



Delivery of "Ask and Act"
The role of the frontline practitioner

This document is issued as a working draft for the purpose of testing its appropriateness. Once finalised, it is intended that this document will be issued as statutory guidance under section 15 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, having first been laid before the National Assembly for Wales in accordance with section 16 of the Act.

Whilst the document is a 'working draft' it is hoped that it will assist those relevant authorities subject to the second phase roll out to plan and implement Ask & Act.

Ministerial foreword

Over the past few years the Welsh Government has led a national response to tackling violence against women, domestic abuse and sexual violence. We have broken new ground with the introduction of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, we have demonstrated strong implementation with the introduction of the National Strategy on Violence against Women, Domestic Abuse and Sexual Violence – 2016 – 2021 and we have shown innovation with the introduction of a National Training Framework on violence against women, domestic abuse and sexual violence, a new campaigns plan and a wide ranging sustainability programme for specialist services.

“Ask and Act” is a further example of our commitment to preventing violence against women, domestic abuse and sexual violence and it is, by far, our most ambitious practice changing innovation yet. It is a process of targeted enquiry to be practiced across the relevant authorities (as named in the Violence against Women, Domestic Abuse and Sexual Violence Act) to identify violence against women, domestic abuse and sexual violence.

“Ask and Act” has the potential to change and save lives and initial feedback from the early adoption work shows that it does achieve this. It is a policy which has been developed with survivors of violence against women, domestic abuse and sexual violence and is therefore informed by lived experience. As we prepare to roll out Ask and Act across Wales we are beginning a journey that can change the face of the public service approach to those who have experienced violence against women, domestic abuse and sexual violence; identifying more people in need, offering efficient and effective interventions earlier and improving the response to these issues.

Thank you for becoming an “Ask and Act” practitioner, your role is crucial in identifying violence against women, domestic abuse and sexual violence and offering help and support to those who experience it. By practicing “Ask and Act” consistently and sensitively you will help to remove the shame, stigma and victimisation that is associated with the experience of violence against women, domestic abuse and sexual violence and improve the response to those who experience these issues. Ultimately by practicing “Ask and Act” you can help to prevent future violence and abuse occurring and improve the health and wellbeing of those affected.

“Ask and Act” is the practice change that will see our legislation and strategic direction delivered at the frontline. We will create a culture change across the public service where the experience of violence against women, domestic abuse and sexual violence is ‘understood in the correct context, where disclosure is accepted and facilitated and support is appropriate and consistent.

Julie James AM

Leader of the House and Chief Whip

A note on language

“Ask and Act” is a Welsh Government policy delivered through guidance, funding and training. The training element of the policy is delivered through groups 2 and 3 of the National Training Framework. The National Training Framework on violence against women, domestic abuse and sexual violence addresses all forms of gender-based violence, domestic abuse and sexual violence. However, the Framework is named to ensure a focus – through delivery - on particular forms of violence and abuse which are disproportionately experienced by women and girls. Evidence shows that women disproportionately experience repeat incidents of domestic abuse, all forms of sexual violence and other forms of violence and abuse such as forced marriage and female genital mutilation.

Whilst it is important that this disproportionate experience is acknowledged and communicated through training delivery, including the “Ask and Act” training, the purpose of the Framework is to ensure that professionals are trained to provide an effective response to anyone affected by any form of gender-based violence, domestic abuse and sexual violence. References in this guidance to “violence against women, domestic abuse and sexual violence” or “violence and abuse” should therefore be read to capture all forms of gender-based violence, domestic abuse and sexual violence as defined in section 24 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015.

Some forms of violence and abuse which meet these definitions are experienced within family settings and relationships, including same sex relationships, between family members and by men who are abused by women. As such, training for each group within the Framework, including the “Ask and Act” training, acknowledges the disproportionate impact of these forms of violence and abuse on women but will be inclusive of all potential victims.

The “Ask and Act” training acknowledges that the experience of men and women of these forms of violence and abuse can be different and often requires a different professional response which takes these differences into account. As this guidance sets out, the specific needs of all clients, whether linked to gender or other characteristics, should be considered carefully in providing appropriate service options.

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Introduction

This guidance is aimed at practitioners who have been trained (via the Welsh Government led national training programme) to “Ask and Act”. The contents of the guidance describe good practice in relation to “Ask and Act” and it should be used as a reference document to assist in the practice of the targeted enquiry approach.

This guidance is aimed at the relevant authorities referred to in the Violence against Women, Domestic Abuse and Sexual Violence Act (2015). These are local authorities, Local Health Boards; fire and rescue authorities and National Health Service trusts. This is because the Welsh Government “Ask and Act” training programme is being rolled out to these organisations. However, should other organisations wish to adopt “Ask and Act”, this guidance will assist in understanding what good practice looks like and how those who work directly with clients; “practitioners” should behave during their interaction with clients.

It provides a detailed process of “Ask and Act” and describes each stage required to undertake this well. It starts with preparing to ask and explores each potential outcome from this point onwards.

How “Ask and Act” works in each organisation may vary slightly, depending on organisational structure and your client group, but the guidance provides good practice information for the delivery of “Ask and Act” by frontline practitioners and it is hoped you can apply this to your own working role.

This guidance contains case studies provided by the organisations who initially piloted “Ask and Act”. These sites have provided instrumental learning and advice to the ongoing project and during the development of this guidance. The document has also been informed by those with lived experience of abuse, whose feedback has been invaluable during the final development phase. We are very grateful to both the early adopter sites and survivors for their ongoing support for “Ask and Act”.

Before you “Ask and Act”.

A number of important factors support “Ask and Act”. These must be in place and have been considered before any practitioner applies the process of “Ask and Act”.

All practitioners who “Ask and Act” should be appropriately trained.

The Welsh Government has funded an “Ask and Act” Train the Trainer programme which is being rolled out across Wales.

Trained trainers working in your area will run a regional training programme, delivered through the “National Training Framework on Violence against Women, Domestic Abuse and Sexual Violence”. The “Ask and Act” training will provide knowledge and skills in how to “Ask and Act”.

All practitioners who are selected to “Ask and Act” within their organisation must attend this training. Your regional or organisational lead can assist you in accessing the training programme in your area.

The client's right to confidentiality.

Those who access a service provided by the relevant authority will be referred to as clients throughout this guidance, as outlined in the definitions section of the document.

An understanding of Data Protection legislation and of local information sharing protocols is essential to "Ask and Act". The General Data Protection Regulation (GDPR) will be adopted into UK law from May 2018 and any sharing of personal data must comply with this regulation from this date. The Information Commissioners Office recommends all public bodies prepare for its implementation.

Clients have a right to confidentiality but this right is not absolute. There may be occasions where a client makes a disclosure as a result of targeted enquiry and a practitioner will have to make a judgement about whether to share some or all of the client's information and if so, what details to share. Any decision to share information must be informed by the relevant data sharing legislation and the common law duty of confidentiality.

It is imperative that each client is aware of their rights to confidentiality and where these rights change; to be able to make informed decisions about what information they choose to share with the practitioner they are working with and have reasonable expectations of how this information will be treated.

When working with clients from minority backgrounds and/or with diverse needs, it is particularly important that you are clear about how their personal information will be treated in order to improve their experience of services.¹

A working knowledge of safeguarding procedures

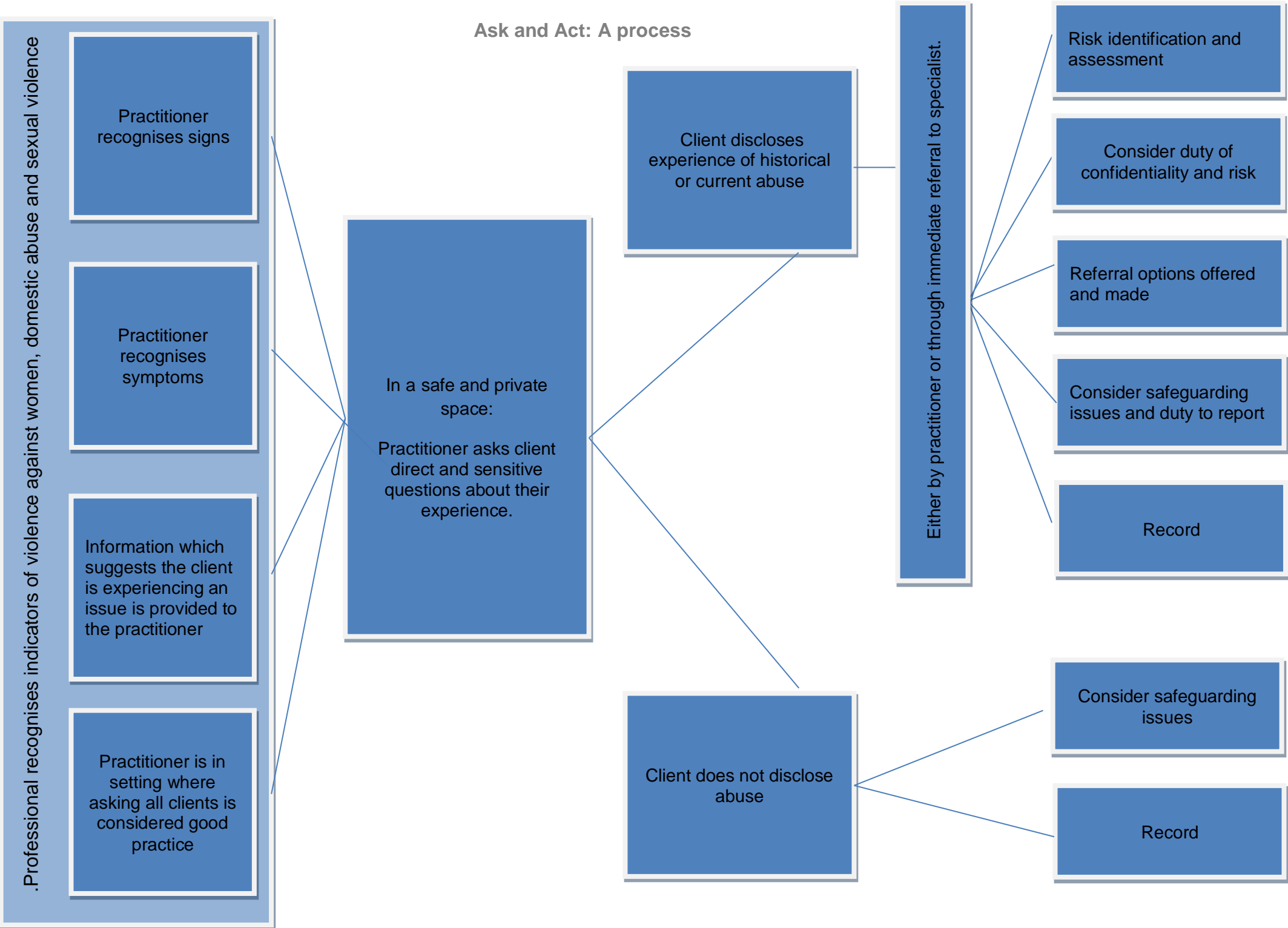
Ask and Act is a policy aimed primarily at adults but there will be cases where it is appropriate to ask a young person about their experiences. It is also very likely that in identifying the experience of forms of violence against women, domestic abuse and sexual violence for an adult, you will also identify a safeguarding issue related to their children or any children they may be associated with.

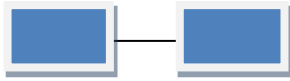
You may also identify indicators of the experience of violence against women, domestic abuse and sexual violence in clients who have additional needs for care and support.

In all such cases it is imperative that you establish a working partnership with specialist safeguarding practitioners (by following your organisational safeguarding procedures) to ensure that the signs of abuse are acted upon whilst formal safeguarding procedures are adhered to.

Ask and Act is a new means for identifying and offering earlier help to those experiencing violence against women, domestic abuse and sexual violence, it does not, however replace or create any new safeguarding procedure.

Existing safeguarding procedures must be used when and if you suspect a child or an adult is at risk.





