A Guide for Healthcare Staff in NHS Lothian

Domestic Abuse Toolkit

Produced by NHS Lothian 2007 and based on original edition by South West Local Health Partnership 2005
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Introduction

This guide is aimed mainly at all healthcare staff in NHS Lothian but may be useful for other disciplines.

It suggests practical approaches for health workers to respond to women who have experienced domestic abuse and men who perpetrate it. It takes as its starting point Responding to Domestic Abuse, Guidelines for Health Care Workers in NHS Scotland issued by the Scottish Executive in 2003 and is consistent with the NHS Lothian Domestic Abuse Strategy, 2004 which aims to ‘ensure that health workers in NHS Lothian respond appropriately to women experiencing domestic abuse’.

Domestic abuse is a serious health care issue. The financial costs to the NHS are considerable, and the impact on the long-term health and wellbeing of individual women, children and men incalculable. The health service is often the first formal agency which women affected by domestic abuse contact for help, often primary care, maternity, obstetrics, dentistry, psychiatry and A&E. For many reasons they may not disclose the abuse. However, many women who do not disclose say they would have done so, if they had been asked.

Healthcare workers play a vital role in responding to those affected by domestic abuse. Providing effective support, treatment and intervention to women and children and holding perpetrators accountable for their actions may reduce abuse in the long-term, and sends out an important message to women, children and men that domestic abuse is not acceptable.

This guide builds on an earlier version aimed at primary care staff and provides information and guidance relevant to all sectors in NHS Lothian.

Aims of the guide
This guide aims to:
- Encourage healthcare staff to be more aware of domestic abuse
- Help healthcare staff respond effectively when they know of or suspect domestic abuse
- Increase knowledge, confidence and skills of healthcare staff
- Improve quality of service for women and any dependent children who have experienced domestic abuse
- Keep women safe.

How we compiled the guide
The first edition of this guide was compiled by a small working group comprising various primary care practitioners. It has been updated with contributions from staff in A&E, midwifery, obstetrics and mental health.
We built up the material in the guide by using a variety of methods. We conducted a literature search of recent domestic abuse guidance, protocols and screening tools for health settings. We met with health care staff developing services for abused women. We held focus groups attended by staff from different settings including school nursing, physiotherapy, health visitors, GPs, midwifery, A&E, paediatrics and mental health to discuss common difficulties and dilemmas. We gathered case study examples from healthcare staff; and we sought advice and comment from colleagues including the Domestic Violence Probation Project.

What to expect of the guide

This guide is meant to be practical. It suggests good practice approaches to bringing up the subject of domestic abuse and responding safely when you suspect or know it is an issue.

We appreciate that healthcare staff are busy and do not have time to read a mass of information. So, we have tried to be brief. This means we have not set out what to do in every circumstance. If you need more information, we have suggested where to get this.

We have provided a list of services as options for onward referral. You can also contact these services for your own information. The list of services is not exhaustive but all those given will be able to tell you about others.

One size does not fit all

The information in this guide is general, but you should use this selectively and in a way which best suits the individual circumstances of your patient(s).

- Domestic abuse can affect anyone, regardless of social circumstances, ethnic background, educational or physical ability. However, the ways in which it manifests or how women experiencing abuse deal with it vary considerably. This guide provides a general approach to responding to domestic abuse but you must be sensitive to individual circumstances. Any woman experiencing domestic abuse faces complex issues. However, services are often based on the experience of white, indigenous, able-bodied women. It is important to be aware of other issues a woman might need to take account of, for example, immigration status, racism, isolation, language barriers and disability to reduce barriers and long-term vulnerability. The directory provides details of services which have particular expertise in such issues.

- With domestic abuse, there is often more focus on crisis response. However, you may have patients who have been affected by domestic abuse perpetrated in the past. You will need to take account of this when deciding how best to respond.

- Similarly, your relationship with the patient will determine how best to respond. Whether this is a one-off contact and whether you are likely to be involved with other members of her family will affect your course of action.
Terminology
Domestic abuse can take place in any relationship, including gay and lesbian partnerships. Although abuse of men by female partners does occur, most domestic abuse is perpetrated by men against women and their children. For this reason, this guide refers to those experiencing domestic abuse as women and those perpetrating domestic abuse as men.

Updates and amendments
The guide is in loose-leaf format so it can be added to. There are pullout desktop references for sections two and three.

Please let us know if there is anything you think we should add or change.

Further information
For further information on domestic abuse and copies of this guide please contact:

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Training
Contact your training department for information on training on domestic abuse.

1 Responding to Domestic Abuse, Guidelines for Health Care Workers in NHS Scotland, Scottish Executive, 2003.
Definition of Domestic Abuse

This guide is based on the Scottish Executive's definition of domestic abuse:

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

X was admitted to A&E at 3am. She had been a frequent attendee over many years with various injuries. On this occasion, she had minor head injuries and rib fractures. She decided that she did not want to go back home to her partner. The staff contacted the housing department. She was given emergency accommodation and then rehoused permanently. She has no dependent children.

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Pilot Routine Enquiry into Domestic Abuse

Leith Community Midwifery Team is piloting routine enquiry on domestic abuse. In preparation, all midwives have received training through the Lothian Domestic Abuse Training Consortium. From January to June 2007, all women will be asked about domestic abuse at their booking appointment. The pilot will be evaluated, audited and extended throughout midwifery services within the NHS. A local NHS-employed specialist is also available to support women and staff.

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Some Facts about Domestic Abuse

- Domestic abuse can be mental, physical and/or sexual.
- It is systematic and the level of repeat victimisation is high.
- Between a quarter and a third of all women in Scotland experience domestic abuse in their lives.
- Domestic abuse is not limited to one social group. But some circumstances may increase risk to women. These include age (young); alcohol or drug use; having young children; marital separation; disability or ill health.
- Women who are disadvantaged by poverty may find it more difficult to get protection.
- Women from minority ethnic communities, disabled women, lesbians and older women may find it more difficult to disclose and to get help.
- Violence may begin or escalate in pregnancy.
- Children are affected by domestic abuse by witnessing the abuse of their mother and/or by being abused themselves. There is evidence of an association between violence towards the mother and physical or sexual abuse of the children.
- The Edinburgh and Lothians Child Protection Committee Child Protection Guidelines state that recurrence of violence within a family/household, particularly between adult partners, should be viewed as an indicator of risk to the children of that family/household.

- Violent men are often abusive in successive relationships.
- Some women remain in relationships with abusive men. This may be because they fear losing their children, family, home, financial security, community support, residency rights, carer, or risk further abuse if they leave. There may be long periods when there is no violence; they may be emotionally attached to the man; or may believe a man’s promises to change or stop the abuse.
- Other women leave abusive men but it may take many attempts to make a final break. Violence may increase when a woman leaves or threatens to leave.
- Domestic abuse is likely to bring a family into contact with many different agencies. It is vital that all agencies work together effectively so that individuals receive the best possible service and proper protection and support.
- There is recourse under housing law for women to stay in the family home without the man; for permanent re-housing in her own or another area; and/or temporary housing while her options are sorted out.
- There is recourse under criminal and civil law for protecting women and children and prosecuting and working with offenders.

Adapted from the NHS Lothian Domestic Abuse Strategy, 2004
How Domestic Abuse Affects Health

Domestic abuse has serious consequences for the physical, sexual and mental health of women and their children.

- The cost to the NHS in England and Wales for physical injuries is around £1.2 billion a year and mental health care is estimated at an additional £176 million.³
- Domestic abuse may result in physical injury, chronic physical ill health and emotional and mental health difficulties. It can lead to acute and chronic physical difficulty, miscarriage, loss of hearing or vision, physical disfigurement and psychological injury.
- Domestic abuse can have long-term health consequences. For example, a recent study found that almost half the women with breast, cervical, endometrial and ovarian cancer reported a history of violence and this correlated with advanced stage at diagnosis despite equivalent adherence to recommended cancer screening.⁴
- The more chronic the abuse, the longer it goes on, the worse the effect.⁵ Older women may be particularly affected by long-term trauma through suffering abuse over long periods.⁶
- One in three women experiences sexual abuse along with physical abuse⁷ and abusive men may forbid their partners to use contraceptives leading to unwanted pregnancies and STIs.⁸
- Domestic violence has been identified as a prime cause of miscarriage or still-birth⁹ and is a cause of maternal death,¹⁰
- Data from ten countries indicates that the physical effects of violence may last long after the actual violence has ended or that cumulative abuse affects health most strongly; mental health problems are common among women who have suffered partner violence; and are much more likely to have ever thought of suicide.¹¹
- Depression is a prevalent consequence¹² and repeated violence by a partner can lead to complex post-traumatic stress disorder.¹³
- Women who have been abused by their partner are five times more likely to attempt suicide, fifteen times more likely to abuse alcohol, nine times more likely to abuse drugs and three times more likely to be diagnosed as depressed or psychotic.¹⁴
- At the extreme, some women are murdered by their partners or ex-partners. Over half of all women murdered in the ten years to 2005 were killed by their partner.¹⁵
- Exposure to family violence is profoundly damaging to children’s emotional and social development.¹⁶
- Children’s health may be seriously affected by witnessing the abuse of their mother or by being abused also.¹⁷
- Domestic abuse may begin, or become more serious during pregnancy.¹⁸
- Abuse during pregnancy may contribute to low birthweight in babies.¹⁹
Children affected by domestic abuse may show symptoms including failure to thrive, anxiety and depression, withdrawal, asthma, eczema, disability caused by abuse of the mother during and after pregnancy, bedwetting, attempted suicide, or death from murder or suicide. Children who witness the violent treatment of their mothers may face multiple health risks as adults.20

Children of abused women experience increased levels of anxiety, psychosomatic illness and depression.21

11 Herman J, (2001) Trauma and Recovery: from domestic abuse to political terror. London. Pandora

Adapted from the Responding to Domestic Abuse, Guidelines for Health Care Workers in NHS Scotland, Scottish Executive, 2003 and NHS Lothian, Domestic Abuse Strategy, 2004
Dilemmas in Dealing with Domestic Abuse

What health workers say
When we spoke to health workers in a variety of settings, you voiced many concerns which affect how you respond (or avoid responding) to domestic abuse. Some of the dilemmas you mentioned are discussed below.

