Treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms.

The MCA sets out a **2-stage test of capacity**:

1) Does the person have an impairment of their mind or brain, whether as a result of an illness, or external factors such as alcohol or drug use?

2) Does the impairment mean the person is unable to make a specific decision when they need to? People can lack capacity to make some decisions but have capacity to make others. Mental capacity can also fluctuate with time – someone may lack capacity at one point in time but may be able to make the same decision at a later point in time.

Where appropriate, people should be allowed the time to make a decision themselves.

The MCA says a person is unable to make a decision if they cannot:

- Understand the information relevant to the decision.
- Retain that information.
- Use or weigh up that information as part of the process of making the decision.
- Communicate the decision.

Safeguarding

- **Adult safeguarding** protects an 'adult's right to live in safety, free from abuse and neglect'.
- Cases of domestic abuse or suspected abuse experienced by people with a LLI are **high risk** and a referral to the safeguarding team or MARAC can be made without consent (although it is best practice to share information with consent if possible).
- A referral to children's services must be made in cases of domestic abuse involving **children**.
- **Mental capacity** is the capacity for someone to make decisions for themselves. If capacity is assessed to be lacking to make specific decisions for themselves, they may need support and, in some situations, a best interest meeting may need to be convened to make decisions on their behalf.

Section 8: Managing domestic abuse in your organisation

Organisation Assessment

All practitioners should be familiar with their organisations policies and protocols on how to respond to and manage domestic abuse.

Domestic Abuse Champion

Appointing Domestic Abuse Champions within an organisation can help act as a point of reference for staff and provide advice and support to them when needed. Although a relatively new concept, evidence suggests Domestic Abuse Champions in healthcare settings have a positive impact and act as change agents through their support and mentorship enabling colleagues to effectively change their practice and engage in the complex and challenging work of detecting and responding to abuse³⁶. Champions need to be trained to an enhanced level but not delegated sole responsibility for managing domestic abuse within the organisation, rather supporting fellow practitioners through the process. While all staff should be given the opportunity to take on the Champion role, they should be those who are approached for problem solving or have line management responsibilities to operate as part of a network of champions within the setting.

What is the role of a Domestic Abuse Champion?

- Acts as the domestic abuse contact for your organisation.
- Raises awareness and cascades knowledge about domestic abuse.
- Can identify those affected by domestic abuse and refer them to local resources and support.
- Provides the link between an organisation and the community.
- Receives more in-depth domestic abuse training.

Roles and responsibilities

It is important that every member of a team understands their own roles and responsibilities when it comes to responding to domestic abuse and is able to act accordingly. ([See Section 9 for further information on Training](#))

³⁶ Saberi, E., Hurley, J., & Hutchinson, M. (2022). The role of champions in leading domestic violence and abuse practice improvement in health care: A scoping review. *Journal of Nursing Management*, 1–9. <https://doi.org/10.1111/jonm.13514>SABERIET AL.9

Staff Support and Supervision

NHS Trusts should work within the NHS Health and Wellbeing Framework³⁷ to ensure staff are offered the help required to ensure their support needs are met. One method of providing support is through supervision. The role of the supervisor is to help ensure safe practice and to support and monitor progress through regular meetings. There are different forms of supervision including:

- **One-to-one managerial supervision** offers an opportunity for staff to review their job role, check skills and competencies, review caseload, discuss training and development needs and review new policies and protocols.
- **Clinical supervision** is reflective scenario based situational learning. Staff working in clinical areas who care for patients should have access to clinical supervision. The clinical supervision sessions offer an opportunity for in depth discussions on clinical cases and review any safeguarding concerns.
- **Safeguarding supervision** is a formal process of support and learning to help staff develop knowledge and skills.

During supervision sessions the supervisor should ask about the practitioner's wellbeing and should ensure appropriate support such as mentoring, or counselling is offered where appropriate. These supervision sessions offer a safe environment for practitioners to discuss cases of domestic abuse that may be particularly challenging. Staff with a safeguarding concern should be able to request group or individual supervision to discuss the case.

In addition to supervision, the NHS and other organisations have a range of support available to practitioners³⁸. This includes helplines, support from practitioners' associations and colleges and, support networks.