Recognition of indicators of violence against women, domestic abuse and sexual violence

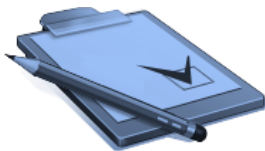
“Ask and Act” is a form of targeted rather than routine enquiry.

Routine enquiry refers to asking all service users about their experience of violence against women, domestic abuse and sexual violence regardless of whether or not there are any signs of abuse, or whether abuse is suspected.

Targeted enquiry involves relevant practitioners applying a "low threshold for asking" whether the client is experiencing violence and abuse when the client presents certain indicators of such abuse. “Indicators” are used to describe all of the signs, symptoms, cues or settings through which violence against women, domestic abuse and sexual violence can be identified. In some health settings, targeted enquiry is referred to as clinical enquiry.

Violence against women, domestic abuse and sexual violence takes place in heterosexual, lesbian, gay and bi-sexual relationships, to cisgender and trans people and can involve other family members, including children and young people. Whilst some groups are more vulnerable to experiencing violence against women, domestic abuse and sexual violence than others, **anyone can experience it** regardless of race, ethnic or religious group, gender, age, social economic status or lifestyle. Evidence would indicate however, some forms of violence against women, domestic abuse and sexual violence are more prevalent within some communities and the practitioner should pay due regard to this, whilst avoiding ill informed or partial judgments based on stereotyping or myth.

It is crucial the process of “Ask and Act” is based on consistent consideration of known indicators of violence against women, domestic abuse and sexual violence, rather than judgments, personal perspectives or any form of stereotyping. These indicators are explored further below.



In practice

Anyone can be a victim of violence against women, domestic abuse and sexual violence and a process of “Ask and Act” should reflect this. Ultimately each person experiencing any form of abuse should gain access to the services they require, whether via public or specialist services and the indicators of these experiences should be monitored across the entire client group.

For the purposes of this guidance, the term ‘indicators’ is used to encompass four triggers for enquiry with clients about their experience of violence against women, domestic abuse and sexual violence: **signs, symptoms, cues and settings**.

Whilst clients will manage their experience of violence against women, domestic abuse and sexual violence differently, these are commonly recognised indicators of the issue which practitioners should be aware of, and which should prompt further enquiry.

It is not possible to provide an exhaustive list of indicators and exactly what form of violence against women, domestic abuse and sexual violence they may relate to. The indicators provided below could indicate many forms of violence against women, domestic abuse and sexual violence or another traumatic experience. Where an indicator is linked directly to a specific form of abuse this is made clear.

However, a person may not show any signs of abuse, despite experiencing something traumatic. Domestic abuse, in particular, is often characterised by the presence of coercive control, which by its very nature, is insidious and can be difficult to explain. It is not for the practitioner to identify signs that aren’t there or interrogate a client; however, it is also not right to assume that identification of indicators is a straight forward process.

Coercive control is a criminal offence in England and Wales and involves a person with whom someone is personally connected, repeatedly behaving in a way which has a serious effect on them, which they knew or ought to have known would have a serious effect on them.

The following types of behaviour are common examples of coercive control (this list is not exhaustive):

- isolating someone from their friends and family;
- controlling how much money someone has and how it is spent;
- monitoring activities and movements;
- repeated put downs and name calling ;
- threats to harm or kill a person or their child.

These indicators could reflect a range of issues and also prompt safeguarding concerns for children or adults at risk. As such, acknowledgment and exploration of them should already be an integral part of good practice.

No matter what the other characteristics of the client are, where one of the four indicators is observed, the practitioner should follow the continued stages of the process of “Ask and Act” as outlined below. It is not necessary that these indicators be witnessed in any form of combination to prompt an enquiry. Witnessing any one indicator constitutes the need to “Ask and Act”.

The four types of indicator



Signs

The potential outward signs someone is experiencing violence against women, domestic abuse and sexual violence will be both physical and linked to the demeanour and behaviour of the client. It is imperative that practitioners recognise the coercive nature of many forms of violence against women, domestic abuse and sexual violence and, consequently, the high prevalence of emotional abuse which often precedes physical abuse. Recognising things like attitudinal change may offer a means of early intervention.

Socio cultural signs	Physical signs
Changes in attitude or behaviour: becoming very quiet, anxious, frightened, tearful, aggressive, distracted, depressed etc.	Unexplained injuries
Constant accompaniment by partner/family, even where this seems supportive and attentive	Change in the pattern or amount of make-up used
Partner/family exerting unusual amount of control or demands over interactions with service, including constant accompaniment	Change in the manner of dress: for example, clothes which do not suit the climate (which may be used to hide injuries) or very different style of dress to that worn before.
Reliance on partner/family for decision making. Lack of free will and independence	Substance use/misuse
Obsession with timekeeping	Fatigue/sleep disorders Difficulty walking, standing or sitting (sign that a woman or girl has been subjected to Female Genital Mutilation ¹)
Secretive regarding home life	Spending longer in the bathroom or toilet (sign that a woman or girl has been subjected to FGM)
Worried about leaving children at home with partner or family	Unusual behaviour after an absence from school or college (sign that a woman or girl has been subjected to FGM or forced marriage)
Partner or ex-partner exerting unusual amount of control or demands over client's schedule	Reluctant to undergo routine medical examinations (sign that a woman or girl has been subjected to FGM or physical abuse)
Social isolation from family/friends Going missing from home, care or education (sign that a person is at risk of CSE or forced marriage)	Attempted suicide or suicidal tendencies.
Spending time with groups of older people, or antisocial groups, or with	

¹ FGM is a procedure where the female genital organs are injured or changed and there is no medical reason for this.

other vulnerable peers (sign that a person is at risk of CSE and online bullying)

Association with other young people involved in sexual exploitation (sign that a person is at risk of CSE or trafficking)

Involvement in gangs, gang fights, gang membership (sign that a person is at risk of CSE or trafficking (but also other forms of abuse)

Older boyfriends or girlfriends (sign that a person is at risk of CSE)

Spending time at places of concern, such as hotels or known brothels (sign that a person is at risk of CSE or trafficking)

Not knowing where they are, because they have been moved around the country (sign that a person is at risk of CSE)

Involvement in petty crime such as shoplifting (sign that a person is at risk of CSE)²

Symptoms

Within this guidance the term “symptoms” is used to describe indicators of violence against women, domestic abuse and sexual violence which are most often seen within a medical or clinical context. As such, it is expected that the identification of symptoms will mainly happen within clinical and medical practice. Symptoms which should trigger an enquiry include (this list is not exhaustive):

- Anxiety
- Alcohol or other substance use
- Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Anal or vaginal soreness (rape and sexual violence)
- An unusual discharge (rape and sexual violence)
- Depression
- Difficulties urinating or incontinence (FGM)
- Eating disorders
- Frequent or chronic vaginal, pelvic or urinary infections (FGM)
- Frequent bladder or kidney infections and kidney failure

- Gynaecological problems³
- Intrusive or controlling partner in consultation
- Medically unexplained chronic pain
- Medically unexplained chronic gastrointestinal symptoms
- Medically unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- Menstrual problems (FGM)
- Miscarriage
- Pregnancy (rape and sexual violence)
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated vaginal bleeding and sexually transmitted infections
- Repeated health consultations with no clear diagnosis or medically unexplained symptoms
- Self harm
- Sexually transmitted infection (STI) (rape and sexual violence)
- Suicide attempts
- Tiredness

Cues

A cue describes either a piece of information or pattern of behaviour which merits enquiry. This could include taking an overview of a client's engagement with services over time and querying the reasons behind sporadic or crisis-based engagement. It might also include information provided by a partner agency based on referral, or shared via use of local Information Sharing Protocols, that indicates concern, suspicion or unsubstantiated intelligence that the client might be experiencing violence against women, domestic abuse and sexual violence.

Some specific cues are provided below:

Female Genital Mutilation (FGM)

It is important to acknowledge that those affected by FGM (and using relevant authority services) may be at risk of having the procedure, have recently experienced the procedure or have experienced the procedure in the past. They will require services which relate to their experience. For example those who are under eighteen will be at higher risk that the procedure will be done to them, whilst for older women, there may be complications linked to having had the procedure in the past and now experiencing pregnancy or related health implications.

A girl at immediate risk of FGM may not know what's going to happen but she might talk about or you may become aware of:

- a long holiday abroad or going 'home' to visit family
- relative or cutter visiting from abroad
- a special occasion or ceremony to 'become a woman' or get ready for marriage

- a female relative being cut – a sister, cousin, or an older female relative such as a mother or aunt.⁴

These are cues which should be acted upon and taken forward within safeguarding procedures. A mandatory reporting duty for known cases of FGM exists. This is discussed further here.

Honour based violence and forced marriage

Many of the cues above could indicate abuse that is being perpetrated in the name of “honour”. Additional potential cues that a person is at risk of forced marriage are below. These are particularly relevant to young people and should be seen as cues to make appropriate enquiries or seek specialist help.

- Hyper-vigilance by the young person
- A history of forced marriage in the family.
- Not being allowed to leave the house.
- Attempts to run away from home.
- Constant monitoring by the family.
- Request for extended leave of absence at school and/or failure to return from the country of origin after holidays.
- Surveillance by siblings or family members who are in the same school.
- Fear about forthcoming school holidays.
- Being withdrawn from school or prevented from continuing with higher education.
- Not engaging in school activities.
- More frequent absence from school for longer periods of time.⁵

To “Ask and Act” is not to interrogate and wherever cues are observed they should be considered alongside the socio-cultural and physical signs listed above. It is important that practitioners are aware of cultural differences and cultural sensitivity.

Where a cue is observed or received, a practitioner should make appropriate enquiry and seek advice from their group 3 champion and specialist services for Black, Asian, Minority Ethnic and Refugees. Practitioners should avoid using jargon as many cultures may express various forms of abuse in a simplistic form. There is a risk that a lack of shared understanding of terminology and jargon could lead to missed opportunities for a client to disclose or to a client misunderstanding the question. Be patient and empathic when making an enquiry.

Case study

A Local Authority based practitioner had a working relationship with a client which had developed over a number of weeks. They met regularly to discuss the client's needs and support plan.

During these meetings the client had made a passing reference to hoping to leave her husband one day and work had been put in place to consider whether new accommodation could be found for her.

The client began cancelling several meetings and provided several different reasons for the cancellations. During calls to cancel meetings the client also demonstrated a different attitude and way of speaking to the practitioner. She also began suggesting that she no longer wanted to take forward parts of her support plan.

The practitioner became concerned that the client's change in attitude may be as a result of more serious problems with her relationship than she had previously understood and asked the client directly if her husband was abusive to her and whether he had ever hurt her? The client responded by saying that nothing had happened and stated that she had health issues.

Two days later the client rang the practitioner in distress saying that she had to get away from her husband as fast as she could and disclosing abuse.

Following disclosure the practitioners secured specialist housing support for the client and made a referral to the local specialist domestic abuse service.

Settings

There is evidence which suggests that in some settings routine enquiry is appropriate, as the reason for the client's engagement within the setting is also a trigger for enquiry in relation to violence against women, domestic abuse and sexual violence.

Practitioners working in the following settings should routinely ask all clients whether they are experiencing violence against women, domestic abuse and sexual violence due to the known co-occurrence of domestic abuse with the core purpose of the service they provide (mental health issues, pregnancy, child maltreatment):

- **Mental health**

The risk of developing depression, post-traumatic stress disorder (PTSD), substance use issues or becoming suicidal is 3 to 5 times higher for women who have experienced violence in their relationships compared to those who [have] not.⁶

Acknowledging attendance at mental health settings as an indicator for "Ask and Act" offers practitioners an opportunity to address these links proactively and offer care which addresses the co-occurring issues.

During consultation on this document, those with lived experience of abuse described their own distress being misinterpreted as a mental health need or “instability” which led to misdiagnosis or lack of appropriate treatment. Some survivors also experienced abuse where their perpetrators accused them of being mentally ill as a way of minimising abuse or further controlling them. It is hoped that greater awareness, within mental health settings, of how mental health is used as part of coercive and controlling forms of abuse will also improve the holistic response provided to those who have experienced it.