You are concerned about lack of time/resources
Busy NHS staff are always under pressure. For example, in A&E it is difficult to guarantee time as the situation can change so quickly. In noisy, busy environments it is important to recognise your limitations. But you can use limited time effectively. Giving a woman the number of Women’s Aid or domestic abuse helpline and telling her that the abuse is not her fault and that there are people who can help takes very little time and could make an immense difference.

The costs to the NHS financially, in staff time, to individuals and their families of not tackling domestic abuse effectively are enormous.

You don’t know what to do
That’s OK. You can't be expected to know everything, but there’s always something you can do. This guide gives you some ideas of action you can take. If you are not sure what to do, you can also ask a colleague or a specialist agency for help.

There are many specialist agencies which can give you further information and advice. These are listed in section 4.

The extent of your involvement and the expertise you need depend on your setting and whether you are likely to have a one-off single contact or a longer-term relationship with the victim, perpetrator or any children.

“*My experience is of previous domestic violence/trauma, where women may come to me years later to have their teeth fixed after they have finished with the relationship. I usually see broken teeth, displaced teeth, broken dentures, soft tissue trauma and broken noses. I listen to their stories but often feel fearful about taking it any further because I am not sure who to refer to.*”

NHS DENTIST

You think it’s a personal issue and don’t want to interfere
Domestic abuse is a major health issue. If you remember this, it will help you to deal with domestic abuse, for example by asking the right questions, providing assistance and keeping good records.

You want to provide a solution
Although it’s tempting to want to find solutions, there are no quick fixes. There is no medical ‘treatment’ for domestic abuse and you are not likely to find a simple answer. But there are many effective interventions. The intervention will vary according to your role and whether or not you are likely to see the victim, the perpetrator or any children again.

What you can do is treat the person, respond to them sympathetically, ask sensitive questions, provide correct information and suggest possible options. You also play an important role in minimising risk.
You think, “Not again!”

You’ve seen this woman before, perhaps more than once.

It is frustrating to see the same woman again and again. You may end up feeling frustrated and that there is no point in trying to help because she “won’t help herself”. You may have additional concerns if she has children.

We often expect women experiencing domestic abuse to leave the violent partner and end the relationship. But many women stay, sometimes through choice, sometimes through fear. For example, they don’t see why they should leave their home; they still love him and hope that things will get better; they are frightened of what might happen to them or their children if they do leave. Fear can motivate but it can also imprison. There may be no immediate threat to a woman’s physical safety if the violence is emotional rather than physical.

If a woman does decide to leave, it may take her a long time, and many attempts, to do so – leaving domestic abuse is a process not an event – and research indicates that women who leave abusive partners typically experience 35 domestic abuse incidents before they do so. This is not because they like the violence or are ‘weak’ or ‘indecisive’. It is because leaving is very difficult and they have other things to take into account, like money, their home, children, consequences of their actions and so on.

The complexities are endless and there may be no ‘right’ decision or black and white answers. As a health worker you need to think about how you can support women in these complex and often ‘messy’ situations.

It is important to remember that abused women are individuals with rights. For example, you can tell a woman what you want for her (e.g. to be safe) but the action she takes is up to her. You might give a woman a helpline number which she might never use. But, knowing that she has options and can ask for help if she needs it, may help her.

Your role is to offer her support whether she stays or leaves; to make sure that she is making any decisions based on good information; and to ensure safety mechanisms are in place. You need to be led by the woman and what she wants to do. Whatever decision she makes, you can support her. But you also need to take into account any child protection issues and she should know that.

You can reassure her that she can come back to the NHS as often as she needs.

You are anxious about your own safety

While you should be ready to discuss domestic abuse, it is important not to put yourself in danger. You need to assess the risks, depending on the situation. Clearly, these may vary depending on whether you are on a home visit or in the workplace, and the circumstances, for example if alcohol or other substances are involved.

Some perpetrators are violent outside the home. However, as a general rule, men who abuse their partners (and/or children) are not abusive to others. The abuse is rooted in the power relationships within the family rather than in individual pathology. The abuser is much more likely to minimise, deny or excuse his behaviour, and you are more likely to run the risk of collusion than assault.
Factors to take into account in deciding whether to visit, or visit alone, or engage with a man who has perpetrated domestic abuse might be:

- Any previous reports of violence or threatening behaviour from other workers – it is obviously important for workers to record any new incidents
- Presence of alcohol or other substances
- Information from the woman on the types of triggers to his violence that she is aware of; in particular any relating to anxiety about her discussing her situation with others, or anxiety about child protection/child contact
- Whether separation is happening and whether he is likely to see the worker as encouraging this and supporting the woman
- Any knowledge about psychotic episodes.

Generally, if some of these factors are present, clinic meetings would be much safer than home visits. If you are sufficiently worried, then the implications for the safety of the woman and any children are such that you should be sharing this information with other professionals, and conducting safety planning with the woman.

**You think if you ask that you might “open a can of worms”**

As a health worker, you have a duty of care to the individual. This duty is set out both in the Responding to Domestic Abuse, Guidelines for Health Care Workers in NHS Scotland, Scottish Executive, 2003 and the NHS Lothian Domestic Abuse Strategy, 2004.

If you are anxious or unsure about what you should do or what the consequences might be, get support from a colleague or manager. There are also materials in this publication which will help you approach the issue sensitively.

**You are anxious that it might make things worse for her**

Rarely would your actions make things worse. But there are things you can do to minimise any risks, and women may need additional support at flashpoints.

Research indicates that violence may increase when a woman experiencing abuse tries to end the relationship, on separation or divorce. Other danger times are during pregnancy or after the birth of a child. She may also be at risk if the man thinks she is disclosing information that might result in a criminal action against him or child protection intervention.

Given this, it is important to make a safety assessment after you have responded to her immediate needs. (An example is in section 2.)

However, it is also important to understand, whilst acknowledging the triggers, that the responsibility for the abuse lies with the perpetrator.

**You are concerned about confidentiality**

Confidentiality is central to the patient/health worker relationship and information should not be disclosed about a patient to anyone else without their consent, except in certain well-defined circumstances such as child protection procedures and vulnerable adult guidelines.
In his annual report *Health in Scotland 2003*, the Chief Medical Officer highlights the need to share personal information when people are vulnerable and calls for a balance saying that health professionals must share information in circumstances that require them to act in order to safeguard the interests of vulnerable people.

There is scope for sharing information whilst complying with the Data Protection Act 1998. Section 55 subsection (2) (a) (i) sets out terms of disclosing personal data and states that subsection 1 does not apply if it is ‘necessary for the purpose of preventing or detecting a crime’ or (2) d ‘that in the particular circumstances the obtaining, disclosing or procuring was justified as being in the public interest’.

You must be extremely careful to protect victims of violence and not disclose information which might breach their safety, for example to a third party trying to use the whereabouts of children to trace a mother.

Similarly, you must be particularly careful if speaking to the perpetrator, that you do not divulge information that could only have been given to you by his partner.

If you have any concerns about confidentiality and need advice you can contact the General Medical Council, the British Medical Association, the Medical Defence Agency or your own professional body.

X’s husband was violent to her, and used his position as a healthcare professional to further threaten and control her. X was too scared to leave her husband as he said no one would believe her, and he would find out if she contacted any services. But she finally left, and went to live in a hostel where staff became concerned about her mental wellbeing. They asked a mental health support worker to visit X and she revealed her fears. Staff reassured the woman about confidentiality and made sure that no information was given to the husband. Health staff were not able to approach or contact the husband because of confidentiality and concerns for her safety.

MENTAL HEALTH TEAM

You can’t get time alone with her

If the man is always with her that might, in itself, make you suspicious. You are the professional and it is your responsibility to engineer it so that you can have a few moments of time on your own with her, without arousing his suspicion.

Never try to talk to the couple together as this is at best pointless and at worst dangerous.
You know that there is a lack of services for perpetrators

At the time of writing there are few specialist services in Edinburgh specifically for perpetrators. The Working With Men Project is a non court-mandated service for men who wish to address their abusive behaviour to women partners. Some perpetrators may benefit from a mental health referral, person-centred counselling or referral to a drug and alcohol service. However, these will not be relevant for many perpetrators. Section 4 lists agencies that may help.