³⁷ NHS England. NHS health and wellbeing framework (2022). Available at: <https://www.england.nhs.uk/publication/nhs-health-and-wellbeing-framework/> (Accessed 4th August 2022)

³⁸ NHS Resolution. Support for practitioners. Available at: <https://resolution.nhs.uk/services/practitioner-performance-advice/advice/support-for-practitioners/> (Accessed 4th August 2022)

Section 9: Training



It is a NICE³⁹ requirement that all health and social care professionals involved in caring for people who might be experiencing or perpetrating domestic abuse receive sufficient and appropriate training to ensure they can enquire about and respond to domestic abuse.

Knowing your Limits

This Toolkit is designed to boost the confidence of those working with people with life-limiting illnesses (LLI) to enquire about and respond to cases of domestic abuse. However, it is important to recognize the scope of your knowledge, skills and experience to work within your

scope of practice. When thinking about your scope of practice you can consider:

- The policies, protocols and legal requirements around managing cases of domestic abuse. For example, when confidentiality may need to be broken.
- Whether you have the skills and knowledge required to manage domestic abuse cases.
- The training options or supervision sessions available to expand your knowledge.

If you identify a case of domestic abuse or are involved in its management and are unsure of anything then you should discuss the case with your supervisor, Domestic Abuse Champion, and the safeguarding lead within your organisation.

Training Levels

Delivering high quality training helps practitioners to feel more confident about asking about and responding to disclosures of domestic abuse. It is also important that all members of staff in an organisation have access to domestic abuse training. People with LLI may choose to confide in those without a healthcare background, such as volunteers, catering and housekeeping and administrative staff. Therefore, it is important all staff feel confident to respond and support those affected by abuse. This section contains some recommendations for successful domestic abuse training.

NICE recommends three levels of training that should be refreshed at least every two years that could be delivered in person or via e-learning:

- **Level 1** training is recommended for all health and social care professionals to help them respond to disclosures and direct people to relevant services. Level 1 training is often covered as part of mandatory safeguarding training.
- **Level 2** training covers how to ask about domestic abuse safely and deliver consistent and appropriate responses. This training is recommended for staff providing direct patient care and support.
- **Level 3** training should be undertaken by practitioners such as an appointed Domestic Abuse Champions and Safeguarding colleagues who are most likely to care for people experiencing domestic abuse. This

³⁹ NICE. Domestic violence and abuse (2016). Available at: <https://www.nice.org.uk/guidance/qs116/resources/domestic-violence-and-abuse-pdf-75545301469381> (Accessed 4th August 2022)

specialist training should cover risk assessment, safety planning and liaising with specialist support services.

Training Recommendations

Below are recommendations and considerations for delivering effective domestic abuse training within an organisation:

- The format and content of the training is key to ensure staff get the most out of the training as possible:
 - The mode of delivery will vary depending on the training level. E-learning tends to be given for Level 1 training and in-person training used for Levels 2 and 3.
 - Healthcare staff should receive training that covers topics such as types of domestic abuse, the indicators of abuse, enquiring about domestic abuse, dealing with disclosure, conversations with perpetrators, risk assessment and referral options.
 - Non-healthcare staff should receive training on issues around confidentiality and who to report disclosures of abuse to.
 - Role play with colleagues or actors can help staff to practice enquiring about and responding to domestic abuse in a safe and constructive environment.
 - Reviewing case studies can help practitioners to identify different forms of domestic abuse and provide examples of how to respond.
- Appointing Domestic Abuse Champions can help act as a point of reference for any queries that staff may have. Domestic Abuse Champions will have received more in-depth training⁴⁰ and will keep up to date on referral pathways and local services. In some organisations the Champion may also help to organise training for their colleagues.
- Consider who is best place to deliver training. If this is someone from within your organisation, they should have enough resources and capacity to deliver best practice guidance. Some organisations may choose for the training to be delivered by an external specialist service. Organisations such as AVA⁴¹, SafeLives⁴², Dewis Choice⁴³, Hampton Trust⁴⁴ and Yellow Door⁴⁵ offer specialist training for staff.
- Organisations should consider whether domestic abuse training should be delivered as part of other training such as safeguarding or should be stand alone.
- The content of the training should be up to date with current safeguarding policies and procedures.
- Staff should be aware about the impact that LLI can have on someone's quality of life and vulnerability to domestic abuse. Training should cover the signs of domestic abuse that may be present in someone with a LLI that may be overlooked e.g., depression or not attending appointments.
- Training needs to address experiences of groups such as LGBTQ+ communities, older people, minority ethnic communities, and those with complex care needs as these groups are often overlooked.
- Training should be refreshed at least every two years to help maintain practitioners' confidence and to keep them up to date with any policy changes.
- Organisations may wish to display posters or create alerts on medical records to raise awareness among staff to always consider domestic abuse in every contact with someone with a LLI.