- **Maternal and post partum settings⁷**

30% of domestic violence starts in pregnancy and is associated with low birth weight and pregnancy complications including miscarriage and still-birth^{8 9}.

“Ask and Act” further strengthens the existing maternity care pathway which uses an evidence based approach to asking all women about domestic abuse in the antenatal period.

- **Settings linked to raised concerns about child abuse or neglect (maltreatment)**

Nearly three quarters of children on the child protection register live in households where domestic violence occurs and 52% of child protection cases involve domestic violence.¹⁰

62% of children exposed to domestic abuse are also directly harmed. Missed opportunities to identify violence against women, domestic abuse and sexual violence are missed opportunities to identify risk to children.

Case study

A client was discussing financial problems with a Debt officer and disclosed that her husband was taking all of the money that she earned through the family business, leaving her with nothing to pay her rent, or to live off. Following further enquiries the client disclosed that her husband had always controlled the finances, taking lump sums from the business to finance his addiction to alcohol.

The client explained that she has recently asked her husband to leave but he refused. The tenant believed that because she was married her husband will have a claim to her council property, of which she was the sole tenant.

Following this disclosure the debt officer provided reassurance about the tenancy and offered and made a referral to the local specialist domestic abuse service.

Provision of a safe and private space for client consultation

The process of “Ask and Act” must be implemented within a culture and environment where the confidentiality, privacy and data of the client group is respected and treated very carefully. Essentially this will require:

- promoting the safety of the client as a priority and explaining carefully the level of confidentiality they can expect; and
- ensuring that private and confidential spaces are available so that clients feel safe and are not worried that the conversation will be overheard.

In practice

The practitioner should address two important considerations prior to asking the question:

- The environment; and
- Their rapport with the client.

Environment

The space you provide in which to ask the client about their experience of violence against women, domestic abuse and sexual violence must be safe. Whether it is safe is down to the judgement of the client. Before you ask any sensitive questions, ensure they feel secure in the space you provide and ask them what would make them feel more comfortable.

Do not broach the subject of the experience of violence against women, domestic abuse and sexual violence if other people are around or if your conversation can be overheard. The client must be alone; without family or a partner present.

Clearly display information in waiting, communal areas and other suitable places about the support on offer for those affected by violence and abuse. This should include contact details of relevant local and national helplines.

Ensure materials are displayed which indicate inclusivity of those clients who may identify as minority or with diverse needs.

Ensure the information on where to get support is available in a range of formats and locally used languages. The former could include Braille and audio versions and the use of large font sizes. There may also be more discreet ways of conveying information, for example, by providing pens or key rings with a helpline number.

Do not assume anyone is a “safe” family member or friend. Some forms of violence against women, domestic abuse and sexual violence involve multiple perpetrators including family members of all genders and extended social networks. This may be particularly true in relation to “Honour” based abuse and within tight knit communities such as those of travellers.

It is not appropriate to use a family member or friend as an interpreter.

A client is less likely to disclose if their children are present. They may be uncomfortable to discuss such information in front of them, they might minimise the violence to protect them and may be in a position where their children are being used by a perpetrator to monitor their actions and will know it is not safe to have the conversation with their children present.

Do not assume the sex or gender of the client or the client's partner and avoid using labels wherever possible.

LGBT+ clients may not be "out" to the person accompanying them and may be reluctant to disclose anything about their private life.

The client must feel they have the full attention of the practitioner.

Rapport

It is important to normalise the process of "asking the question". The best way to encourage the client to open up is to adopt a considerate questioning approach. Try to avoid "shutting down" disclosure through adopting either an apologetic approach or being too forthright.

Talking about violence against women, domestic abuse and sexual violence can be an emotionally charged event for both the person being abused and the confidante and needs to be handled sensitively.

The practitioner must appear confident to ask the question. A practitioner who appears nervous to ask may convey to the client they are not able to deal with the answer.

The practitioner should be aware of their non verbal communication to ensure they appear "open" to receiving the answer to their question.

The practitioner should use their active listening skills to ensure the client feels they are being given their full attention.



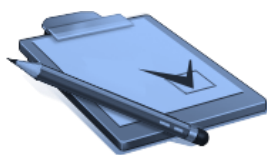
Practitioner asks client direct and sensitive questions about their experience

The questioning style

The indicators of violence against women, domestic abuse and sexual violence could reflect a range of issues and also prompt safeguarding concerns for children or adults at risk. As such, acknowledgment and exploration of them should already be an integral part of good practice.

Targeted enquiry typically results in a doubling of identification rates of domestic abuse and it increases referrals to outside agencies.¹¹ As such it has the potential to provide a positive impact on the lives of many victims of violence against women, domestic abuse and sexual violence and those of their children. The priority of all services engaged with “Ask and Act” should be to address the needs and the safety of these victims.

The majority of those surveyed on this issue were in favour of a process of enquiry about domestic violence, provided it is conducted in a safe, confidential environment.¹² **Practice-based feedback indicates those who experience violence against women, domestic abuse and sexual violence want practitioners to ask them about their experience and it is easier for a client to respond to a direct question than to offer the information up independently.**



In practice

It is generally best practice to “ask” in a conversational style, provide full attention to the client and listen carefully to their answers. However, questioning techniques should be adapted to best suit the needs of the practitioner setting and client group. Some work areas may choose to utilise a screening tool due to time and capacity pressures within this area.

It is important that use of these tools does not impact on the engagement between the practitioner and the client. If tools are used, the following practice-based considerations should inform how they are used and the choice of screening tools²:

- **The context/environment in which screening tools are being used:** screening tools used in healthcare settings should be brief, comprehensive and tested in diverse populations.
- **The time frame on which the screening tools are based:** screening tools vary widely in relation to the timescale they consider. This timescale is the

² The term Intimate Partner Violence is used in this section to reflect the language used in the related evidence.

period of time in which the abuse was experienced. Some tools consider the present time, some consider abuse experienced over the last 12 months, and others consider if abuse has ever been experienced.

- **Types of abuse:** Most screening tools don't address all forms of violence against women, domestic abuse and sexual violence, focussing on those which most often take place within intimate relationships.

Emotional abuse often precedes physical abuse and as such, is an important indicator to enable early identification and intervention. Secondly, women who experience sexual abuse are at higher risk of adverse health outcomes than women who experience physical or emotional abuse. Finally some forms of abuse may be isolated to threats and coercive/controlling behaviour.

Screening tools should conceptualise Intimate Partner Violence as broadly as possible.

- **Pregnancy:** not all screening tools ask specifically about abuse during pregnancy. It is important that this is considered in terms of settings used by pregnant women.
- **Use with male populations and diverse groups:** some screening tools have been tested with men but it remains unclear whether these screening tools, originally designed for use with women are suitable for use with men.

Screening tools should not be confused with risk identification or assessment tools which serve a different purpose than the identification of the issue and provide a subsequent step in a process of "Ask and Act". It should also be noted that many screening tools are limited to one form of violence against women, domestic abuse and sexual violence.

The question

The information below provides guidance for practitioners on how to begin a conversation with a client following an observation of an indicator that they may be experiencing violence against women, domestic abuse and sexual violence. A number of ways to begin the conversation are discussed but it will be important, with every client, to consider the possibility of suggestibility. This applies particularly with young people, those with lower intellectual functioning or learning disabilities. In some cases these clients may be more likely to "agree" with a suggestion they are being abused when this is not the case and practitioners must not lead any client disclosure.

To start a conversation, explain to the client what you have observed and that you are concerned about what the observation/s you have made could be linked to. This should lead to either a direct or indirect question – the "ask".

Indirect questions

Given that the indicators of violence against women, domestic abuse and sexual violence could also be indicators of wider social and public health issues, the practitioner may wish to approach targeted enquiry through a conversation involving indirect questions. This will further establish the rapport with the client.

These questions may include an explanation of why they are being asked such as:

“I have noticed these signs/symptoms”

“I have been provided with this piece of information”

which are then followed with an indirect question such as:

Are there any problems or reasons which may be contributing to these signs and symptoms?

Is there anything going on for you which may be causing these signs and symptoms?

These questions may prompt disclosures of violence against women, domestic abuse and sexual violence or of other issues requiring support from your clients. For other clients, such an approach will lack the required clarity for understanding or will not be enough to overcome their personal barriers to disclosure. It is therefore important practitioners also follow up indirect questioning with direct questioning where necessary. The practitioner must be certain they have asked the question required of “Ask and Act” and this question has been understood by the client.

Direct questions

Whilst direct questions must be clear and concise they should also be asked with great sensitivity and care. It is important the practitioner practices and thinks through the questions which can be asked comfortably and clearly in a way which normalises the process for the client.

The following are some examples of direct questions to begin the development of practitioner practice in this area. This section should not be used as a script – it is provided as guidance only.

“Abuse at home is very common and can sometimes result in people behaving or feeling the way you have described today. Abuse is a term used to describe a partner or family member hurting or upsetting you - this might mean physically hurting you, it might mean controlling your finances or it might mean calling you names or being hurtful through the things they say. It might also mean pushing you to do things you don’t want to sexually. Is this happening to you?”

“Some of the things you have told me today have worried me and I am concerned about what you might be experiencing in your personal life. Is

somebody hurting you in any way or are you afraid somebody might hurt you in the future?"

"Some of the things you have described are indicators a person is suffering harm or abuse by a partner or family member. Is it happening to you?"

Many of those who experience violence against women, domestic abuse and sexual violence do not recognise this language. It is important the practitioner is able to explore and explain what these terms mean and to break them down into questions on behaviour, rather than terminology. This will be particularly true for younger people who may tend to normalise the experience of partner violence, coercion or sexual violence.

Below are some examples of behaviour-based questions:

"Does your partner/ family member(s) get jealous of you seeing friends, talking to other people, going out? If so, what happens?"

"Does your partner ever punish you if don't do what they want."

"Does your partner/ family member lose their temper with you? If so, what happens as a result?"

"Has anyone in your family threatened to hurt you or make you do anything you don't want to do?"

"Do you feel frightened of anyone in your life?"

"Who makes decisions about what you can and can't do?"

"Is there anything happening for you right now, that makes you uncomfortable?"

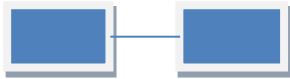
"Has anything happened to you in the past that has made you uncomfortable?"

"Do you have access to your own money and free choice about how to spend it?"

It is important the practitioner does not over-focus on physical violence to the detriment of emotional, psychological, financial and other aspects of violence against women, domestic abuse and sexual violence, all of which are damaging and harmful and should be taken seriously.

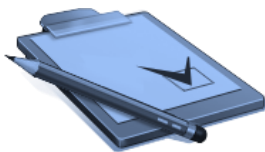
Where a client makes some reference to violence against women, domestic abuse and sexual violence or partly acknowledges their experience, it is important the practitioner does not pressurise them to fully disclose if the client is uncomfortable with this. Remember a client will need to overcome a series of personal barriers to make a disclosure; have patience, be consistent and sensitive.

More information on overcoming barriers to disclosure is available [here](#).



Dealing with disclosure

The response which is provided by the practitioner is as important as the question which is asked. This may be the first time the client has disclosed and they are likely to be fearful of the implications of doing so. The practitioner response will be crucial in reassuring the client. Survivors describe losing trust in professionals who did not appear to take their disclosure seriously.



In practice

- **Client discloses experience of current or historical abuse**

Where a client discloses the experience of abuse, it is important the practitioner believes and validates the information the client provides. Many clients will fear they won't be believed and it is important the practitioner validates the experience and acknowledges violence against women, domestic abuse and sexual violence are serious issues which are taken very seriously by the organisation.

Validating statements must be congruent to practitioner demeanour and therefore should not be scripted, however, some examples of validating statements are:

"It takes huge strength to share what you have today"

"No-one deserves to be abused. There is no excuse for violence and you deserve better"

"I am concerned about your safety and well-being but there are options and resources available to you"

"You are not alone"

"The abuse / violence is not your fault"

Reassure the client that the organisation has an understanding of how abuse and violence may affect them and the support which can be offered.