You think that maybe it’s better to do nothing just to be on the safe side

Doing nothing is not a safe option because:

- The message that gives to the victim, the perpetrator and any children is that domestic abuse is acceptable. Domestic abuse is a serious health issue and the NHS has a duty of care to those affected by it. Showing that domestic abuse is not acceptable is a vital primary and secondary care responsibility.
- If you don’t know and don’t ask you may not give the best course of treatment. If you do not understand exactly how a woman’s injuries were caused you may not be able to treat the injuries or the individual properly. For example, if you do not know that a woman has been raped by her partner, you may not offer emergency contraception, or you may not understand why she does not come for her cervical smear. The consequences in either of these scenarios could be enormous.
- If you don’t ask, they may not tell. Research indicates that a substantial number of women would disclose domestic abuse, if they were asked and also that the majority of women do not mind being asked. Similarly, men who are concerned about their abusive behaviour may present with other problems, yet when asked, acknowledge it as an issue.
- NHS staff are in a unique and valuable position to identify and assist in cases of domestic abuse, and may often be the only professionals who have privileged access to individual family members.
- Domestic abuse won’t go away and evidence suggests that it may become more frequent and severe over time. The personal costs to the victim, the perpetrator and any children involved are likely to affect them for the rest of their lives and may mean long-term, chronic physical and/or mental ill health and even death.
- The financial and other costs to the NHS of undiagnosed and untreated health and social problems will only escalate over time.

X is in her first pregnancy and has had numerous admissions to the antenatal ward since the onset of the pregnancy with hyperemesis, bleeding and pain. She discloses, on admission to the ward at 36 weeks pregnant, that the partner has been physically abusive and that his family treat her like a slave. She is fearful for her baby and does not want to return to his home. She wants to try to get in touch with her own family who live a considerable distance away. Her husband and family have not allowed her to contact her family since she married him. Staff help her to make contact, and arrange for her to move to another area with her own relatives without the partner and his family’s knowledge.
Good Practice Guidelines for Working with Women Affected by Domestic Abuse

**LOOK**
- **Suspicion of domestic abuse?**
  - **YES**
    - **Ask**
      - Disclosure?
        - **NO**
          - **No action**
        - **YES**
          - **Inform**
            - Listen and believe. Deal with immediate healthcare needs. Give literature. Refer to NHS specialist or other agencies.
          - **Record**
            - Keep door open.
  - **NO**
    - Deal with any healthcare needs. Give literature. Keep door open for her to return.

**Inform**
- Listen and believe. Deal with immediate healthcare needs. Assess immediate safety risks. Give literature. Refer to NHS specialist or other agencies.

**Respond**
- Are you likely to see her again?
  - **YES**
    - **Inform**
      - Listen and believe. Deal with immediate healthcare needs. Assess immediate safety risks. Give literature. Refer to NHS specialist or other agencies.
    - **Record**
      - Keep door open.
  - **NO**
    - **Inform**
      - Listen and believe. Deal with immediate healthcare needs. Give literature. Refer to NHS specialist or other agencies.
    - **Record**
      - Keep door open.

**Consider NHS support.**
- Refer to specialist agency. Give literature.

**Record**
- Keep door open.

**Refer to Women’s Aid/Housing/Social Work for (emergency) accommodation. Consider further NHS support.**

**Record**
- Keep door open.

*Remember if you think that children are at risk, you must follow Child Protection Guidelines (see appendix).*
Any woman presenting in a health setting might be affected by domestic abuse. However, the nature and effects of the abuse may vary considerably. This means that it is important for all health practitioners to be aware of possible indicators of abuse whether these are current or historical. The consequences of abuse experienced in the past may be deep-seated and may present as chronic physical and/or mental health problems.

X is in her late 20s. She is sole carer of her three children aged 7, 3 and 1. She split from the father of her children a year ago, however continues to have regular contact with him. He has violently attacked and abused her on several occasions. She was admitted to A&E, following an overdose of painkillers triggered by his continuing intimidation. A nurse specialist reviewed her the following day, and assessed her mental and emotional state. X stated she had come to breaking point, had no sense of self worth, felt “unfit as a mother” and that her children were “better off without her.” The assessing nurse spent time in a secluded area of the ward and listened to her. She established if there were any support services in place and where her children were. She was able to convey that domestic abuse is never acceptable, and gave information about safety planning in risky situations. Further information and numbers for police domestic abuse liaison officers and Women’s Aid were given to X before discharge. The local children and families social work team followed her up.

PARASUICIDE ASSESSMENT SERVICE

Pilot Domestic Abuse Better Outcomes for Children Pathfinder

North Edinburgh has been selected as one of four areas across Scotland to pilot new ways of ensuring agencies work together to provide better support and intervention for children affected by domestic abuse. The pathfinder project will put the needs of children at the heart of new ways of coordinating services and sharing information. A new framework will guide local agencies such as health professionals, the police, social work services, the children’s hearings system and voluntary organisations on how to respond.
We recommend the following five-stage approach in working with women you suspect may be affected by domestic abuse:

1. **Look/listen**
   It is important to be able to recognise potential symptoms of domestic abuse. These are many, and can be physical, emotional, sexual and/or behavioural (see page 20). Women often go to great lengths to conceal the abuse so you may find the checklist on page 21 helpful. Women may present with health problems related to domestic abuse that happened some time ago.

2. **Ask**
   If you suspect that a woman may be affected by domestic abuse, **it is your responsibility** to sensitively introduce the subject and ask her. If you are to build trust and encourage disclosure, you need to show empathy and respect. Where you talk to her is also important. Aim to:
   - Create an atmosphere and a manner that encourage disclosure (see page 22).
   - Ask open, indirect and non-threatening questions (see examples on page 23).
   She might tell you that there are problems at home, but she might equally be hesitant or give you an answer that does not seem plausible.
   If her response suggests that there might be problems, probe gently by asking direct but non-threatening questions (see examples on page 3).

   If she says, for example, that injuries are accidental but you suspect they are not, don’t be afraid to question further but do this as sensitively as you can. For example you could say something like, “It’s hard to understand how the incident you describe caused this injury.”

   Whether or not a woman discloses, respect her response as this will build up trust. A woman may come to services many times before disclosing domestic abuse.

   You can always make your own position clear, so she knows where you stand, by saying something like, “If any woman were suffering, I’d like to be able to help…”

   **KEEP THE DOOR OPEN** and reassure her that she can come back any time to any member of the healthcare team. This is also important to stress if the woman is not on her own, but be careful about what you say in front of others.

   A good way to encourage this is to give the woman a card with your name and number and say, “If you need to contact me here’s my number.”

3. **Respond**
   **No disclosure**
   If the woman does not disclose domestic abuse, you should deal with any immediate healthcare needs. If you suspect that abuse has indeed taken place, give her literature “just in case she or someone she knows ever needs it”. Reassure her that she can come back any time. However, if you suspect that her children are abused or are at risk of physical and/or emotional harm, you must follow child protection guidelines.
Disclosure
How you respond to a woman who discloses domestic abuse depends on your role within health services and whether or not you are likely to have ongoing contact with the woman. However, if you suspect that her children are abused or are at risk of physical and/or emotional harm, you must follow child protection guidelines.

One-off contact
If this is likely to be a one-off contact, then your main priority is to signpost her to the relevant department or agency for in-depth help, to ensure her safety and to deal with any healthcare needs.

Ongoing contact
If the contact with the woman is likely to be ongoing then you are more likely to have the chance to conduct any safety and healthcare planning yourself and with other healthcare staff.

The key priorities are to:

- Treat the woman for any physical injuries or refer for further assessment, treatment or specialist help as required. Any treatment should be based on fully understanding what has actually happened to the woman and the potential short and long-term consequences to her health. If you do not know exactly what has happened to her, you may not treat appropriately.

- Assess the current risk to the woman and any dependent children. This may help her think more about her situation and help her make decisions about what she needs to do (see page 24).

4. Inform
Depending on your own role within health services, whether the woman has disclosed or not and what the woman wants to do, there are various options:

- Provide the woman with accurate information about local support agencies. A list of agencies is in section 4. The domestic abuse helpline number is 0800 027 1234.
- Give the woman supporting literature, in her own language if possible.
- Refer the woman to a specialist support agency. She may find it helpful if you offer to make the first contact. Keep a record of the name of the worker and their telephone number so you can give this to the woman and also follow up the referral if necessary.
- Consider other specialist health services, for example, counselling.
- If appropriate, provide aftercare and follow-up. It is vital that you always consider the woman’s safety and how any approach you make might affect this.

These options apply equally to women who wish to remain in the same situation or who want or need to leave now or at a later date. These are major decisions and may take some time to process. There may be many obstacles for the woman to overcome, whether real or perceived. Typical anxieties include worry about children being taken into care if social work is involved or abuse disclosed; fear of losing her home; and disrupting children’s lives. You have an important role in exploring these with her, reassuring her and putting in touch with specialist services such as Women’s Aid if necessary.
If a woman decides to remain in the same situation:

- Conduct safety planning (see page 25)
- Refer to specialist support organisation
- Provide contact numbers for support agencies such as Women’s Aid
- Discuss crisis plan, if appropriate (Women’s Aid, for example, would also do this with her)
- Stress that she can ask the NHS for help at any time

If she decides/has to leave

- Conduct safety planning (see page 25)
- Refer to Women’s Aid for information, advice and/or safe refuge
- Consider friends or relatives
- In an emergency, contact Women’s Aid, Emergency Housing or Children and Families Department
- Stress that she can ask the NHS for help at any time

X is 41 and lives in a hostel. She has a history of both physical and sexual abuse and is currently on a trial separation from her abusive partner. She has four children (two in foster care and two live independently). She has used alcohol heavily over the last 20 years in an attempt to ‘deal’ with the issues she has faced.

She was referred to occupational therapy to help structure her daily routine and work with her on alcohol intake and her desire to rebuild her life after years of domestic abuse.

Because of the years of sustained abuse, X had little understanding of her strengths and underestimated her abilities. She was anxious about change and would drink to diminish feelings of unworthiness. She had lost her role as mother, worker and partner. She felt guilty, frustrated and bored and used alcohol to deal with this.