⁴⁰ Reducing the Risk of Domestic Abuse. DA Champion training. Available at: <https://reducingtherisk.org.uk/da-champion-training/> (Accessed 4th August 2022)

⁴¹ Against Violence and Abuse. E-Learning. Available at: <https://avaproject.org.uk/ava-training/elearning/> (Accessed 4th August 2022)

⁴² Safe Lives. Domestic Abuse Training for Employers. Available at: <https://safelives.org.uk/training/DA-training-for-employers> (Accessed 4th August 2022)

⁴³ Dewis Choice. Training. Available at: <https://dewischoice.org.uk/what-we-do/training/> (Accessed 4th August 2022)

⁴⁴ Hampton Trust. Training. Available at: <https://hamptontrust.org.uk/professionals/> (Accessed 4th August 2022)

⁴⁵ Yellow Door. Training. Available at: <https://yellowdoor.org.uk/workwithus/training/> (Accessed 4th August 2022)

- Staff should be encouraged to use their clinical supervision or support system to discuss any concerns they may have about managing cases of domestic abuse.

Training

- All staff working in healthcare should receive the relevant level of domestic abuse training.
- Training should cover the vulnerability, signs, and impact of domestic abuse on those with life-limiting illnesses.
- If you are involved in a domestic abuse case and are unsure of anything then you should seek support from your supervisor, manager, Domestic Abuse Champion, or the safeguarding lead within your organisation.

Section 10: Resources

For information on local domestic abuse services see your organisations intranet and policy documents. Below are other organisations and sources of information that you may find helpful.

Local Wessex Organisations

Aurora New Dawn is Hampshire based and offers safety, support advocacy and empowerment to survivors of domestic abuse.

<https://www.aurorand.org.uk/>

Hampton Trust provides a range of services for those affected by domestic abuse including domestic violence prevention programmes running in Wessex.

[Hampton Trust](#)

Pippa Helpline (02380917917) (Prevention, Intervention & Public Protection Alliance) Helpline for people living in Southampton that provides support for those experiencing domestic abuse.

Yellow Door offers a range of services to prevent and respond to domestic and sexual abuse to residents in Southampton and the surrounding area.

[Homepage - Yellow Door](#)

You Trust supports vulnerable people across Hampshire, Dorset, Somerset, the Isle of Wight, and West Sussex and deliver services that reduce harm and increase safety for all victims and survivors of domestic abuse.

<https://theyoutrust.org.uk/>

National Organisations

Older Adult support services

We Are Hourglass provides information and support to older people who have experienced or concerned about abuse.

[Hourglass \(wearehourglass.org\)](http://wearehourglass.org)

Age UK helps older adults

<https://www.ageuk.org.uk/>

The Silver line is a helpline for older people set up by Esther Ranzen on 0800 4708090

LGBTQ+ Support

Galop provides hate crime, domestic abuse and sexual violence support services to lesbian, gay, bisexual and trans + community.

[Galop - the LGBTQ+ anti-abuse charity - Galop has provided advice, support, research and lobbying around the issues of LGBTQ+ policing for over 30 years.](#)

Support for the deaf or hard of hearing

Sign Health support and advice for survivors of domestic abuse who are deaf or hard of hearing.

<https://signhealth.org.uk/>

Other Useful Information

Citizens Advice offers advice to victims of domestic abuse.