It is important that the practitioner does not appear shocked or panicked by the disclosure.

It is also important the practitioner considers the following:

- The safety of the client and of any associated children or adults;
- Whether immediate medical attention is required for any injury;
- The safety of the client to return home and what can be offered to mitigate risk;
- How the disclosure will be addressed, either within the organisation or using partnerships (see the remaining stages of the process for additional information); and
- Options for continuity of care.

As this guidance has explored, many physical and mental health conditions are indicators of the experience of violence against women, domestic abuse and sexual violence. However, it is very important that, following disclosure, the client still receives care for the presenting health condition. Survivors report experience and fear that disclosure of abuse can and does lead to the removal of services for health issues, based on an assumption that helping them escape the abusive situation means that the presenting indicators will disappear. It is important that a holistic approach is taken so that the experience of abuse is seen as an additional need, not a need that replaces another. Survivors report a fear that they may be forced to choose between getting medical help or disclosing the abuse.¹³

Client does not disclose abuse

There will be cases where an indicator of violence against women, domestic abuse and sexual violence is observed and a client does not disclose abuse. In such cases it is important to consider the following:

“Ask and Act” is not an interrogation

A practitioner may still be concerned for the client but challenging them on their answer is unlikely to improve their engagement. A client should always have choice about what they choose to disclose and they may not be ready to share information.

Do not dismiss your professional judgement

There will be cases where a client does not disclose but where a practitioner remains concerned for their safety and wellbeing. A practitioner’s intuition can be one of their greatest skills and as such should not be dismissed. A practitioner should consider what their concerns are and what evidence they have for their concern. This should be further raised with a manager to consider whether the concern would satisfy legal criteria to share information and what actions can be taken to safeguard the client.

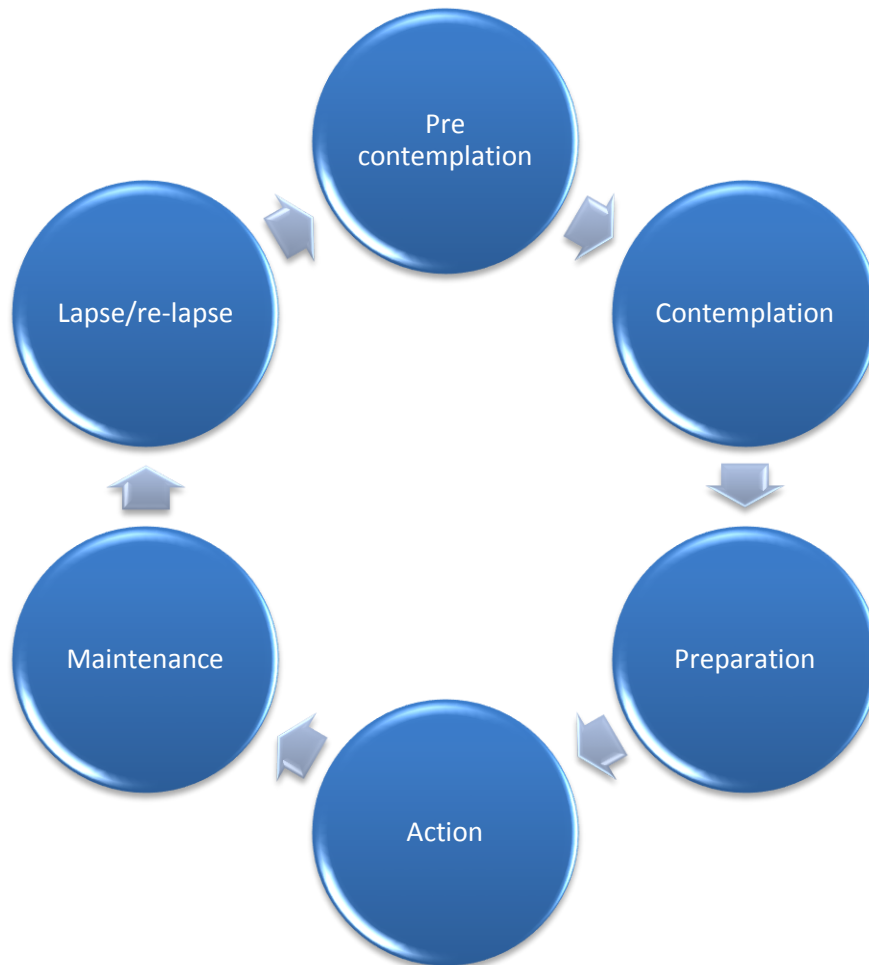
Indicators of violence against women, domestic abuse and sexual violence are also indicators of other risks and concerning behaviour.

It is important to remember the experience of the client may not relate to violence against women, domestic abuse and sexual violence, but could be a sign of other risks. A follow up question as to whether there is anything else the client would like to share could be effective. A directory of relevant local services linked to other complex needs such as substance misuse, mental health or self harm will assist you to make appropriate referrals.

All organisations should have basic awareness raising materials for local services which can be handed to clients (if safe to do so) should they wish to use them in the future.

Above all, it is crucial “Ask and Act” is not considered a single intervention. Those who experience violence against women, domestic abuse and sexual violence are often described as moving through **Stages of Change** in their view of their situation.¹⁴ The stages determine how able and ready a client feels to make a change in their life, in relation to violence against women, domestic abuse and sexual violence. This may mean their readiness to recognise their situation, to disclose information or to take action to escape the abuse they are experiencing.

The stages of change



Examples of Stages of Change in relation to the experience of violence against women, domestic abuse and sexual violence involve the following:

Pre contemplation: A client not recognising their experience as abuse or not recognising why services have concerns.

Contemplation: A client recognising an issue in their relationship, having some concerns but not necessarily wishing to do anything about it or not knowing what to do.

Preparation: A client recognising abuse, wanting things to change and considering what could make the difference: this may involve reading leaflets, thinking about options to leave or identifying help.

Action: A client makes a change. This may involve calling a helpline or calling the police for the first time.

Maintenance: A client has made a change, for example leaving an abusive partner and is maintaining the change by refraining from contact and reporting ongoing incidents.

Lapse/relapse: A client has previously made a change and maintained it for a period of time. However they have now either reverted slightly back to their previous situation, for example by answering phone calls from an abuser or completely reverted to previous behaviour, for example by returning to the family home to restart a relationship with the abuser. Lapse and relapse are important parts of a client's experience. They are also completely normal and relate to the complexity and insidiousness of the abuse. A victim must never be blamed for the choices they make at this stage of change.

This particular model of work has been interpreted in different ways since its creation. Some proponents now present the stages of change in a spiral to reflect their clients' journeys more appropriately. More recent research also suggests that the Stages of Change Model may not be the most accurate way to represent motivation for change.¹⁵ For example, readiness for treatment may be better described as a continuum that people move across quite fluidly rather than a series of distinct stages.¹⁶ Also, this model tells practitioners very little about why someone may or may not be ready for change and is therefore not very responsive to individual needs. It is, however, still useful as a reminder that your clients will be at their own stage of a very personal journey.

It is important for the relevant authority to offer services and apply targeted enquiry at **every relevant opportunity**. In doing so, opportunity is increased to offer services at the point in time when they are most likely to be accepted or to ask questions when the client is ready to answer them. Whilst a client who is pre-contemplative may not disclose abuse, one who is in contemplation or preparation may be receptive to the question and in asking it, a practitioner can offer a raft of services which can further stabilise the change the client wishes to make and improve their safety. This model, should, of course, be considered alongside a client's individual needs.



Risk Identification

Risk identification is generally a process best undertaken by a specialist in violence against women, domestic abuse and sexual violence. An organisational approach which refers clients to specialist services for risk identification is an acceptable method of providing this service to the client. However this section describes the purpose and a potential process for risk identification for those organisations who wish to incorporate it into their own practices.

The aims of “Ask and Act” include identification of violence against women, domestic abuse and sexual violence. This consists of a wide variety of behaviours, perpetrated by partners, ex partners and family members or strangers and acquaintances including:

- Domestic abuse
- Sexual violence (within and not within relationships)
- Female Genital Mutilation (FGM)
- Forced marriage
- “Honour” based abuse
- Stalking and harassment (within and not within relationships)
- Sexual exploitation

For a number of these experiences a process of risk identification has been established. Risk identification work can relate to both the risk posed by the perpetrator and the risk faced by the victim. In this guidance we focus specifically on the risk faced by the victim as risk identification and assessment of perpetrators is a specialist activity. The tools and processes identified here are not appropriate for use with perpetrators.

In this context, “risk identification” does not mean **identifying who is most likely at risk of experiencing these issues; it is to be used when it is known someone is experiencing these issues**. The risk being assessed relates to particular types of behaviour which are linked to serious harm and death and the escalation of abuse.

There are a number of risk identification tools in existence internationally which apply to a combination of domestic abuse, sexual abuse (within relationships), forced marriage, honour based abuse and stalking and harassment. They are not linked to the specific experience of Female Genital Mutilation, sexual violence committed by a stranger or acquaintance, or other forms of gender based violence and should not be used in such cases.

Other risk identification/assessment tools are available for other forms of violence against women and sexual violence but as these are either not made available to a broad audience (i.e. are for specialist use) or are currently under review they are not further discussed in this guidance. However further information on sexual violence

tools can be found here. Further information on a tool to better identify risk of Child Sexual Exploitation tool is available here.

Risk identification is not a compulsory part of the “Ask and Act” process. However, it might be a step that organisations choose to include if they believe it would work well for their client group. The Welsh Government training on “Ask and Act” will cover risk identification as a concept but will not offer formal training on the use of any tool. Information on a potential tool is provided below.

Addressing immediate danger

Even if a formal process of risk identification is not taken forward organisationally, it will still be necessary for every practitioner who practices “Ask and Act” to consider whether the person who has made a disclosure to them is in immediate danger and what needs to happen to offer them protection.

In order to understand whether the client is in immediate danger you may wish to consider the following questions:

- Where is the perpetrator now?
- Is it safe for you to return home?
- Are you worried about returning home?
- Are you worried about what will happen when you leave here today?
- Are you injured?
- Where are your children; are they injured?

If a client is in immediate danger you should phone 999.

Case study

A housing officer observed a female tenant being subjected to aggressive behaviour by their partner. The housing officer was also subjected to this aggressive behaviour. The tenant also mentioned that she did not have a key to her property but her partner did, which concerned the housing officer.

The Housing Officer made sensitive enquiries with the tenant about her partner's behaviour, expressing concern about behaviour they had witnessed. The tenant responded to the enquiry by saying that there were no issues and declined offers of support.

The day after the initial enquiry was made, the tenant contacted the housing officer and disclosed that her partner had gone to her place of work, acted aggressively and as a result passers by had contacted the police. The tenant said that she did require support and wanted to end the relationship.

An appointment was made to meet with the tenant and an Independent Domestic Violence Adviser was invited to this meeting. However, the following day the tenant rang to cancel the appointment, suggesting she no longer required support as she and her partner had talked and he had agreed to get help with some of the issues he was dealing with (no details were given on what these issues were).

As the Housing Officer had remaining concerns for the client they discussed details with their Group 3 trained 'champion'. A decision was made that in this case to pursue a civil injunction against the tenant's partner on the grounds of his aggressive and abusive behaviour towards local authority social housing staff – which was later successfully obtained.

Those involved felt confident that this action would have a positive impact on the tenant but did not force her into taking action that she was not yet ready to take.

Risk identification tools

Across Wales, in relation to domestic abuse, sexual abuse (within relationships), forced marriage, honour based abuse and stalking and harassment, one risk identification tool is used by the majority of criminal justice agencies, specialist services and some relevant authorities.

This tool is known as the DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence) Risk Identification Checklist. It is published by the charity Safelives and was developed in partnership with Laura Richards on behalf of the Association of Chief Police Officers and in consultation with CAFCASS, Respect and independent subject experts.¹⁷

Aim of the DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence) Risk Identification Checklist:

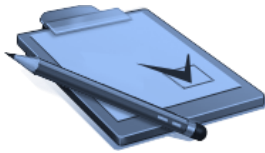
- To help frontline practitioners identify risk in cases of domestic abuse, stalking and 'honour'-based violence.
- To decide which cases should be referred to the Multi Agency Risk Assessment Conference (MARAC) and what other support might be required. A completed form becomes an active record which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

It is this tool that is most likely to be used within your locality.