Occupational therapy helped X see her strengths and abilities and identify goals. She attended literacy classes and linked in with community resources. This increased her confidence and independence. She began to look at why she drank and contacted an agency that provides help and advice on alcohol issues. She said she would like to learn to swim so we included that in the therapy.

She is looking for accommodation, with a view to living with her children. She now realises that it is not acceptable to be abused.

SENIOR COMMUNITY OCCUPATIONAL THERAPIST
5. Record

It is important to keep detailed records. This is important health information which will enable continuity of care. Good records may also help in any future legal proceedings and may build up a picture, over time, of the nature of the abuse.

Document injuries and symptoms and disclosure of abuse. Record what the patient says and not what you think but note if you have any concerns.

Record the information and file in her case notes. Remember that medical records are strictly confidential and if the woman is concerned reassure her of this. Never record such information in hand held notes.

If a woman requests that significant information about the abuse is not recorded, reassure her about confidentiality and about the benefits of keeping accurate records but, at the end of the day, you must respect her decision.

Remember to record missed appointments and unanswered telephone calls.

However, if an individual, especially a child may be at risk of significant harm, this will override any requirement to keep information confidential. You should explain this to the woman.

See page 27 for a checklist for record keeping and page 28 for a body map.

X is in her early 20s and has three children. She went to see her GP with bruising on her body and said her partner had assaulted her. The GP told her about Women’s Aid and with her agreement, contacted the health visitor. X told the health visitor about the history of violence from her partner and said she wanted to leave him but was worried about the children. The health visitor went with her to see Women’s Aid who advised her. X went to live in temporary accommodation.

The health visitor passed on details to the health visitor in the new area and also contacted social work. The social work department helped arrange visits with the children and started to make arrangements for re-housing. X returned to her partner. The health visitors suspect that the lack of family and friendships left her isolated and unable to make decisions about a new life. Several weeks later, the whole family has moved and the health visitor has passed on concerns to new primary care health team.

HEALTH VISITOR
Potential Symptoms of Domestic Abuse

**Physical**
- Chronic pain or pain due to diffuse trauma without physical evidence
- Repeated or chronic injuries
- Injuries that are untreated and of different ages, especially to the head, neck, breasts, abdomen and genitals
- Physical symptoms related to stress
- Dental emergencies and facio-maxillary trauma
- Medically unexplained symptoms
- Frequent presentation to A&E and unscheduled care

**Emotional**
- Feelings of isolation and inability to cope
- Suicide attempts
- Self-harm
- Depression
- Panic attacks and other anxiety disorders
- Post-traumatic stress reactions
- Alcohol and drug misuse; frequent use of prescribed tranquillisers, anti-depressants or pain medications

**Sexual**
- Gynaecological problems such as frequent vaginal and urinary tract infections, dyspareunia and pelvic pain
- Evidence of rape or sexual assault such as injury to genitals

**Behavioural**
- Woman misses appointments and/or does not comply with treatment
- Frequent appointments (for woman and her children) for apparently minor complaints
- Denies or minimises abuse/injuries
- Exhibits an exaggerated sense of personal responsibility for relationship including self-blame for the partner's violence
- Appears embarrassed, ashamed or frightened
- Overbearing partner who may also be surprisingly ‘charming’
- Partner is always/often present and may insist on a female health worker
- Defers to partner or does not speak when he is present or generally behaves differently in his presence

*Adapted from Responding to Domestic Abuse: Guidelines for Healthcare Workers in NHS Scotland, Scottish Executive, 2003*
Checklist: Possible Signs of Domestic Abuse in Women

- Does the woman make frequent appointments for vague complaints or symptoms?
- Does she often miss appointments?
- Poor or non-attendance at ante-natal clinics?
- Does she have injuries which don’t fit her explanation of the cause?
- Are injuries to the face, head and neck, chest, breasts and abdomen?
- Does she have multiple injuries at different stages of healing?
- Does she have recurring STIs or urinary tract infections?
- Does she minimise the extent of injuries or hide them?
- Early self discharge from A&E?
- Does she seem frightened, anxious, depressed or distressed?
- Does she fail to comply with treatment?
- Does she present repeatedly with depression, anxiety, self-harm or psychosomatic symptoms?
- Does she have a history of psychiatric illness?
- Does she have a history of alcohol/drug dependency?
- Is she often accompanied by a partner and, if so, does she tend to defer to him?
- Does he appear overly dominant and reluctant to allow her to speak for herself?
- Is he overly charming and affectionate in your presence?
- Does she behave differently when not in his presence?
- Is there a history of miscarriage, termination of pregnancy/still birth or pre-term labour?
- Does she have children who are exhibiting behavioural difficulties/distress/developmental problems?
- Does she have children who are on the child protection register or who have been referred to other specialists for difficulties/distress/developmental problems?
- When visiting the house are there physical signs suggesting abuse such as damage around the locks, footmarks or other damage to door panels, holes in walls or damaged furniture?

Adapted from Responding to Domestic Abuse: a handbook for health professionals, Department of Health, 2005
Good Practice in Talking to Women about Domestic Abuse

Preparation and Setting
- Provide a private, quiet space where you will not be interrupted or overheard and ask not to be disturbed if possible
- Aim to see the woman on her own, without her partner, carer, relatives or children. This may be difficult and you may need to think up a pretext to see the woman or get her to come back on her own
- Provide an interpreter if the woman is deaf or her first language is not English. The interpreter should be trained and should not be a friend or relative
- Emphasise confidentiality but explain the limits, for example if there are children involved who might be at risk from the abuser
- Consider the welfare of any children and follow child protection guidelines if you think children are at risk

Manner
- Be honest about why you are asking and explain that many women experience domestic abuse
- Listen carefully to what she says – she may talk around the subject
- Believe her and say so
- Tell her she is not to blame
- Respond constructively and avoid being judgemental
- Let her control the discussion and go at her own pace

Response
- Be prepared to deal with any disclosure over several contacts
- Give accurate information and refer appropriately
- Support the woman in whatever decision she makes
- Check whether she is in immediate danger
- Make sure she knows she can approach healthcare staff again in future (this is also important to stress if a woman is not on her own)
- It is an enormous step for a woman to disclose. Respect that and keep the woman’s trust by doing what you say you will do and following this up.

Adapted from Responding to Domestic Abuse: Guidelines for Healthcare Workers in NHS Scotland, Scottish Executive, 2003 and Responding to Domestic Abuse: a handbook for health professionals, Department of Health, 2005
Examples of Questions

1. Open, Indirect, Non-threatening Questions
   - How are you feeling generally?
   - How are things going at home?
   - Are you getting much help at home?
   - Who is there to help you at home?

2. Follow-up Questions
   - I notice you have a number of bruises/scratches, how did they happen?
     (If explanation seems improbable continue to probe.) Did someone do these to you?
   - We all argue at home. What happens if you and your partner argue or disagree?
   - Do you ever feel afraid of your partner?
   - Has your partner ever destroyed things you cared about?
   - Have you ever been in a relationship with a partner who hurt or threatened you?
     Is that happening now?
   - Has your partner ever threatened or abused your children?
   - Does your partner ever stop you from doing the things you want to do?
   - Has your partner ever forced you to have sex when you didn’t want to or to have sex that makes you feel uncomfortable?
   - Does your partner ever get jealous of you seeing friends or talking to other people?
     If so, how does he treat you?

Adapted from Responding to Domestic Abuse: Guidelines for Healthcare Workers in NHS Scotland, Scottish Executive, 2003
Checklist: Risk Assessment and Safety Planning

1. Risk Assessment
This section applies to any woman experiencing physical violence and is designed to help you work with her to predict the risks she faces and the likelihood of further physical violence.

Risk is complicated and the abuser may not be a woman’s only concern. She may fear homelessness, poverty or loneliness more than her partner. Your responsibility as a health professional is to support the woman in the decisions and choices she makes.

In considering risk management and safety planning, you need to think about risk from the man, her own situation and the impact of any agency intervention which might increase risk (service-generated risk).

You can build up a picture of likely risk from the information given to you by the woman, other professionals and your own knowledge. However, you will need to use your discretion. The checklist below should help.

The key questions in evaluating service-generated risks are:

1. What is the history of abuse of the woman and her children?
2. Has the abuse increased in frequency or severity or is there increasing use of weapons or other instruments?
3. Are there typical triggers, for example: pregnancy, childbirth?
4. Is there anything that might represent loss to the abuser, for example divorce papers coming through; recent separation; change in custody/access arrangements; woman’s infidelity and so on?
5. Is the abuser:
   - Making threats
   - Physically violent to others
   - Self harming
   - Threatening to harm or abduct the children
   - Physically harming the children
   - Frightening, disturbing or threatening others such as other family members, friends and neighbours
   - Frequently intoxicated on alcohol or other substances and more abusive when so
6. Are there any recent psychotic or manic episodes (victim or abuser)?
7. Is there sexual violence or pressuring and sexual jealousy on the part of the abuser?
8. Is the woman using retaliatory violence?
9. How frightened is the woman of the situation?
10. Does she believe she is in immediate danger?
10. Has she threatened/attempted self-harm or suicide?

11. Has she tried to get help previously, for example from police, courts or Women’s Aid?

12. How much support will she get from friends and family?

**Child Protection**
If you think that children are at risk, you must follow child protection guidelines (see appendix). You should discuss the procedures with the woman and get her consent if possible.