[Domestic violence and abuse - getting help - Citizens Advice](#)

Coercive Control offers information and resources on coercive and controlling behaviour.

[Additional resources | Coercive Control \(ripfa.org.uk\)](#)

Local authority websites- provide information on how to make a referral for any adults at risk that you have concerns about.

Macmillan Cancer Support physical, emotional and financial support.

<https://www.macmillan.org.uk/>

Men's advice line a helpline for male victims of domestic abuse.

[Domestic Abuse Helpline for Men | Men's Advice Line UK \(mensadviceline.org.uk\)](#)

Refuge supports women, children and men experiencing domestic violence with a range of services.

<https://www.refuge.org.uk/>

Women's Aid is a national charity for women working to end domestic abuse.

[Home - Women's Aid \(womensaid.org.uk\)](#)

Further Reading

AVA (Against Violence & Abuse) aims to stop gender-based violence and abuse.

[Home - AVA - Against Violence & Abuse \(avaproject.org.uk\)](#)

Dewis Choice is the centre for age, gender and social justice and has information and advice for professionals

<https://dewischoice.org.uk/>

Safelives has online resources for survivors, professionals and policy makers.

[About us | Safelives](#)

Section 11: Appendices

APPENDIX 1: SafeLives DASH Risk Checklist

SafeLives Dash risk checklist



Aim of the form

- To help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'- based violence.
- To decide which cases should be referred to Marac and what other support might be required. A completed form becomes an active record that can be referred to in future for case management.
- To offer a common tool to agencies that are part of the Marac¹ process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence.
- To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

How to use the form

Before completing the form for the first time we recommend that you read the [full practice guidance](#) and [FAQs](#). These can be downloaded from the '[Resources for identifying the risk victims face](#)' section on the SafeLives website. Risk is dynamic and can change very quickly. It is good practice to review the checklist after a new incident.

Recommended referral criteria to Marac

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

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

What this form is not

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

¹ For further information about Marac please refer to the 10 principles of an effective Marac: <http://www.safelives.org.uk/node/361>

SafeLives Dash risk checklist for use by IDVAs and other non-police agencies for identification of risks when domestic abuse, 'honour'-based violence and/or stalking are disclosed

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

Tick the box if the factor is present. Please use the comment box at the end of the form to expand on any answer.	YES	NO	DON'T	State source of info
15. Has [name of abuser(s)] ever attempted to strangle / choke / suffocate / drown you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Does [name of abuser(s)] do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? If someone else, specify who.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Is there any other person who has threatened you or who you are afraid of? If yes, please specify whom and why. Consider extended family if HBV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Do you know if [name of abuser(s)] has hurt anyone else? Consider HBV. Please specify whom, including the children, siblings or elderly relatives: <ul style="list-style-type: none"> Children <input type="checkbox"/> Another family member <input type="checkbox"/> Someone from a previous relationship <input type="checkbox"/> Other (please specify) <input type="checkbox"/> 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Has [name of abuser(s)] ever mistreated an animal or the family pet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Are there any financial issues? For example, are you dependent on [name of abuser(s)] for money/have they recently lost their job/other financial issues?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Has [name of abuser(s)] had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? If yes, please specify which and give relevant details if known. <ul style="list-style-type: none"> Drugs <input type="checkbox"/> Alcohol <input type="checkbox"/> Mental health <input type="checkbox"/> 				
22. Has [name of abuser(s)] ever threatened or attempted suicide?				
23. Has [name of abuser(s)] ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? You may wish to consider this in relation to an ex-partner of the perpetrator if relevant. <ul style="list-style-type: none"> Bail conditions <input type="checkbox"/> Non Molestation/Occupation Order <input type="checkbox"/> Child contact arrangements <input type="checkbox"/> Forced Marriage Protection Order <input type="checkbox"/> Other <input type="checkbox"/> 				
24. Do you know if [name of abuser(s)] has ever been in trouble with the police or has a criminal history? If yes, please specify: <ul style="list-style-type: none"> Domestic abuse <input type="checkbox"/> Sexual violence <input type="checkbox"/> Other violence <input type="checkbox"/> Other <input type="checkbox"/> 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Total 'yes' responses				