The DASH Checklist was introduced as a multi agency risk assessment tool in 2009.

The Checklist has been designed **for use by both domestic abuse specialists and practitioners working across the public service**. It is **evidence based**; the risk factors included are drawn from extensive research by leading academics in the field into domestic homicides and 'near misses'. The research base for each factor can be found in the tool's practice guidance, a link to which is provided in the useful links

section of this guidance. The listed indicators can be organised into factors relating to the behaviour and circumstances of the alleged perpetrator(s) and to the circumstances of the victim. Most of the available research evidence, upon which the risk factors are based, is focused on male abusers and female victims in a current or previous intimate relationship. Generally the risk factors refer to the risk of further assault, although some are also linked to the risk of homicide.



In practice

When to use the checklist

- **The Checklist should be used with every client who discloses current domestic abuse, stalking and ‘honour’-based violence to a practitioner.**

The Checklist has been developed on the basis that someone is a victim of ‘current’ abuse where there has been any form of abuse (including psychological, financial, sexual and physical abuse) occurring within the last three months. However this is not an absolute; risk can change and each client’s situation will differ. Therefore it is essential practitioners consider the timescale above alongside each client’s own circumstances.

The checklist includes questions about static and dynamic risk factors:

- The static risk factors are those which will not change. For example, if the perpetrator has *ever* threatened to kill the victim or someone else or has *ever* threatened or attempted suicide.
- The dynamic risk factors are those which relate to the client’s current situation, such as pregnancy, a change in financial status, disability or sexual abuse.

Where the questions on the checklist refer to ‘current’ (e.g. “has the current incident resulted in injury” as outlined above) a timeframe of up to three months should be used to define this term. For this reason, in practice the checklist will not easily apply to historical cases, i.e. if the abuse has ceased and the client is in need of support to recover from a historical trauma.

Who should the checklist be used with?

The checklist is designed for use with adult victims of domestic abuse, stalking and ‘honour’-based violence (those who are over eighteen). A specific, amended form for use with young people is also available and work is currently underway to consider whether an additional tool for older people should be developed.¹⁸

When using the checklist:

The checklist can be used as a useful prompt to help you understand what a client is experiencing and think about what services they would benefit from. However, if you are using the checklist formally (as part of an organisational policy that risk identification forms part of “Ask and Act” or to link in with local formal multi agency fora which use the checklist as a referral tool), consider the following:

- ✓ It is very important to ask **all** of the questions on the checklist to get a comprehensive view of the risks somebody is experiencing. If a question is missed there is a danger something significant could be missed, resulting in an inadequate response to a client.
- ✓ The practitioner should be familiar with the checklist before they use it with their first client to feel confident about the relevance and implications of each question.
- ✓ The practitioner should be sure they have an awareness of the risk management and safety measures they can offer and must be familiar with local and national resources for the client.

Applying the Risk Identification Checklist in practice.



Confidentiality policy of organisation explained
Policy to “Ask and Act” explained
Indicator of abuse identified
Safe space provided
Question asked
Disclosure made

Option 1 – refer for risk identification

Arrange for immediate contact with a specialist service provider for initial risk identification and service options explanation

This can be facilitated in a number of ways, depending on the circumstances of the organisation:

- ✓ Through a co-located service
- ✓ Through effective local referral protocols
- ✓ Through use of the Live Fear Free helpline

Explain service which can be offered through public service

Prior to completing the checklist a professional should establish:

How much time the client has to talk to them.

The safe contact details of the client in case the call is terminated or they have to leave in an emergency.

Whether the perpetrator is around, due back or expected back at a certain time.

If this is a telephone call, whether it is safe for them to talk right now.

And:

Introduce the concept of risk to your client and explain why you are asking these questions.

Option 2: offer risk identification process “in house”

Where possible complete the checklist on your first contact with the client.

Introduce and explain the Risk Identification Checklist

Ask client if questions on the form can be asked

Go through form

Explain results of form

Consider service options with client

Explain service which can be offered by specialist service

Specialist service provision

Professional judgment and escalation

9 ticks or less*

Specialist services

10 ticks or more

IDVA services
Specialist services

14 ticks or more

IDVA and MARAC

*It is up to each individual service to take a decision on thresholds for service provision and for local partnerships to agree threshold for multi agency fora.

The Risk Identification Checklist can be used to set thresholds which can form the basis of how local services are structured and to create the gateway for local multi agency fora. Agreeing appropriate thresholds which meet local need is a matter for local partnerships, however an outline (based on the Safelives recommended threshold) is provided below:

Professional judgment

The practitioner's professional judgment is crucial in all cases; the results from a checklist are not a definitive assessment of risk. The results provide a structure to inform judgment and act as prompts to further questioning, analysis and risk management. The checklist does not demonstrate any scale or weighting of risk.¹⁹

If a practitioner has serious concerns about a victim's situation, they should refer the case to MARAC or to the Independent Domestic Violence Advisor service attached to MARAC. This should be considered as referral protocols are developed.

There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information which might highlight their risk more clearly. This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers particularly in cases of 'honour'-based violence. This judgment would be based on the practitioner's experience and/or the victim's perception of their risk even if visible risk factors and escalation are not observed.

'Visible high risk': the number of 'ticks' on the checklist. If 10 or more 'yes' boxes are ticked, the case should be considered "high risk". However, the majority of local MARACs set their criteria higher than this, at 14 ticks, to provide for a workable, appropriate threshold for this forum.

The 'don't know' option is included on the form where the victim does not know the answer to a specific question. It should be used when ticking 'no' would give a misleadingly low risk level.

Potential escalation: professionals must be alert to any disclosure that there has been an escalation in frequency and/or severity of abuse. This should be considered carefully through discussion with the client but a practitioner should also consider the number of known incidents of abuse experienced by a victim as a result of domestic abuse in the past 12 months. This criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information.

MARACs set their own thresholds in relation to this but many start at three or more incidents taking place in a 12 month period. This will be reviewed depending on local volume and level of police reporting.

Service generated risk

The term “service generated risk” is used in the Caledonian System’s Women’s Services’ Framework for Safety Planning as part of this perpetrator programme in Scotland.²⁰ The term is used to name the scenario in which systems or practice of practitioners creates or increases the perpetrator’s risk to the client, or creates additional obstacles for the client.

By working together and including a step in planning which asks whether the actions intended will increase the perpetrator’s risk or difficulties the client faces, the practitioner (and subsequent multi agency fora) can ensure they are working to mitigate risks as they become clear.

Identifying a service-generated risk is not a reason to step back from action, but a reason to safety plan further in an individual case and to address and alter any structures which regularly generate such risks.

Explaining risk identification to clients and explaining the results of the risk identification work

Explaining risk and confidentiality

A practitioner should remind their client of their organisation’s confidentiality policy prior to completion of the checklist. It may also be useful to provide documentation of this, wherever safe to do so. This will create transparency and clarity for the client about how and when the information they disclose might be used and shared. It can also be useful to explain that completion of the checklist will help them to understand their situation better and make decisions on the most appropriate services to offer them.

Before you begin the checklist it may be useful to also understand:

- ✓ How much time the client has to talk to you.
- ✓ The safe contact details of the client in case they have to leave in an emergency.
- ✓ If it is safe to leave a voice mail message or send a text to the clients phone number.
- ✓ Whether the perpetrator is around, due back or expected back at a certain time.
- ✓ If a telephone call, whether it is safe for them to talk right now.

Explaining the results of risk identification

It is important this is handled in a sensitive and careful manner to ensure the client doesn’t become frightened or overwhelmed at the outcome of the risk assessment or, conversely, feel like their situation is being minimised. It is imperative the client does not feel embarrassed for seeking help or unsupported in dealing with the outcome.

Consider the following principles as you explain the result of the form to the client:

Provide your evidence

It is important you state what your concerns are by using the answers the client gave to you and by explaining your practitioner judgement.

Be clear about the action you will take

It is important you explain what the next steps are to be, i.e. risk management, safety plans, referrals to MARAC and the need to report a child or adult at risk.

Ensure you address the client's immediate safety concerns

In many cases, the victim will need reassurances there are systems in place to ensure family members or the wider community will not be contacted or informed. Such contact may put the victim at greater risk.

Using the tool with different forms of violence against women, domestic abuse and sexual violence

The Risk Identification Checklist is based on the experience of domestic abuse, stalking and harassment and "Honour" based violence in all of its forms. As stated above the evidence base for the form is made up primarily of female victims of male perpetrators; as such practitioners should make additional considerations when using it with clients whose identity or situation is different from the primary evidence base.

The form is not suitable in cases of slavery, sexual violence perpetrated by a stranger or acquaintance or for Female Genital Mutilation. No equivalent risk assessment exists for these forms of abuse. However it will provide use for domestic abuse, sexual violence within family or intimate relationships, "honour" based abuse, and stalking and harassment (within or post relationships).

'Honour' based violence

The questions on the Risk Identification Checklist include the possibility a client is at risk from more than one perpetrator as it is common for multiple perpetrators to be present, especially in cases of 'honour' based abuse. Further, there are direct questions about 'honour' based violence in the guidance for the checklist which will help practitioners to identify these cases.

A practitioner's judgement will be crucial in identifying risks in relation to 'honour'-based violence as many of the questions in the checklist cover wider criminal behaviour which may be absent in these cases. In such cases the score on the checklist is unlikely to meet the actuarial threshold for referral to MARAC despite the situation being gravely serious. In such cases the professional judgement of the person conducting the risk assessment (or supporting this practitioner) should still prompt a referral to MARAC. Please note; **professional judgement should never be used to downgrade a risk assessment, leading to no referral.**

The security issues around information sharing are particularly relevant in cases of 'honour'-based violence.

Stalking

The checklist is designed for use in cases of intimate partner and wider family violence and thus is not appropriate for use in cases where stalking occurs and there has been no previous relationship.

In cases where stalking is identified as part of the domestic abuse, this should be taken very seriously. The checklist guidance also lists additional questions to consider where stalking is identified and specialist services will utilise additional stalking risk assessment tools upon receipt of referral.

LGBT+ victims

Lesbian, Gay and Bisexual individuals accessing services will have to disclose both their experience of violence against women, domestic abuse and sexual violence and their sexual orientation. Some trans people may also need to disclose their transgender status if this is linked to the abuse they are experiencing. Creating a safe and accessible environment where victims feel they can do this and by using gender neutral terms such as partner/ex-partner is essential.

Some questions on the Risk Identification Checklist relate only to the experience of women, for example the question on pregnancy. Male clients should not be asked this question and the client should personalise the completion of the checklist as far as possible to facilitate conversation rather than as a question-answer exercise.

However, the practitioner should also be aware this removes a question (and therefore a score) on the checklist and makes the professional judgment of the practitioner crucial.

Family violence

As risk, identified through use of the Risk Identification Checklist, relates to the risk faced by an adult victim based, in part, on their perception of the risk posed by their abuser, the checklist is suitable for use in cases of adolescent to parent violence where the victim is over 18 (even if the person using the abusive behaviour is under 18). The form should be completed and assessed in the same way as for an intimate partner case.

The local Safeguarding Children Team should be involved where a child is identified as using abusive behaviour.

Young people and children

This form will provide valuable information about the risks children are living with but it is **not** a risk assessment for young people and children. The presence of children increases the wider risks of domestic violence and step-children are at particular risk. If risk towards children is highlighted you should make a safeguarding referral to obtain a full assessment of the children's situation.