**Your Protection**
In doing a safety assessment, you also need to take account of your and your colleagues’ safety and minimise any risks you might face from the perpetrator.

2. **Safety Planning**
The following checklist is not exhaustive but suggests a common sense approach and a series of questions to ask yourself or a woman affected by domestic abuse.

- If a woman says she needs help to get immediate safety, never simply give her a leaflet pointing her to other services.
- If the woman is reluctant to contact the police, she or you can phone the police domestic abuse liaison officer for advice.

**Crisis Safety Planning**
A crisis safety plan should be done for a woman when she feels afraid, is in danger, that she can’t take any more or if she has decided to leave.

1. How does the woman feel about the situation today? Are things getting worse? Assess whether she is in crisis. If she is, ask her if she needs to take action today?

2. If so, what does she want you to do? You also need to take account of the implications of any responsibilities she has for children, dependants or pets.

   If you do not know what to do, ask for help. Ask a more experienced colleague or phone Women’s Aid, duty social work or police domestic abuse liaison officer.

   Women will appreciate your honesty, and will wait for you to find out what to do. If she needs transport, be prepared to organise this.

3. If she does not want to leave or take action immediately discuss with her:
   - Does her partner have typical triggers?
   - What does she already do to protect herself and her children and do these things work?
   - Does she have friends, family, neighbours who can help?

The following points and tips are helpful in discussing safety planning with a woman:

- Phone: if a landline, can she phone out?
- Mobile: tell the woman to keep her mobile with her, charged and in credit
- Handbag: encourage her to know what she has in her handbag. This should include taxi fares, emergency cash, important phone numbers
Overnight bag: encourage her to pack an overnight bag with everything she needs for 24 hours, including medication and keep it elsewhere.

Documents: suggest she keeps her and children’s passports elsewhere along with marriage certificate and any other important papers/benefit books.

Neighbour: ask her if there is a neighbour she can trust and suggest she discusses what she’d like the neighbour to do in a crisis.

Take great care when and where you discuss this, and make sure that the woman’s children are not in earshot. Depending on their age, maturity and relationship with you and the man, they may divulge information that could increase any risks to themselves and/or the woman.

Do not be afraid to discuss with her what she might have to do or say to defuse tension if she is in a situation which she sees as being high risk. Where the immediate safety of the woman or her children is at stake, keeping safe is the most important consideration.

If she leaves the house, how will she do this? Does she think children or other dependants will be at risk (or safer) if she leaves the house without them?

Long Term Safety Planning

Safety planning is not simply about what to do in a crisis. Many women find it difficult to end the relationship with their partner and you should not focus on her leaving or ending the relationship because this may be dangerous. So, women need to know how to be safe in the long-term. Some health care staff are involved in the long-term with service users, so you have a vital role in boosting a woman’s safety and reducing risk. You can:

- Be aware of her vulnerabilities and ongoing risks
- Remind her that she can make choices
- Talk to her about her long-term plans and refer her to other support services (see section 4)
- Focus on her strengths and try to boost them
- Appreciate any changes she makes
- Find out about any other agencies involved with the woman and, with her permission, introduce yourself to them
- Contribute to any multi-agency planning and case conferences
- Pass information on to relevant agencies
- Continue to go over crisis plans with her regularly, remind her of support available and do not ‘get used to’ the abuse

Remember that while you respect her confidentiality, you cannot assume that she will do the same. She may repeat conversations you have with her and even tell her partner about your discussions. So, you should support her without being critical of the partner. Otherwise you may increase risk to yourself and the woman, and she may disengage with you if she returns to him.

Checklist: Record Keeping

Record accurately and in detail any information about or alleging domestic abuse whether physical, sexual and or emotional.

Note the date and time that any incident occurred.

If it is a physical assault note:

- Injury pattern, describe location and extent of injuries including pain reported (use body map on page 28)
- Evidence such as torn clothing, emotional state
- Woman’s description of assault
- Your own observations
- Alleged perpetrator

Note any treatment and interventions provided.

Note any risk assessment conducted.

Note any action agreed and referrals made.

Date and sign the record.

Keep these records in strict confidence and never in hand held notes.
Record Keeping: Sample Body Map

Indicate, with an arrow from the description to the body image, where any injury was observed. Indicate the number of injuries of each type in the space provided. Mark and describe all bruises, scratches, lacerations, bite marks and so on.

Cuts ______
Bites ______
Bruises ______
Burns ______
Bone fractures ______
Punctures ______
Abrasions ______
Bleeding ______
Dislocations ______
Good Practice Guidelines for Working with Men Perpetrating Domestic Abuse

Remember if you think that children are at risk, you must follow Child Protection Guidelines (see appendix).
You may encounter perpetrators of domestic abuse as patients, partners of patients or fathers/carers of children whom you know or suspect to be affected by domestic abuse. The approach you take depends on whether a man is directly acknowledging his domestic abuse as a problem; is seeking help for a related problem; or has been identified by others as abusive.

We suggest the following six-stage approach:

1. **Look/listen**
2. **Ask**
3. **Assess risk**
4. **Respond**
5. **Refer**
6. **Record**

### 1. Look/listen

**Abusive men as patients**

Some men may identify their abusive behaviour directly and ask for help to deal with their violence. This is likely to have been prompted by a crisis such as a particularly bad assault, an arrest or ultimatum from the abused partner. Such men – even though they have come voluntarily – are unlikely to admit responsibility for the seriousness or extent of the abuse, and may try to ‘explain’ the abuse or blame other people or factors. Even those who are concerned enough about the abuse to approach a health worker may present with other related problems such as alcohol, stress or depression, and may not refer directly to the abuse.

Some men may say they are victims of their (female) partner’s violence. While any such allegations must be treated seriously, research indicates that a significant number of male victims are also likely to be perpetrators of domestic abuse.

In the acute sector, such men may present having attempted suicide or used other self-destructive behaviour or with injuries consistent with punching walls or putting fists through glass.

See page 37 for indicators of abuse and heightened risk.

**Abusive men as partners of patients**

You may encounter men who insist on accompanying their partners to appointments or who want to talk for their partners. They may have driven the woman to the hospital and be in the waiting room or want to stay with the woman at all times. You may have patients whom you know to be abusive because their partners are also your patients and they have told you about it. These men may appear to you to be caring and protective of their partners and very plausible.

The normal standards of patient confidentiality and the overriding need to avoid any intervention that might increase risk to the woman, mean that directly engaging with an abusive man who is not your patient may be difficult. However, being aware of indicators of abuse is important for your dealings with the man.

See page 37 for indicators of abuse and heightened risk.

**Abusing men as fathers/carers of patients**

There are clear links between domestic and child abuse, and there is evidence of the detrimental effects on children of witnessing domestic abuse. In your role as a health worker,
you may know children affected by domestic abuse, and consequently, the abuser. You may be in contact with him in clinics, in his home or at child protection case conferences. If the issue of the man’s violence has been openly stated as a cause of a child’s problem – for example as the reason for a child being on the child protection register – it may be appropriate and necessary to speak to him directly about his abusive behaviour. You should, in any case, be guided by and implement child protection procedures.

See page 37 for indicators of abuse and heightened risk.

2. Ask

Your response to any disclosure, however indirect, could be significant for encouraging responsibility and motivating a man towards change. If the man presents with a problem such as drinking, stress or depression, for example, but does not refer to his abusive behaviour, these are useful questions to ask:

“How is this drinking/stress at work/depression affecting how you are with your family?”

“When you feel like that, what do you do?”

“When you feel like that, how do you behave?”

“Tell me about your moods. Do you get depressed/suicidal?”

“Do you find yourself shouting/smashing things?”

“Do you ever feel violent towards a particular person?”

“It sounds like you want to make some changes for your benefit and for your partner/children. What choices do you have? What can you do about it? What help would you like to assist you to make these changes?”

There is a link between suicidal and homicidal ideation in men who abuse, and either or both should be seen as significant risk factors for domestic abuse. Equally, threatening suicide is in itself a common form of controlling behaviour. When assessing risk both to the woman and the man, it is important, particularly for a man being treated for the effects of self-harm, to ask questions about his actual intentions and degree of desperation. As well as the questions you would normally ask about the man’s mood or the seriousness of the attempt, you should also ask:

“When were your partner or children when you made the attempt?”

“Did you leave a note for her?”

“What sort of relationship were you in at the time – living together, separated, in contact with the children, partner in a new relationship?”

If the man has stated that domestic abuse is an issue, these are useful questions to ask:

“It sounds like your behaviour can be frightening; does your partner say she is frightened of you?”

“How are the children affected?”

“Have the police ever been called to the house because of your behaviour?”

“Are you aware of any patterns – is the abuse getting worse or more frequent?”

“How do you think alcohol or drugs affect your behaviour?”
“What worries you most about your behaviour?”

If a man responds openly to these prompting questions, more direct questions relating to heightened risk factors may be appropriate:

Examples of more direct questions are:

“Do you feel unhappy about your partner seeing friends or family – do you ever try to stop her?”

“Have you assaulted your partner in front of the children?”

“Have you ever assaulted or threatened your partner with a knife or other weapon?”

“Did/has your behaviour changed towards your partner during pregnancy?”

The information you gather will be the basis for your decision about how best to engage and what kind of specialist help is required – either for the man or to manage risk.

3. Assess risk

It is important to assess risk before deciding what to do next.