For consideration by professional

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

<p>Do you believe that there are reasonable grounds for referring this case to Marac?</p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>
<p>If yes, have you made a referral?</p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>
<p>Signed</p>	<p>Date</p>
<p>Do you believe that there are risks facing the children in the family?</p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>
<p>If yes, please confirm if you have made a referral to safeguard the children?</p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>
<p>Signed</p>	<p>Date referral made</p>
<p>Name</p>	<p>Date</p>

Practitioner's notes

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

APPENDIX 2: Domestic Violence and Abuse Tool (DVA Tool)

The Domestic Violence and Abuse Tool⁴⁶ is designed to help practitioners understand and establish the level of concern they have following a discussion with someone with a life-limiting illness who may be experiencing domestic abuse. This can help to ensure an appropriate response is given.

Level of Concern	Low	Medium	High
General Relationship Dynamics	<p>Consensual & respectful, equal relationship</p> <p>Joint decision making</p>	<p>Relationship imbalance in power and decision making</p> <p>Consider ethnicity/culture, age gap/difference in ability.</p>	<p>Significant relationship imbalance</p> <p>Power and control used in relationship</p> <p>Forced compliance</p> <p>Consider previous violence or abuse in this or other relationship</p>
Jealous and controlling behaviour	<p>Freedom of choice</p> <p>Communicates freely with friends and family</p>	<p>Pressure to act in certain ways</p> <p>Possessive, unsupportive and critical</p> <p>Withdrawal from friends and family</p> <p>Limiting access to medical treatment</p>	<p>Coercion or forced to act in certain ways- feels unable to refuse</p> <p>Person prevented from making own decisions due to controlling behaviour of the perpetrator</p> <p>Isolated from friends and family</p> <p>Denied access to medical treatment</p>
Separation		<p>May attempt or wishes to separate</p>	<p>Scared to separate/attempts to separate</p>
Verbal abuse	<p>Healthy disagreements using appropriate language</p>	<p>Aggressive or disrespectful language to the person</p> <p>Making jokes or insensitive comments</p>	<p>Person directly threatened and intimidated</p>

⁴⁶ Southern Health NHS Foundation Trust Domestic Violence and Abuse Policy Version 5 (2020)

Physical abuse		Rough manhandling Minor physical injuries where medical attention is sought	Deliberate placing of obstacles to cause trips and falls Escalating aggressive behaviour e.g. hitting, kicking, strangulation Injuries that require medical attention but do not seek medical care Broken bones, deliberate injury to surgical sites or wounds
Financial abuse	Able to freely access money	Limited access to finances	Perpetrator controls finances Misuse of payments from state benefits
Sexual activity	Consensual	Rough treatment during sex which had not previously manifest in relationship	Non-consensual sexual activity Feels unable to say no due to fear of consequences
Mental Health and Substance Misuse	Emotionally stable	Low mood Substance/alcohol misuse	Self-harm/suicidal ideation Panic attacks/anxiety Substance/alcohol misuse
Individual at risk		Insight into the risk to themselves	Fear of statutory services
Perpetrator		Engages with services Victim makes excuses for behaviour	Does not engage with services No remorse Blames victim No insight into impact of abuse

APPENDIX 3: Key Stages for Enquiring about Domestic Abuse

Definition of Domestic Abuse

An incident or pattern of behaviour within a relationship that is used to gain power and control. It encompasses physical, sexual, emotional, financial, or psychological actions. Anyone can experience domestic abuse regardless of their background.

Creating a safe space

- Privacy
- Independent interpreter
- Personal safety

Opening Questions

Create a safe space to ask about domestic abuse. Example opening questions include:

- How are things at home?
- You seem worried about something, and I wondered if there is anything you would like to talk about?
- What do I need to know to support you?

Further Questions

Gently probe further with open questions:

- Do you feel safe
- Tell me more about...
- What if you challenge the behaviour? What are the consequences?
- Who do you trust/can confide in?
- What is important to you at this time?