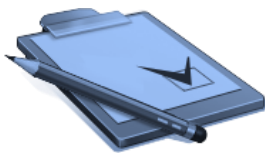
Specific tools are available to understand the risk faced by young people who are the direct victims of abuse within their own relationships or as part of child sexual exploitation. Where a young person is identified as in this situation, their risk should be taken very seriously and specialist services should be alerted immediately.²¹



Consider whether risk requires the sharing of client information

Personal and sensitive information related to the client should only be shared with their consent, subject to practice policy on child protection and adult safeguarding. In exceptional circumstances information may be shared without the client's consent as 'consent' is just one of the methods under the Data Protection Act 1998 by which personal data may be shared. The 1998 Act recognises and allows for situations where data may be legitimately shared where a practitioner does not have the explicit consent of the client.

Where this is the case practitioners who "Ask and Act" must be able to demonstrate defensible decision making which means information shared and actions taken are lawful, necessary and proportionate to protect the safety of the client and, in many cases, their children.



In practice

There are three possible scenarios following the disclosure of the experience of violence against women, domestic abuse and sexual violence:

1. Risk identification indicates immediate or high risk to an adult victim, child or other.
 - The client consents to their information being shared
 - The client does not consent to their information being shared
2. Risk identification does not indicate high risk and the client consents to their information being shared.
3. Risk identification does not indicate high risk and the client does not consent to their information being shared, or consent cannot be obtained for their information being shared.

Each of these scenarios will require different considerations and each decision must be based on the detail of the individual case and data protection legislation.

Case study

A patient attended a clinic for treatment. The doctor had recently completed the “Ask and Act” Group 2 training and identified that the patient was demonstrating some of the indicators of the possible experience of violence against women, domestic abuse or sexual violence. The doctor sensitively asked the patient if she had suffered domestic abuse. The patient disclosed, resulting in the doctor making the appropriate referral to specialist support services with the patient’s consent. The patient was also referred to the local MARAC. A few weeks later, the same patient had a follow up appointment at the clinic and saw the same doctor. The patient thanked the doctor for asking her the question (on domestic abuse) and referring her. She commented that this action had transformed her life, as she now felt safe in her own home which she hadn’t done for a long time.

The doctor admitted that prior to the “Ask and Act” training she would probably not have raised the discussion around domestic abuse. The doctor shared the patient’s feedback with her colleagues emphasising the importance of the “Ask and Act” training and the value of “Ask and Act” in practice.

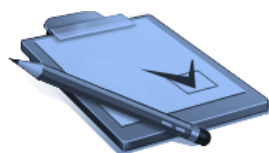


Referral options offered and made

Public and specialist services at a local level should be integrated so as to provide:

- robust identification of those who are experiencing violence against women, domestic abuse and sexual violence;
- clear and efficient referral pathways (within organisations or externally);
- interventions at all stages of a client's experience;
- management and support for those who perpetrate abuse.

These referral pathways should also ensure people who misuse alcohol or drugs or who have mental health problems and are affected by violence against women, domestic abuse and sexual violence are also referred to the relevant public and specialist services.



In practice

The local implementation of “Ask and Act” must be based on a referral protocol which outlines where clients who disclose abuse can be referred for specialist support. This referral protocol must be based on the consent of the victim unless the exceptions related to immediate and high risk of harm are met (as outlined above) and in accordance with data protection legislation.

The local referral pathway will relate to violence against women, domestic abuse and sexual violence as this will be the need identified for referral. However it is good practice to consider the wider needs of the client and ensure these inform referrals. Not doing so may affect the likelihood of the client engaging with the referral agency and lacking trust in the help on offer. It is important to remember that a client may have additional needs, even if they are not immediately obvious or disclosed.

The mandatory reporting duty for FGM

A mandatory reporting duty for FGM was introduced via the Serious Crime Act 2015. The duty requires regulated health and social care practitioners and teachers in England and Wales to report known cases of FGM in under 18-year-olds to the police.

‘Known’ cases are those where either a girl informs the person that an act of FGM – however described – has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out

and the person has no reason to believe that the act was, or was part of, a surgical operation within section 1(2)(a) or (b) of the FGM Act 2003.

The UK Government has published procedural guidance on this duty, giving relevant practitioners and the police an understanding of the new female genital mutilation (FGM) mandatory reporting duty.

The Independent Inquiry into Child Sexual Abuse (IICSA)

The Independent Inquiry into Child Sexual Abuse (IICSA) is currently under way and will investigate whether public bodies and other non-state institutions in England and Wales have taken seriously their responsibility to protect children from sexual abuse, and make meaningful recommendations for change in the future. It may be the case that those who disclose historical sexual abuse will wish to contribute to IICSA as part of the Truth Project.

The Truth Project allows victims and survivors of child sexual abuse to share their experiences with the Inquiry. Those who wish to take part can attend a private session at one of the IICSA offices across England or Wales to share their experience with a member of the Inquiry. Their accounts are not tested, challenged, or contradicted. The information supplied is anonymised and will be considered by the Chair and Panel members when reaching their conclusions and making recommendations for the future. As part of the Truth Project, victims and survivors will be given an opportunity to write a message to be published together with the Inquiry's annual reports.

It is important that a client who wishes to participate in the Truth project considers carefully the potential impact on their own health and wellbeing. A specialist sexual violence service will be able to offer advice.

A directory of the services available across Wales is available at www.gov.wales/livefearfree



Consider safeguarding issues

The experience of forms of violence against women, domestic abuse and sexual violence by or against adults with additional needs for care and support related to, for example, disability, mental health, substance misuse or age can increase the dangers of harm and neglect. Moreover children who live in households where there is domestic abuse are exposed to a significant risk of harm (All Wales Child Protection Procedures). Section 120 of the Adoption and Children Act 2002 expands the definition of harm in section 31 of the Children Act 1989 (care and supervision orders) to include 'impairment suffered from seeing or hearing the ill treatment of another'.

Duty to report a child at risk

Section 130 of the Social Services and Well-being (Wales) Act 2014 introduces a 'duty to report children at risk' and defines a "child at risk" as a child who:

- a) is experiencing or is at risk of abuse, neglect or other kinds of harm; and
- b) has needs for care and support

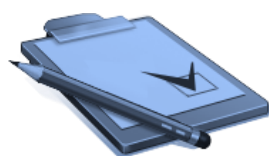
If a relevant partner³ has reasonable cause to suspect that a child, including an unborn child, is at risk the report must be made as soon as possible to the local authority. However, if there are immediate concerns about a child's safety or a criminal offence against a child they should contact the emergency services without delay to protect the child/children from the risk of serious harm.

Section 128 of the Social Services and Well-being (Wales) Act introduces a duty to report adults at risk.

Section 126 of the same Act defines an "adult at risk" as an adult who:-

- a) is experiencing or is at risk of abuse or neglect;
- b) has needs for care and support (whether or not the authority is meeting any of those needs); and
- c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it

Relevant agencies and their staff should understand their statutory duty to inform the local authority where there is reasonable cause to suspect that a child or an adult is at risk.



In practice

Every practitioner with a responsibility to "Ask and Act" should:

- understand their role and responsibilities to safeguard and promote the welfare of children and adults at risk;
- be familiar with and follow their organisation's procedures and protocols for safeguarding and promoting the welfare of children and adults at risk and know who to contact in their organisation to express concerns in relation to this;
- be alert to indicators of abuse and neglect and/or concerning behaviour;

³ As defined in section 130(5) of the Social Services and Wellbeing (Wales) Act (2014)

- understand the principles and practice contained in the guidance under Part 7 of the Social Services and Well-being (Wales) Act 2014 and the National Protection Procedures.
- know when and how to refer any concerns about abuse and neglect to social services or the police;
- know a child, parent, caregiver, relative or member of the public who expresses concerns about a child's or vulnerable adult's welfare to a practitioner and /or agency employee must never be asked to make a self referral to social services or the police. The practitioner and/or agency employee must make the referral.

No matter what your concern for a child (that their own behaviour is worrying or that they are at risk from others), it is important that they are not labelled in any way. Children should be referred to social services efficiently to ensure they have access to a holistic, trauma informed service which addresses their needs.

If any practitioner has knowledge, concerns about a child or suspicions a child is suffering, has suffered or is likely to be at risk of harm, it is their responsibility to ensure the concerns are referred to social services or the police, who have statutory duties and powers to make enquiries and intervene when necessary.

This is not a matter for individual choice²²



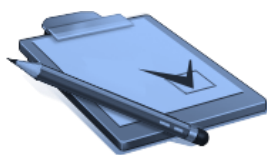
Recording

All practitioners should record the questions they ask the client and the response accurately in relevant case notes or files. Clients have a general right of access to their own personal data under the Data Protection Act 1998 so it's vital that the records are relevant and accurate.

These records should be:

- ✓ contemporaneous; written at the time the question is asked or as soon afterwards as possible to ensure an accurate record of events;
- ✓ concise yet detailed enough for it to be useful to manage and progress the case;
- ✓ legible so others within your team can access them in your absence or in emergencies;
- ✓ accurate - distinguishing between fact and opinion;
- ✓ relevant to your case work.²³

It is particularly important that decisions made following a client's disclosure are recorded, principally where a decision to share their information without their consent is deemed necessary in improving their safety.



In practice

As outlined in the section above there are three possible responses to a question on the experience of violence against women, domestic abuse and sexual violence.

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

The client consents to their information being shared

The client does not consent to their information being shared

Where a client is identified as being at high risk, it is likely a multi agency response will be required to improve their safety and to protect any children. In order to co-ordinate this response it is likely the practitioner will need to share the client's information with relevant partners to initiate a response.

Where children are at risk of harm, individual choice is subordinate to safeguarding the child. If a practitioner has knowledge, concerns or suspicions a child is suffering, has suffered or is likely to be at risk of harm, it is your responsibility to ensure the

concerns are referred to social services or the police. It is good practice to gain parental consent to this referral, but a judgement should be made whether this could increase risk to the child. Additional advice can be provided by named or designated professionals for child safeguarding or Local Authority Emergency Duty Teams.

However where children are not involved, or not considered to be at risk, the decision is more complex. In cases such as these, “information sharing is not mandatory but is permitted”.²⁴ All information sharing must be compliant with data protection legislation and in these cases a practitioner will need to consider carefully what information can be shared lawfully, with whom and for what purpose. In practice, gaining the client’s consent is the simplest and most effective basis on which to share information. However it is important to remember:

“It cannot be ethically justified if we hold information that we know could prevent serious harm to others and yet knowingly decide not to share it.”²⁵

Should a practitioner choose not to share information based on a disclosure they should:

- record the decision, including the reasons it was made.
- consider ways to reduce the risk to the client and their children.
- consider proactive ways to assist the client to access help from other agencies.

Should a practitioner choose to share information without client consent, based on a disclosure they should:

- seek managerial advice.
- record their decision and their reasons for it.
- make decisions/enquiries about the information to disclose, how and to whom.
- discuss with the client, if appropriate and safe.
- note when and whether the client was informed and reasons why, if not.

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

Where a client provides explicit, informed consent to share their information it is important a record of this is kept on file, stating which information is to be shared, with whom and for what purpose.

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

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

- record the assessment of risk and actions on file;
- reassure client of ongoing offer of services;

- mark/flag the client file to ensure a sensitive, heightened response is provided, should the client return to the service for any purpose.

Applying “Ask and Act” to those with additional diverse needs

An organisational process of “Ask and Act” should take account of the diversity of the population it serves and the known research on violence against women, domestic abuse and sexual violence. Acknowledgement of this diversity should be woven into all areas of practice and form part of a response to each client.

Training on “Ask and Act” will include consideration of a multitude of client groups which mirrors the population of Wales and which draws out any specialist needs and responses required.

Partnership between specialist and other public services offers an effective response to minority communities.

Consideration of the diverse needs of a client should not be an “add on” to service provision, nor should assumptions be made as to the experience of any client. Each should be treated individually. However in order to ensure the typical considerations required by practitioners are set out, this chapter summarises some of the barriers to disclosing an experience of abuse. The content is not exhaustive, nor is there any suggestion every client will experience these barriers. It is hoped the observation of them will influence a practitioner’s likelihood to trigger enquiry.

Those at risk of “honour” based abuse²⁶

The terms “Honour” or “izzat” relate to issues of family honour and reputations. A person (in most cases a woman) can be considered to bring shame to their family through behaviour which is judged by their family or community to damage that reputation.