Although risk assessment is primarily informed by the woman’s experience and insights (see safety planning on page 25), there may be other factors which you identify through your contact with or knowledge of the perpetrator. See page 38 for a risk assessment checklist. Research shows that these are significant indicators of heightened risk. You should consider these in deciding whether to undertake multi-agency consultation or risk management measures, together with agencies such as children and families social work, police domestic abuse liaison officers or other health practitioners. Some of these risk factors are static and some may be subject to change. Risk awareness should be a continuous process and risk assessments should be regularly reviewed.

Risk management should be a multi-agency responsibility, and the process of gathering, assessing and sharing information should be done jointly.

4. Respond

Domestic abuse is a serious health issue and all health professionals involved have a role in providing good healthcare, which holds perpetrators responsible. Your response to the man and any disclosures could affect the extent to which he accepts responsibility for his behaviour and, therefore, for the need to change. You can say things to a perpetrator that make a difference and you can influence the situation.

In any dealings with perpetrators you should adopt the following good practice response. This is not a ‘cure’ or a ‘treatment’ but principles to observe within your own healthcare context, which are safe and constructive.

Good practice in dealing with perpetrators of domestic abuse

- Be clear that abuse is always unacceptable
- Be clear that abusive behaviour is a choice
- Affirm any accountability shown by the man
- Be respectful and empathic but do not collude
- Be positive and non-judgmental, men can change
- Be clear that you might have to speak to other agencies and that there is no entitlement to confidentiality if children are at physical or emotional risk
Whatever he says, be aware that on some level, he is unhappy about his behaviour.

Be aware, and tell the man, that children are always affected by living with domestic abuse, whether or not they witness it directly.

Be aware, and convey to the man, that domestic abuse is about a range of behaviours, not just physical violence (see definition on page 4).

Be encouraging; do not back him into a corner or expect an early full and honest disclosure about the extent of the abuse.

Be aware of the barriers to him acknowledging his abuse and seeking help (such as shame, fear of child protection process, self-justifying anger).

Be aware of the likely costs to the man of continued abuse and assist him to see these.

If you are in contact with both partners, always see them separately if you are discussing abuse.

**Safety planning with abusive men**

**If, and only if,** the man has responded to your questions in a way which suggests that he is worried about his behaviour, and is ready to take responsibility for his need to change, it may be appropriate to start to discuss plans for keeping his partner safe from his abusive behaviour. Ask questions such as:

- “What kind of situations do you get worked up about?”
- “What are the physical sensations you can note when you are getting wound up?”

- “What are the feelings you have or the thoughts that come into your head during these times?”
- “What would your partner recognise in you at these times?”

Encourage the man to think about how he could use this knowledge about early signals to keep his partner or children safe in the future. It may be appropriate to discuss a ‘time-out’ plan with him for use when the warning signals are present, and he feels that he is becoming risky to her. This involves a man deciding, in advance, to remove himself from the high-risk situation for a time-limited period in order to keep his partner safe. If you discuss such ‘time-out’ strategies with him there are points you must emphasise:

- Time-out should only be used as an emergency measure to keep her safe; not to avoid hearing criticism.
- He should discuss the plan with his partner in advance so that she knows its purpose and exactly what he will do.
- He must decide (and she should know) how long he will leave for (usually one hour) and where he will go.
- He must not drink and should not drive during the time-out.
- He must not use time-out to rehearse and strengthen his own arguments nor put her under further threat or fear of his intentions.
- He should telephone at the end of the time-out period to check if she feels safe and negotiate his return.
Safety issues

- If you are the woman’s main support, he will probably see you as a threat. Be mindful of this in any contact with either partner.
- Be aware that, for safety reasons, a woman may tell her partner what you have said about him.
- If you are in contact with both partners, always see them separately when discussing violence and abuse.
- If your information about the man’s violence comes only from the woman, you cannot use that to challenge the man. Her safety is paramount.
- Do not attempt ‘couple work’ as this is likely to be ineffective or dangerous.
- Be especially careful if he is under the influence of alcohol or other substances and do not engage with him about his violence at such times.

5. Refer

Specialist services for perpetrators of domestic abuse

The primary role of specialist services for perpetrators is to confront and tackle the violence.

Edinburgh has an established project working with men convicted of domestic violence offences (Domestic Violence Probation Project). Any man who is facing sentence following a court conviction can be considered for this programme (see contact list in section 4).

There is also a recently established service for men who have not been dealt with by the court. Working with Men has grown from a successful pilot in one area of the city and can now take referrals from across Edinburgh. However, lack of resources means that the project can only work with a limited number of men and their partners (see contact list in section 4).

The national Respect Phoneline (0845 122 8609) offers a clear, non-collusive response to men concerned about their abusive behaviour and advice on short-term strategies to prevent further abuse (see contact list in section 4).

Generic services

It may be possible to refer a man to a generic service. The primary role of such a service is not to address the violence.
While alcohol/substance use is neither an excuse nor a cause of domestic abuse there are links and, for some abusive men, it is appropriate to refer to alcohol/drug services. This may help reduce the risk of him using violence.

If you suspect that a man is suffering from a mental health problem it may be useful to refer him to mental health services.

Some abusive men you encounter will have issues relating to past traumatic experiences and might benefit from a referral to a general counselling/psychotherapy service. However, there is a risk that focusing on such issues may allow the man to avoid responsibility for his current behaviour and attitudes – especially if such a service is provided in the absence of a specialist domestic abuse perpetrator programme. You should be aware of this in making any referral and should, in any case, continue your involvement with the man in line with the good practice approach outlined above.

For more information about services which may be useful contact Working with Men (see contact list in section 4).

**Multi-agency response**

The purpose of attempting to engage with an abusive man is not simply the hope of assisting him to change his attitudes and behaviour, but to ensure that his behaviour and his responsibility for it, are at the centre of a multi-agency response. Some men will not change even if they have the opportunity to attend a perpetrator programme.

Communication with other agencies involved with a family is important and, when children are involved, essential. If a man refuses to engage, or does not change his abusive behaviour, the response of other agencies involved with that family may need to change in response to this. For example, risk management measures such as reporting to the police and increased police monitoring may need to be put in place or further development be offered in safety planning with the woman. Ultimately, it is not possible for a single agency to address the complexity of domestic abuse situations. Agencies can share their knowledge, skills and awareness of risk and offer services that might reduce risk. Sometimes, they may have to record that they have nothing more to provide.

**6. Record**

It is important to keep detailed records if a man discloses abusive behaviour. This is important health information which will enable continuity of care. Good records may also help in any future legal proceedings which the woman or the police/procurator fiscal may take.

Record the information and file in his case notes. Remember that medical records are strictly confidential. However, if an individual, especially a child, may be at risk of significant harm, this will override any requirement to keep information confidential. You should explain this to the man.

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**GP**

received a request from a male patient for counselling to help with his ‘anger management’ and low mood. He was sexually abused as a child. He lives with his pregnant partner and acknowledges that he is verbally abusive, is aggressive towards her and has assaulted her twice in the past. He had previously received counselling from a local health project and both his previous and his current GP think he is motivated to change. He thinks that he is violent in response to provocation from his girlfriend. The GP has explained that violence is unacceptable and has re-referred him to the primary care mental health team for assessment and possible therapeutic input.

**GP**
Checklist: Indicators of Domestic Abuse

An abusive man may present in the following ways:

- I’ve got a problem with drink
- I need anger management
- I’m not handling stress at work
- My wife/partner says I need to see you
- My wife/partner and I are fighting a lot
- My wife/partner and I need counselling
- My wife/partner is not coping and taking it out on me
- The kids are out of control and she’s not firm enough
- I’m depressed/anxious/stressed/not sleeping/not coping/not myself
- I feel suicidal (or have threatened or attempted suicide)
- I’m worried about my rage at work, in the car, in the street, at the football.

Additional indicators/behaviours to be aware of:

- Attempts to accompany or speak for the woman
- Sexual jealousy or possessiveness
- Psychotic/manic/paranoid symptoms
- Substance use/dependence
- Excessive telephoning or texting the woman
- Following the woman or constantly checking her whereabouts
- Injuries or behaviour consistent with assault or defence. Although rare, a man might present with a physical injury such as a hand injury caused by punching, or you might notice injuries caused by the woman defending herself, such as scratch marks.
Checklist: Risk Assessment

- Recent or imminent separation
- Past assault of family members
- Past assault of strangers or acquaintances
- Past breach or ignoring of interdicts, court orders or conditions
- Victim and/or witness of ‘family’ violence as child or adolescent
- Recent psychotic and/or manic symptoms
- Personality disorder with anger, impulsivity or behavioural instability
- Past physical assault of partner
- Partner pregnant or recently given birth
- Sexual assault or sexual jealousy
- Past use of weapons or threats of death
- Recent escalation in frequency or severity of assaults
- Extreme minimisation or denial of domestic violence history
- Attitudes that support or condone domestic abuse

Adapted from the Spousal Assault Risk Assessment Guide, British Columbia Institute Against Family Violence, 1995
Useful Contacts

There are many services which can help. The following list suggests some agencies which can also give further information and signposting. They are all free and confidential.

You can phone the Domestic Abuse Helpline free at any time on 0800 027 1234.