Dealing with Disclosure

It is important to acknowledge disclosures of domestic abuse:

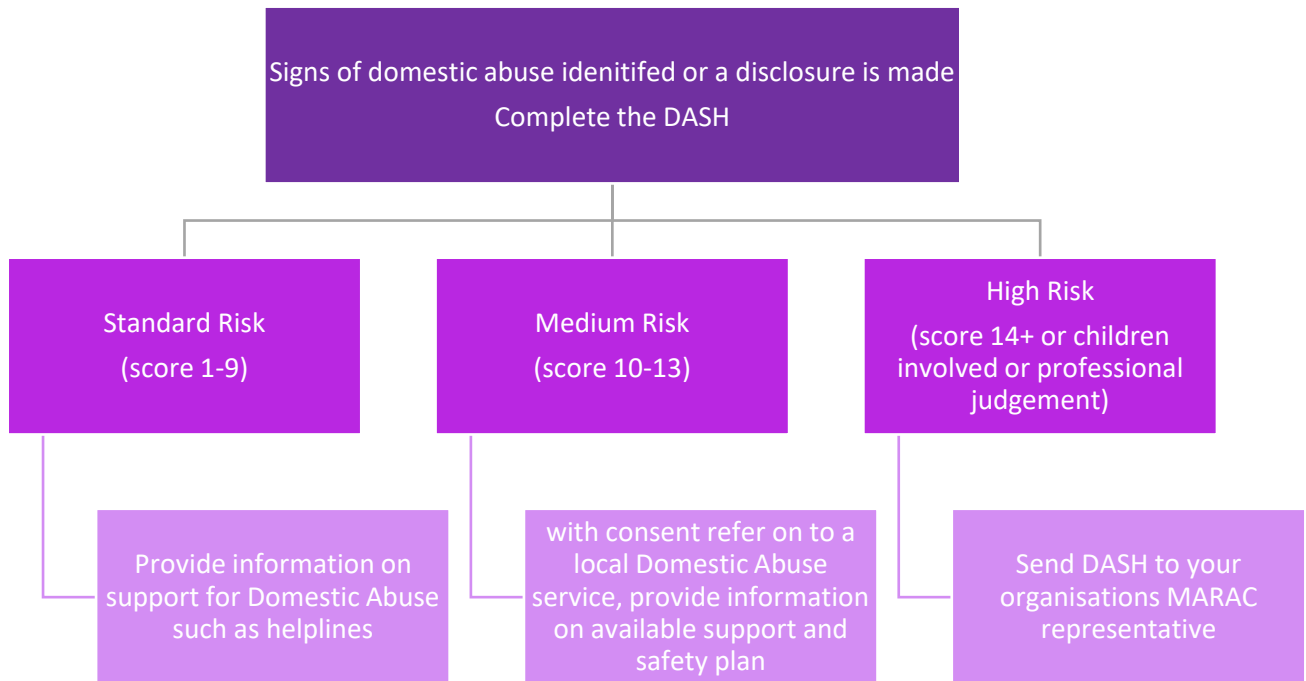
- Thank you for telling me
- It is not OK to be treated like that
- This is not your fault; you are not to blame

Support Following Disclosure

Ask the person what they would like to happen next:

- What would you like to happen?
- Is there anything you would like me to do?
- Who else can support you?

APPENDIX 4: Referral Pathway⁴⁷



Remember

If you have **immediate** concerns over someone's physical safety, please call the Police on 999.