Remaining true to a person’s culture and maintaining family reputation within society is central to “honour” or “izzat”. Maintenance of family honour has been linked to personal shame. Those who are brought up in cultures where “honour” is prioritised can feel trapped in difficult or abusive relationships. Moreover, fear of reflected shame and loss of “izzat” are regarded as key reasons why those who feel responsible to uphold family “honour” do not seek help.

An additional barrier for those who are at risk of “honour” based abuse is fear that practitioners will not keep confidentiality or that records will not be kept securely enough to maintain confidentiality.²⁷

Black, Asian, Minority Ethnic, Refugee individuals²⁸

There is under-reporting of violence against women, domestic abuse and sexual violence by people from Black and Minority Ethnic, Refugee (BAMER) communities in the general population. Some of the additional barriers to reporting faced by them could be:

- language barriers - interpretation;
- immigration status and no recourse to public funds;
- racism (either a perception or fear of a racist response or an actual racist response from a service provider);
- assumptions made by practitioners, based on appearance or skin colour;
- cultural beliefs and practices; fear of rejection by their community; and mistrust of authorities;
- violence in the country of origin - Asylum-seeking and refugee people may have experienced abuse or violence prior to their arrival in the UK.

For those who are asylum seekers; the asylum or substantive interview can be a traumatic experience for those who have experienced violence against women, domestic abuse and sexual violence which is material to their claim, and some may not feel able to disclose information, particularly around sexual violence, due to cultural taboos and a lack of preparation and support.

Older people from ethnic minority communities may be less likely than younger people to speak or understand English, and/or may have been kept from learning about availability of sources of help and support.

Divorce or separation may seem impossible to contemplate for some people from BAMER communities who may be concerned about upholding family “honour”.

Male victims

Male victims of domestic abuse, sexual violence and gender based violence, may be reluctant to disclose their experience due to fear of being ridiculed, not being believed or being treated unfairly by agencies. They may have misguided notions of masculinity which cause additional feelings of shame and embarrassment at experiencing domestic abuse, violence and gender based violence.

Much of the imagery and public information on domestic abuse, sexual violence and gender based violence presents it as a problem of heterosexual relationships with the woman as the victim. Male victims of either male or female abusers may be less likely to identify themselves as experiencing abuse if the imagery used to describe the experience does not include them.

Case study

A male tenant of Local Authority held social housing sent a text to a Community Services Support Worker expressing suicidal thoughts. Subsequent to this text, he attended a meeting at the local authority's social housing office to discuss his situation further. At this meeting the Neighbourhood Housing Manager made further enquiries and the tenant disclosed suffering financial and emotional abuse from his estranged partner.

The manager provided reassurance to the tenant and suggested that it would be useful for him to talk further with a specialist who could also complete a risk assessment with him. The tenant was referred to specialist services and also discussed with the housing team, the possibility of a referral to a specialist male refuge

The Community Services Support Worker further discussed details of the case with their Group 3 'champion' to ensure they had considered all of the clients needs.

As a result of "Ask and Act" a risk assessment was completed and a referral was made to a male refuge.

Staff worked with the police on the tenants behalf and organised assistance to collect belongings. The tenants details were passed to a third sector homelessness organisation, via local authority homelessness department and emergency B&B accommodation was put in place whilst the refuge stay was arranged.

Young people at risk of forced marriage

The age of 16 is a high risk trigger point for forced marriage due to the ending of formal education and the age of consent in the UK. It is not the only age of risk and practitioners should be vigilant towards all young people.

In cases where the concept of "honour" is at stake, there is a significantly increased potential for multiple perpetrators. The client may be frightened of a range of people, including both male and female relatives, as well as others from the wider community or figures of authority, and they may find it extremely difficult to trust anyone. As a result, social isolation becomes one of the biggest problems for young people at risk of forced marriage.

Lesbian, Gay, Bisexual and Trans people

Much of the imagery and public information on violence against women, domestic abuse and sexual violence presents it as a problem of heterosexual relationships; physical violence perpetrated by the bigger, 'stronger' heterosexual man against the smaller, 'weaker' heterosexual woman. LGB people may be less likely to label themselves as experiencing abuse if they are unable to identify with the characteristics this "public story" presents.²⁹

Trans people can of course be in heterosexual relationships just in the same way they might be in same-sex relationships so practitioners should not conflate sexuality

with gender identity. A trans woman, for example, may well identify with the ‘public story’ if she experiences abuse from a male partner.

Assumptions that women are not violent, or violence taking place between two women or two men is less serious than in heterosexual relationships or is likely to be mutual abuse can result in practitioners misunderstanding or minimising the risk experienced by LGB and T victims.

Research into the experience of abuse for LGB and T people describes a “gap of trust” between those in same-sex relationships and public services. This is typically based on a fear these agencies may be homophobic or transphobic, will not be sympathetic or will not understand the experiences of the client.³⁰ For some clients, this will arise from previous experience of real or perceived trans or homophobia from service providers. Moreover, some services may appear heterosexist (i.e. they assume all clients are heterosexual) and, as such, inadvertently exclude LGB and T individuals.

In order to disclose the experience of abuse an LGB or T person may ‘out’ themselves to services. This can also lead to concerns around confidentiality if the client is not ‘out’ in every part of their life (e.g. to colleagues or family). This may be information they are not yet prepared to share, or they may fear repercussions if the ‘wrong’ people hear about their sexuality or gender identity.³¹

Although 80% of respondents to the Scottish Survey of Transgender People’s Experiences of Domestic Abuse identified having experienced some form of abusive behaviour from a partner or ex-partner, only 60% of respondents recognised the behaviour as domestic abuse.³²

Trans people commonly describe their gender identity being used as part of their experience of violence against women, domestic abuse and sexual violence. The type of abuse most frequently experienced by trans people is transphobic emotional abuse, with 73% of the respondents experiencing at least one type of transphobic emotionally abusive behaviour from a partner or ex-partner.³³

Older people³⁴

It is important that practitioners are particularly alert to potential abuse from wider family members to older people.

Older people may find it particularly difficult to disclose given a traditional notion people should hide their problems, particularly if they involve family members.³⁵ Some older people will be experiencing abuse by their children for example. This dynamic may make it harder to speak out and ask for help.

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

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

A “public story” of violence against women, domestic abuse and sexual violence is also applicable to older people; images portrayed in the media frequently feature younger people and may convey the impression violence against women, domestic abuse and sexual violence is not expected to affect those in later life.

Young people

Younger women (aged 16-24 years or under) are most likely to experience physical abuse from an intimate partner.³⁶

A person is most likely to experience domestic abuse in their first relationship and the majority of these will occur during teenage years. There is also a high level of normalisation of abuse, violence and controlling behaviour amongst young people. A young client may not recognise the abuse and may minimise the harm they are experiencing.

There can also be overlaps between gang involvement and sexual exploitation and these disproportionately affect young people. These experiences may broaden the number of potential perpetrators and have links to organised crime. As such young people may fear speaking out due to the experience of facing multiple threats.

Young people are more likely than others to be using social media. Social networking sites provide those using abuse with additional opportunities for control and online tracking. Young people’s use of new technologies makes young victims more vulnerable to being controlled, e.g. through threats to circulate humiliating visual images. This may prove a further barrier to disclosure.

Disabled people

Disabled people are more likely to be physically vulnerable than non-disabled people and may need more support to remove themselves from an abusive situation.

Disabled women are twice as likely to experience domestic abuse as non-disabled women.³⁷ They are also likely to experience abuse over a longer period of time and to suffer more severe injuries as a result of the violence.

Threats to withhold care or remove mobility or sensory devices required for independence limit disabled people’s ability to disclose, further compounding the social isolation of some disabled people.

It is important to note that many disabilities are not visible.

People with learning disabilities

Very little research is available in relation to this client group. However the small scale studies completed to date describe the experience of domestic abuse

(specifically) of women involving multiple forms of abuse, much of which is severe. It describes unique grooming or “softening up” behaviour used by perpetrators against this client group as part of the development of abuse.

Those with learning disabilities may have additional fears and barriers for disclosure associated with fear of being institutionalised or losing their children.³⁸

Ask and Act – the involvement of perpetrators

“Ask and Act” is aimed at identifying the experience of being abused and is therefore highly victim focussed. However, many perpetrators will also often have their own experiences of abuse and, as such, will make disclosures as a result of “Ask and Act”, or use any pertinent questions as opportunities to raise concerns about their own behaviour. In order to prepare you for these instances this section of the guidance outlines some practical considerations to make. It is also important to note that your “Ask and Act” group 3 champions will have received specific training on these issues and should be sought out for support.

Direct work with perpetrators of forms of violence against women, domestic abuse and sexual violence is a specialist area of practice, underpinned by risk assessment and best offered via a tailored, individualised approach. However you are likely to encounter those who use abuse in your everyday roles and it is important you are able to practice in the safest way possible and are able to provide opportunities for perpetrators who wish to address their behaviour.

There is a significant body of research available on work with perpetrators across multiple offending domains – including sexual offending. This guidance will focus on the perpetration of domestic abuse (including some focus on forced marriage, “honour” based violence and stalking and harassment) as this is likely to be the most commonly encountered issue.

Working with perpetrators

There is growing recognition that, in tackling domestic abuse, both victims and perpetrators must be engaged and offered effective services to affect both the symptoms, impacts and cause of the issue. It is also clear that relevant authorities have a crucial role to play in relation to engagement of perpetrators of domestic abuse, risk assessment and mitigation and referral work.

The relevant authority role is crucial because:

These services are already working with perpetrators of domestic abuse.

- Most perpetrators of domestic abuse are not involved with the Criminal Justice System. Even where they have been convicted and imprisoned they are likely, at some point, to return to live in their community. They will often live with their family and they will use public services.

Domestic abuse is a child protection issue

- Most perpetrators have ongoing contact with their children, even if the relationship between the parents has ended. Domestic abuse is linked to direct child abuse and poses a significant risk when considering contact arrangements.³⁹

Support for perpetrators of domestic abuse is often requested by their partners

- Whilst expectations of perpetrator programmes can be unrealistic, where a couple intend to stay together, it is often something that those who have experienced abuse want to try before they will consider taking any other action. Perpetrators of domestic abuse often make promises to change and their partners will believe, or want to believe, that this is possible.

It is also important to note that staying with a perpetrator of domestic abuse may be the safest decision, for those who are experiencing it, to make. In other cases there may not seem that there is a choice for those who have been abused. Many victims stay with the perpetrator due to fear, access to housing, financial dependence, social status and maintaining a relationship for the economic or perceived wellbeing of children.

Most perpetrators will move onto other relationships, potentially creating new victims

- The perpetrator of domestic abuse is always the source and cause of the abuse. They will not change their behaviour because they are in a new relationship and are likely to go on using abusive behaviour, impacting on the physical and mental health of the people they abuse and their families and therefore cause further impact to the Welsh public service.

It is therefore important that relevant authorities are aware of their own role in relation to working with perpetrators of domestic abuse. Whilst detailed and intense work with perpetrators of domestic abuse is a specialist area of practice, there are small things that relevant authorities can do as part of their own roles.

Practice considerations to be made when working with perpetrators of domestic abuse

Many relevant authorities work with families. Where domestic abuse is disclosed or suspected, the focus on the family must continue. However those practitioners working with families where domestic abuse is an issue must be aware of the risks and practice issues associated with such work and ensure action, scrutiny and practice is in place to mitigate such risk.

The following section outlines some of the core practice considerations to be made when working with perpetrators of domestic abuse or with families where domestic abuse is a known or suspected issue.

Capacity and separate working

Where a relevant authority is working with a whole family it is important that in relation to domestic abuse, victims and perpetrators are worked with separately.

In such cases the work with both those who have been abused and perpetrators to reduce harm will need to be given sufficient priority within practitioners' caseloads. In many cases it will require the appointment of a second practitioner to work with the family to ensure the needs of both adults are recognised and the risk of collusion is mitigated. Both practitioners will need to liaise closely to maintain practitioner objectivity and safeguard any children or vulnerable adults.