<table>
<thead>
<tr>
<th>Name &amp; Address</th>
<th>Tel/Fax/Email</th>
<th>Opening Times</th>
<th>Appt. Needed</th>
<th>24hr Service</th>
<th>Referral From</th>
<th>Description of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broken Rainbow</td>
<td>T: 08452 60 44 60</td>
<td>Mon-Fri 9am-1pm &amp; 2-5pm</td>
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<td></td>
<td>National helpline for LGBT people experiencing domestic abuse.</td>
</tr>
<tr>
<td>Citizen's Advice Scotland</td>
<td>T: 0131 550 1000</td>
<td>Office hours</td>
<td></td>
<td>No</td>
<td>Anyone</td>
<td>General advice service. Check for details of nearest service.</td>
</tr>
<tr>
<td>Disability West Lothian Ability Centre</td>
<td>T: 01506 774030 (voice) T: 01506 774044 (text) F: 01506 774031 Mob Text: 07742 232978 E: <a href="mailto:enquiries@dwl.demon.co.uk">enquiries@dwl.demon.co.uk</a> <a href="http://www.dwl.demon.co.uk">www.dwl.demon.co.uk</a></td>
<td>Mon-Fri 9.30am-3.00pm</td>
<td>No</td>
<td>No</td>
<td>Anyone</td>
<td>Disability Information Service and range of other support for people in West Lothian.</td>
</tr>
<tr>
<td>Domestic Abuse Helpline</td>
<td>T: 0800 027 1234</td>
<td>24 hours</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Advice and information for women who have experienced domestic abuse and friends, families and agencies.</td>
</tr>
<tr>
<td>Name &amp; Address</td>
<td>Tel/Fax/Email</td>
<td>Opening Times</td>
<td>Referral From</td>
<td>Description of Service</td>
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<tr>
<td>Domestic Violence Probability Project</td>
<td>T: 0131 469 3408 F: 0131 469 3410</td>
<td>Mon-Thurs 8.30am-4.40pm Fri 8.30am-3.40pm</td>
<td>Sheriff Court</td>
<td>Intervention service for men convicted of domestic violence offences. Men attend as a condition of a Probation Order. A support service is offered to the women who attend. Support for women who have experienced sexual violence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edinburgh Women’s Rape and Sexual Abuse Centre (EWRASAC)</td>
<td>T: 0131 557 6737</td>
<td>No set hours</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>24hr Service referral from Sheriff Court</td>
</tr>
<tr>
<td>Family Mediation Lothian</td>
<td>T: 0131 226 4507 F: 0131 220 4324</td>
<td>Mon-Thurs 9.15am-5pm Fri 9.15am-3.30pm</td>
<td>Self</td>
<td>Yes</td>
<td>No</td>
<td>24hr Service referral from Sheriff Court</td>
</tr>
<tr>
<td>Grapevine Norton Park Centre</td>
<td>T: 0131 475 2370</td>
<td>Mon-Fri 9.30am-4pm</td>
<td>Self</td>
<td>Yes</td>
<td>No</td>
<td>24hr Service referral from Sheriff Court</td>
</tr>
<tr>
<td>Health in Mind</td>
<td>T: 0131 225 8508</td>
<td>Fri 9am-4.30pm</td>
<td>Anyone</td>
<td>Phone for details of different services</td>
<td>Phone for details of different services</td>
<td>Phone for details of different services</td>
</tr>
<tr>
<td>Name &amp; Address</td>
<td>Tel/Fax/Email</td>
<td>Opening Times</td>
<td>Appt. Needed</td>
<td>24hr Service</td>
<td>Referral From</td>
<td>Description of Service</td>
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<tr>
<td><strong>Housing/Homelessness</strong></td>
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<td></td>
<td>任何人可以联系,为重新入住提供住宿服务。</td>
</tr>
<tr>
<td>City of Edinburgh Council Housing Options Team</td>
<td>T: 0131 529 7584</td>
<td>Mon, Wed, Thurs 8.30am-5pm</td>
<td>No</td>
<td>Yes</td>
<td>没有提供。</td>
<td>任何人可以联系,为重新入住提供住宿服务。</td>
</tr>
<tr>
<td>1 Cockburn Street</td>
<td>T: 0131 529 7368</td>
<td>Tues 10am-5pm 8.30am-3.40pm</td>
<td></td>
<td></td>
<td></td>
<td>没有提供。</td>
</tr>
<tr>
<td>Edinburgh EH1 1ZJ</td>
<td>T: 0131 529 7674</td>
<td>Fri 8.30am-3.40pm</td>
<td></td>
<td></td>
<td></td>
<td>没有提供。</td>
</tr>
<tr>
<td>East Lothian Council Homeless Response Team</td>
<td>T: 0800 169 1611</td>
<td>Mon-Thurs 9am-5pm</td>
<td>No</td>
<td>Yes</td>
<td>没有提供。</td>
<td>任何人可以联系,为重新入住提供住宿服务。</td>
</tr>
<tr>
<td>6-8 Lodge Street</td>
<td></td>
<td>9am-5pm</td>
<td></td>
<td></td>
<td></td>
<td>没有提供。</td>
</tr>
<tr>
<td>Haddington EH41 3dx</td>
<td></td>
<td>Fri 9am-4pm</td>
<td></td>
<td></td>
<td></td>
<td>没有提供。</td>
</tr>
<tr>
<td>Midlothian Council Buccleuch House</td>
<td>T: 0131 271 3613</td>
<td>Mon-Thurs 9am-5pm</td>
<td>No</td>
<td>Yes</td>
<td>没有提供。</td>
<td>任何人可以联系,为重新入住提供住宿服务。</td>
</tr>
<tr>
<td>1 White Hart Street</td>
<td>T: 0131 271 3618</td>
<td>9am-5pm</td>
<td></td>
<td></td>
<td></td>
<td>没有提供。</td>
</tr>
<tr>
<td>Dalkeith EH22 1AS</td>
<td>T: 0131 271 3617</td>
<td>Fri 9am-3.45pm</td>
<td></td>
<td></td>
<td></td>
<td>没有提供。</td>
</tr>
<tr>
<td>West Lothian Council Contact nearest Customer</td>
<td>T: 01506 775000</td>
<td>Office hours</td>
<td>No</td>
<td>Yes</td>
<td>没有提供。</td>
<td>任何人可以联系,为重新入住提供住宿服务。</td>
</tr>
<tr>
<td>Service Office</td>
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<td></td>
<td>没有提供。</td>
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<tr>
<td>West Lothian Council Housing and Customer Services</td>
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<td>没有提供。</td>
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<tr>
<td>West Lothian House</td>
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<td></td>
<td>没有提供。</td>
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<tr>
<td>Livingston EH54 6QG</td>
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<td></td>
<td></td>
<td>没有提供。</td>
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<tr>
<td>Name &amp; Address</td>
<td>Tel/Fax/Email</td>
<td>Opening Times</td>
<td>Appt. Needed</td>
<td>24hr Service</td>
<td>Referral From</td>
<td>Description of Service</td>
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<tr>
<td>Police Domestic Abuse Liaison Officers</td>
<td>Edinburgh St Leonard’s Police Station Family Protection Unit</td>
<td>T: 0131 662 5000 T: 0131 662 5773</td>
<td>Mon-Fri 8am-4pm</td>
<td>Can phone anytime, but make an appointment for face-to-face meeting.</td>
<td>No but outwith hours, contact local Police Station or in an emergency 999.</td>
<td>Anyone</td>
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<tr>
<td></td>
<td>Midlothian Dalkeith Police Station</td>
<td>T: 0131 663 2855</td>
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<tr>
<td></td>
<td>East Lothian Dalkeith Police Station</td>
<td>T: 0131 663 2855</td>
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<tr>
<td></td>
<td>West Lothian Livingston Police Station</td>
<td>T: 01506 431200</td>
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<tr>
<td>Respect Phoneline</td>
<td>T: 0845 122 8609 <a href="http://www.respect.uk.net">www.respect.uk.net</a> E: <a href="mailto:phoneline@respect.uk.net">phoneline@respect.uk.net</a></td>
<td>Mon/Wed/Fri 10am-12pm and 2-4pm Tues 2-5pm</td>
<td></td>
<td>No</td>
<td></td>
<td>Phoneline for domestic abuse perpetrators. Welcomes calls from (ex) partners, friends, relatives and frontline workers.</td>
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<tr>
<td>Name &amp; Address</td>
<td>Tel/Fax/Email</td>
<td>Opening Times</td>
<td>Appt. Needed</td>
<td>24hr Service</td>
<td>Referral From</td>
<td>Description of Service</td>
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<tr>
<td>Saheliya</td>
<td>T: 0131 556 9302 F: 0131 556 9302 E: <a href="mailto:saheliya@connectfree.co.uk">saheliya@connectfree.co.uk</a> <a href="http://www.saheliya.org.uk">www.saheliya.org.uk</a></td>
<td>Mon-Thurs 9am-4.30pm Fri 9am-2.30pm</td>
<td>No</td>
<td>No</td>
<td>Anyone</td>
<td>Counselling, befriending, complementary therapies and one-to-one support for black and minority ethnic women with mental health problems. Works with women who have experienced domestic abuse and other forms of violence.</td>
</tr>
<tr>
<td>Sexual Abuse Survivors Support in Edinburgh (SASSIE)</td>
<td>T: 0131 220 4722 E: <a href="mailto:sassie@homecall.co.uk">sassie@homecall.co.uk</a></td>
<td>Office hours</td>
<td>No</td>
<td>No</td>
<td>Anyone</td>
<td>Group support to adult women (16+) who are survivors of childhood sexual abuse.</td>
</tr>
<tr>
<td>Shakti</td>
<td>T: 0131 475 2399 F: 0131 475 2301 E: <a href="mailto:info@shaktiedinburgh.co.uk">info@shaktiedinburgh.co.uk</a></td>
<td>Mon-Fri 10am-5pm</td>
<td>No</td>
<td>No</td>
<td>Anyone</td>
<td>Emotional and practical support and safe temporary accommodation to black and minority ethnic women and children (if any) experiencing domestic abuse.</td>
</tr>
<tr>
<td>Name &amp; Address</td>
<td>Description of Service</td>
<td>Social work services</td>
<td>Referral From</td>
<td>Tel/Fax/Email</td>
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<tr>
<td><strong>Social Work</strong></td>
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<td>Midlothian</td>
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<tr>
<td>Dalkeith Social Work Centre</td>
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<tr>
<td>T: 0131 554 4301 F: 0131 271 3860</td>
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<tr>
<td>East Lothian</td>
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<tr>
<td>Haddington Office</td>
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<td>T: 01620 826600</td>
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<tr>
<td>Mid &amp; East Lothian</td>
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<td>West Lothian</td>
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<tr>
<td>Bathgate Office</td>
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<tr>
<td>T: 01506 775666</td>
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<td>West Lothian</td>
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<tr>
<td>Broxburn Office</td>
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<tr>
<td>T: 01506 77401/2</td>
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<tr>
<th>Name &amp; Address</th>
<th>Description of Service</th>
<th>Social work services</th>
<th>Referral From</th>
<th>Tel/Fax/Email</th>
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<tbody>
<tr>
<td><strong>Victim Support</strong></td>
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<tr>
<td>Edinburgh</td>
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<tr>
<td>2 Nicolson Square</td>
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<tr>
<td>EH9 9BH</td>
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<tr>
<td>T: 0131 668 6686 F: 0131 668 9909 E: <a href="mailto:victimsupportedinburgh@btconnect.com">victimsupportedinburgh@btconnect.com</a></td>
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<tr>
<td>Mid &amp; East Lothian</td>
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<tr>
<td>T: 0131 660 3030 F: 0131 660 1900 E: <a href="mailto:vsmae@btconnect.com">vsmae@btconnect.com</a></td>
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<tr>
<td>West Lothian</td>
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<tr>
<td>T: 01506 65050 F: 01506 65050 E: <a href="mailto:vsme@btconnect.com">vsme@btconnect.com</a></td>
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</tr>
<tr>
<td>Name &amp; Address</td>
<td>Tel/Fax/Email</td>
<td>Opening Times</td>
<td>Appt. Needed</td>
<td>24hr Service</td>
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<tr>
<td><strong>Women’s Aid</strong></td>
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</tbody>
</table>
| Edinburgh Women’s Aid  
4 Cheyne Street  
Edinburgh  
EH4 1JB | T: 0131 315 8111  
F: 0131 343 2426  
E: info@edin  
womensaid.co.uk | Mon 1-3pm  
Tues, Wed, Fri  
10am-3pm  
Thurs 2-7pm  
Sat 10am-1pm | No | No | | Works with women  
and children who  
have experienced  
domestic abuse.  
Provides refuge. |
| East Lothian Women’s Aid  
69 Eskside West  
Musselburgh  
EH21 6RA | T: 0131 665 9552  
E: eastlothian.  
womensaid@virgin.net | Mon-Fri  
10am-3pm | No | No | | |
| Midlothian Women’s Aid  
29a Eskbank Road  
Dalkeith  
EH22 1HG  
10 Carnethy Avenue  
Penicuik  
EH26 8AR | T: 0131 663 9827  
F: 0131 663 9032  
E: mwamid@aol.com | Mon-Fri  
9am-4pm  
Drop in Mon & Fri  
10am-1pm  
Tues & Thurs  
12noon-3pm  
Wed 10am-1pm | No | No | | |
| West Lothian  
Women’s Aid  
92 Ivanhoe Rise  
Dedridge  
Livingston  
EH54 6HZ | T: 01506 413721  
E: wlwomensaid@  
msn.com | Summer  
Mon-Fri  
10am-10pm  
Winter  
10am-8pm  
Mon-Wed  
10am-3.30pm  
Thurs 10am-10pm  
(winter) 10am-  
8pm (summer)  
Friday 10am-12pm | No | Yes | | |
<table>
<thead>
<tr>
<th>Name &amp; Address</th>
<th>Tel/Fax/Email</th>
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</thead>
<tbody>
<tr>
<td>Working with Men Project</td>
<td>T: 0131 529 5070 (project worker)</td>
</tr>
<tr>
<td></td>
<td>T: 0131 553 8493 (development staff available for consultation)</td>
</tr>
<tr>
<td>Description of Service</td>
<td>Non court-mandated service for men who wish to address their abusive behaviour to their abusive partners. Runs citywide training courses and encourages and supports development of similar projects.</td>
</tr>
<tr>
<td>24hr Service Needed</td>
<td>No</td>
</tr>
<tr>
<td>Referral From</td>
<td>Self and agencies</td>
</tr>
<tr>
<td>Opening Times</td>
<td>Office hours</td>
</tr>
<tr>
<td>Appt. Needed</td>
<td>Yes</td>
</tr>
</tbody>
</table>