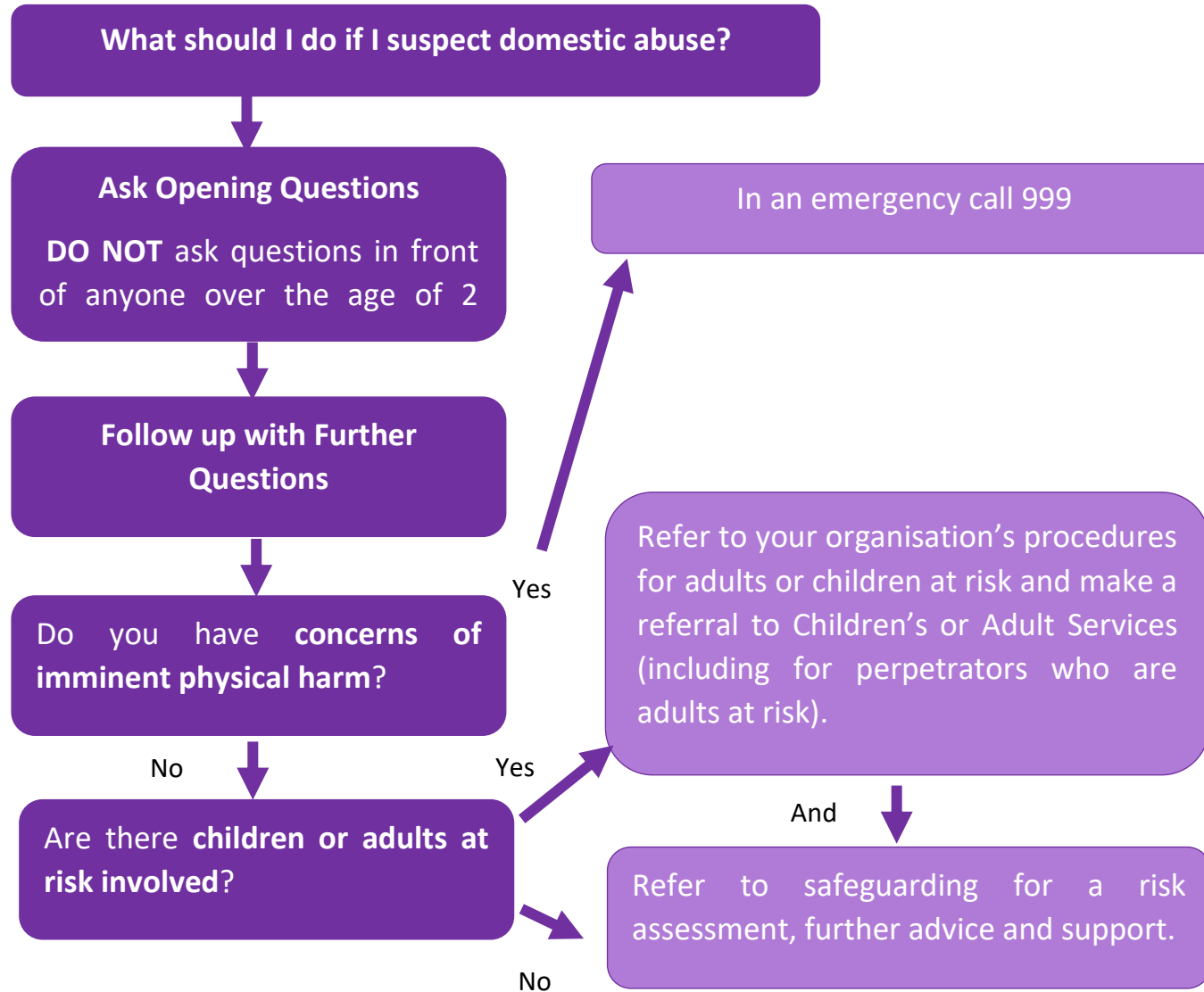
Be guided by the risk assessment score and personal judgement. If there is immediate risk to a vulnerable adult, initiate your organisations safeguarding adult procedures.

All risk assessments should be completed **promptly** and sent within 2 working days of identifying the risk to the appropriate agency.

Risk assessments should be conducted **regularly** to identify any changes to the risk of harm.

⁴⁷ Somerset Safeguarding Adults Board. Guidance for Safeguarding Adults in Somerset. Available at: <https://ssab.safeguardingsomerset.org.uk/adult-safeguarding-procedures-intro/domestic-abuse-and-maracs/> (Accessed 4th August 2022)

APPENDIX 5: What to do if you suspect Domestic Abuse?



Top Tips

- Be compassionate and non-judgemental.
- Make sure you are in a safe and private environment.
- Do not use family or friends as interpreters.
- Be aware of who else might be present when having conversations over the phone.

In all cases, undertake the following actions:

- Talk to the person about safety planning.
- Consider what your organisation should do to help them and keep them safe, and which other agencies should be contacted.
- Ask if they want further support or information.