For partner support, see Domestic Violence Probation Project.
Further Information

Guidelines
Child Protection Guidelines, Edinburgh and The Lothians Child Protection Committee
Protecting Vulnerable Adults, Ensuring Rights and Preventing Abuse, NHS Lothian and partners, 2003
Responding to Domestic Abuse: Guidelines for Health Care Workers in NHS Scotland,
Scottish Executive, 2003
Scottish Partnership on Domestic Abuse, National Strategy to Tackle Domestic Abuse in Scotland,
Scottish Executive, 2000

Websites
British Medical Association: www.bma.org.uk
British Medical Journal: www.bmj.com
Department of Health: www.dh.gov.uk
Health Scotland: www.healthscotland.com
Royal College of General Practitioners: www.rcgp.org.uk
Royal College of Midwives: www.rcm.org.uk
Scottish Executive Domestic Abuse website: www.domesticabuse.co.uk
Scottish Executive site for victims of crime: www.scottishvictimsofcrime.co.uk
Scottish Executive: www.scotland.gov.uk
Scottish Women’s Aid: www.scottishwomensaid.org.uk
Zero Tolerance: www.zerotolerance.org.uk

Resources
NHS Lothian information cards and posters
Tel: 0131 536 9451/2/3

NHS Lothian library has many books, videos, education packs and reports
Tel: 0131 536 9451/2/3
Email: library@lhb.scot.nhs.uk
Website: www.nhslothian.scot.nhs.uk
Member of staff suspects a child is being, or has been abused, or is at risk of abuse

Discuss with manager or appropriate senior colleague/s (if possible/necessary) and Paediatrician on-call for Child Protection or local Child Protection Advisor. If this is not possible, advice can be sought or your concerns discussed with Social Work or Police*

No Child Protection Concerns

Ensure appropriate follow-up services are notified

Inform appropriate colleagues in primary care (e.g. GP, Health Visitor, School Nurse)

Health Telephone Numbers
(Ask for ‘Paediatrician On-Call for Child Protection’)

Edinburgh
Office Hours: 0131 536 0467
Office Hours: 0131 536 0000

Midlothian
Office Hours: 0131 536 8107
Office Hours: 0131 536 0000

East Lothian
Office Hours: 0131 536 8107
Office Hours: 0131 536 0000

West Lothian
Office Hours: 01506 422783
Office Hours: 0131 536 0000

Please see over for other agency numbers

* Staff must ensure that vital time is not wasted if they suspect a child is at risk of abuse. For further guidance, staff should consult The Edinburgh & Lothians Child Protection Committee Inter-Agency Guidelines.

Child Protection Concerns

Make Child Protection Referral Immediately
(To one of the following agencies to initiate Initial Referral Discussion – IRD)

Record all Observations, Interventions, Actions and Communications (also sign, date & record)

Police

Social Work

Paediatrician on-call for Child Protection

IRD decides appropriate course of action and feeds back to referrer
# Additional Telephone Numbers

## Child Protection Advisory Team

<table>
<thead>
<tr>
<th>Area</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edinburgh South</td>
<td>0131 316 6676</td>
</tr>
<tr>
<td>Edinburgh North</td>
<td>0131 316 6675</td>
</tr>
<tr>
<td>East &amp; Mid Lothian</td>
<td>0131 316 6674</td>
</tr>
<tr>
<td>Edinburgh (Acute Sites)</td>
<td>0131 536 0170</td>
</tr>
<tr>
<td>West Lothian</td>
<td>01506 524 421</td>
</tr>
<tr>
<td>Nurse Consultant for Vulnerable Children – Anne Neilson</td>
<td>0131 316 6634</td>
</tr>
</tbody>
</table>

## Inter-Agency Telephone Numbers

### Edinburgh

**Social Work**
- Children & Families HQ: 0131 469 3000
- Duty SW RHSC: 0131 536 0501
- Emergency & Out of Hours: 0800 731 6969

**Police**
- Amethyst Team: 0131 316 6600

### Midlothian

**Social Work (Children & Family)**
- Dalkeith Social Work Centre: 0131 271 3860
- Emergency & Out of Hours: 0800 731 6969

**Police**
- Dalkeith Police Station: 0131 663 2855

### East Lothian

**Social Work (Children & Family)**
- Haddington Office: 01620 826600
- Musselburgh Office: 0131 665 3711
- Emergency & Out of Hours: 0800 731 6969

**Police**
- Dalkeith Police Station: 0131 663 2855

### West Lothian

**Social Work (Children & Family)**
- Livingston Office: 01506 777777
- Bathgate Office: 01506 776700
- Broxburn Office: 01506 775666
- Emergency & Out of Hours: 01506 77401/2

**Police**
- Livingston Police Station: 01506 431200