In any interaction where both partners are present, staff will need to be very careful to avoid increasing the risk to the victim, disclosing information that has been shared in confidence or assuming that the partners are on an equal footing in relation to family decision making and routine.

Where those who have been abused also use the organisation's services and the relationship remains ongoing, any organised contact sessions should be conducted separately.

Where those who have been abused also use the organisation's services and the relationship has terminated, appointments should be arranged so as to minimise the risk of contact between them and the perpetrator.

Safeguarding processes and domestic abuse

Capacity and separate working is likely to arise as an operational issue when Child Protection Conference or safeguarding strategy meetings (for both adults and children) are held.

The meeting Chair, in consultation with relevant practitioners, should assess the risks carefully in relation to the participation of the perpetrator.

This risk assessment should consider not only issues of safety at the meeting itself but any travel arrangements before and after, as well as the contents and addresses (including schools) on the minutes of the meeting which may pose a risk if disclosed.

The same careful approach to disclosure of information (as described earlier in this guidance) should be adopted with the records of all meetings, i.e. Core Group, Planning meetings etc.

Relevant authority managers with safeguarding responsibility for children will need to be made aware of information pertinent to their role. They should be responsible for disseminating this information to frontline staff and overseeing the implementation of any required risk management activity.

Even where practitioners only work with children and have limited contact with adults, they should be made aware when there is a risk that a perpetrator will remove that child from the service (for example; a school) in contravention of either a Child Protection Agreement or Criminal Justice related restrictions.

Practitioner safety

Perpetrators of domestic abuse can pose a risk to those outside of their family and this can include the practitioners they work with. Care must be taken to assess any potential risks to practitioners who are involved in providing services to a family where domestic abuse is an issue. This includes support services offered to a victim or child.

Home visits

Thorough risk assessment should be completed prior to a home visit where domestic abuse is an issue.

Where a risk assessment does not raise any concerns it should generally be the case that home visits are not completed by a lone practitioner and that, where necessary, the assistance of the police or other partners is sourced. Practitioners should speak with their manager and refer to their own agency's guidance for staff safety.

Collusion

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

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

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

It is also important that practitioners are mindful of the importance of working with victim complexity. Those who have experienced domestic abuse are not always easy to engage, compliant or passive. Practitioners should not infer a reduction in risk on this basis. In fact where both partners have a propensity to violence the risk to both adults and to children is increased.

Information sharing

Working with perpetrators of domestic abuse may lead to the disclosure of information which indicates a risk to another adult or child. In such cases it is important that this information is treated and shared in a manner that is appropriate and lawful. Staff should consult their organisational information sharing protocol and their safeguarding procedures in such cases.

Managing dual or counter allegations

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

It is important that all allegations of domestic abuse are taken seriously and offered an effective response. There will be cases where violence and abusive conduct has been or is used by both partners and this merits exploration by practitioners. It does not mean that either party should lose out on relevant services.

In such cases it is useful to engage services for both parties. In most cases specialist services will do initial work with both parties separately to understand their needs. In the case of counter allegations this may include some assessment of underlying controlling behaviour to help understand better the dynamics of the relationship. This is a specialist piece of work and should only be undertaken by a specialist organisation.

It is important to note that making false allegations is a form of abuse and where this is found to be the case it may be evidence of ongoing violence.

Referral options

Work in relation to engaging perpetrators of domestic abuse is still an area of development. The better established models of work are discussed later in this guidance but, in general, there is limited provision available across Wales and many projects are in their infancy in terms of evidence and availability.

Community based perpetrator programmes

A small but well developed approach to intervention with perpetrators within the community (outside of the criminal justice system) is in place, offering Domestic Violence Perpetrator Programmes (DVPPs) to those who seek help to address their own behaviour.

These programmes offer a potential referral pathway to the relevant authorities to offer support and address the behaviour of clients who are using abuse and violence.

Domestic Violence Perpetrator Programmes (DVPPs) are community based, group work programmes which work directly with perpetrators of domestic abuse with the aim of changing their behaviour and stopping further abuse and violence. They can vary in length, size, number of clients, model of work and organisational setting.

DVPPs will often also offer safety and support services to partners and, in some cases, children. Many take an advisory role to the family courts, children services, CAFCASS and child protection conferences. It will be important, in many cases, for DVPPs to link with substance misuse and mental health services; to address the triad of difficulties that may need to be addressed.

Domestic Violence Perpetrator Programmes do not aim to keep families together, or to split families up. They aim to work effectively with perpetrators in order to keep their partners and children safe. The best outcome of a perpetrator's attendance at a DVPP is that all violence and abuse stops and there is no longer a risk to their partner, ex-partner, future partners or children.⁴⁰

Establishing and managing expectations for DVPPs.

Whilst all relevant authorities should give due consideration to the role community based DVPPs can play as part of wider service provision it is important that, in doing so, they use the programmes appropriately and understand the impact and realistic outcomes associated with them.

Perpetrator attendance on DVPPs may offer hope to their partners that they will change. This hope can be shared by organisations. Whilst DVPPs can be effective, they will not work with all perpetrators of domestic abuse and may not change all elements of abusive behaviour. For example, sexual violence may end but other controlling behaviour could remain. It is important that victims are supported to have realistic expectations and that practitioners maintain a healthy scepticism about the impacts of these programmes to ensure they remain focussed on the risks involved for a family.

Some survivor led organisations raise concerns that attendance at a perpetrator programme can provide perpetrators with additional opportunities to manipulate and control their partners. These forms of manipulation can include lying about attendance, using the material of the programme to criticise and control the victim's behaviour, using jargon and concepts learnt on the programme to manipulate the victim and using attendance on the programme as a way to influence other practitioners' decisions such as Social Workers, CAFCASS officers, Courts.⁴¹

Criminal Justice options

It will not be possible for a relevant authority to recommend or refer to any particular sentencing option, should a perpetrator of domestic abuse be prosecuted for relevant offences.

However a number of criminal justice initiatives now exist which do offer opportunity for involvement by the relevant authorities and, as such, it is useful if practitioners have an awareness of these.

Domestic Violence Protection Orders

Domestic Violence Protection Orders (DVPOs) were implemented across England and Wales in March 2014.

DVPOs enable the police and magistrates to take immediate action in the aftermath of an incident of domestic abuse. They are applicable even where there is not enough evidence to charge immediately and bail conditions are not an option. DVPOs should provide a far more efficient option than a civil law injunction.

A DVPO prevents, with immediate effect, a perpetrator from returning to a residence and from having contact with the victim for up to 28 days, allowing the victim time to consider their options and get the support they need.

The process

Following an incident of domestic abuse the police may issue a Domestic Violence Protection Notice (DVPN) to the alleged offender. This will place certain conditions on them such as stopping them from entering, and being within a certain distance, of the victim's home.

Within 48 hours the police will apply for a DVPO through the Magistrates' Court. At court, evidence will be heard and the alleged perpetrator will be allowed the opportunity to provide their own evidence. The Court will decide on this evidence whether to make a DVPO. If an order is made it will last for a minimum of 14 days and a maximum of 28 days.

The Magistrates may make a DVPO even if the victim of abuse does not agree to it. In addition, they will take into account the welfare of anyone under 18 who the police consider will be affected by the DVPO.

The Domestic Violence Disclosure Scheme ('Clare's Law')

The Domestic Violence Disclosure Scheme (DVDS) (also known as 'Clare's Law') also commenced in England and Wales in March 2014.

The DVDS gives members of the public a formal mechanism to make enquires about an individual who they are in a relationship with, or who is in a relationship with someone they know, where there is a concern that the individual may be violent towards their partner.

Right to ask

Members of the public can make an application for a disclosure, known as the 'right to ask'. Anybody can make an enquiry, but information will only be given to someone at risk or a practitioner in a position to safeguard the victim (this could well include some staff within relevant authorities). The scheme is for anyone in an intimate relationship regardless of gender. Partner agencies can also request disclosure is made of an offender's past history where it is believed someone is at risk of harm.

Right to know

If a potentially violent individual is identified as having convictions for violent offences, or information is held about their behaviour which reasonably leads the police and other agencies to believe they pose a risk of harm to their partner, the police will consider disclosing the information. A disclosure can be made if it is legal, proportionate and necessary to do so.

Statutory perpetrator programmes

Community Rehabilitation Companies deliver specific domestic abuse focussed programmes to perpetrators who are convicted of relevant offences.

The primary programme delivered across probation services in Wales is Building Better Relationships (BBR). This programme aims to reduce re-offending and promote the safety of current and future partners and children whilst working collaboratively with other agencies to manage risk.

The course consists of two preliminary sessions, four group work modules consisting of six sessions each and four individual sessions at the end of the course. The course is aimed at men with a current conviction related to Intimate Partner Violence (IPV) who have been assessed as presenting a moderate risk of further violence or greater using the Spousal Assault Risk Assessment (SARA). There is also scope to refer men with no current IPV related conviction but there needs to have been evidence of at least one episode of non-convicted IPV within the 24 months leading up to the current conviction and an assessment of high risk of further violence using the SARA.

The ethos behind the programme views domestic abuse as the outcome of a complex interaction of a range of risk and protective factors. It utilises a traffic light system known as stop, prepare and go. The 'stop' phase involves participants

reflecting on their relationship aggression and developing insight and understanding into their behaviour patterns. The 'prepare' phase involves the acquisition and rehearsal of skills which will bring about change. And finally, the 'go' phase involves the application of the skills in the real world.

For those offenders not suitable for BBR, a 10 session, one to one course entitled Respectful Relationships is also delivered by probation staff in Wales. Whereas BBR is an accredited programme (i.e. it has received significant scrutiny in terms of the theoretical basis and evaluation), Respectful Relationships was developed locally and is a collection of resources available for use by probation staff.

Services which may not be appropriate referral options for work with perpetrators.

There are several initiatives which are occasionally mistakenly offered to perpetrators of domestic abuse due to a lack of understanding of the dynamics and causes of abusive behaviour.

Couples work, mediation and anger management practices are not normally appropriate responses to address the behaviour of perpetrators.

Couples work/mediation

As domestic abuse often involves the misuse of power and control from one partner to another it is often not possible for both parties in an abusive relationship to represent themselves appropriately in joint sessions. Couples work can increase the risk posed to a victim if they are required to discuss the abuse whilst the perpetrator is present.

For any counselling to be successful the parties taking part need to be able to be open and honest about their situation. In domestic abuse cases many victims will not feel safe to disclose the abuse as they will be in fear of repercussions.

Anger management

Coercive control, which characterises many survivors' experiences of domestic abuse, is not about anger but the use of power and control. Anger management programmes are not appropriate in dealing with these cases as they do not address the fundamental causes of such violence and abuse; focus on the safety of the victim; or hold the perpetrator to account.

Definitions

Abuse: Physical, sexual, psychological, emotional or financial abuse.

Accreditation: For the purposes of this guidance the term “accreditation” describes authority or sanction to a training course provided by an official body when recognised standards have been met.

“Ask and Act”: A process of targeted enquiry across the Welsh public service in relation to violence against women, domestic abuse and sexual violence and a process of routine enquiry within maternal and midwifery services, mental health and child maltreatment settings.

Child sexual exploitation: The coercion or manipulation of children and young people into taking part in sexual activities. It is a form of sexual abuse involving an exchange of some form of payment which can include money, mobile phones and other items, drugs, alcohol, a place to stay, ‘protection’ or affection. The vulnerability of the young person and grooming process employed by perpetrators renders them powerless to recognise the exploitative nature of relationships and unable to give informed consent.

Client: Client is used here as a term to describe a person experiencing violence against women, domestic abuse and sexual violence. The term encompasses the terms “victim”, “survivor”, “service user” and “patient”. Different partners use different words to define their relationship to the person at risk and so the guidance reflects this.

In practical terms it is suggested a person experiencing violence against women, domestic abuse and sexual violence selects the term they prefer, where a term is required. It should generally be possible to use a client’s name rather than other descriptive terms.

Domestic abuse: Abuse where the victim of it is or has been associated with the abuser.

A person is associated with another person for the purpose of the definition of “domestic abuse” if they fall within the definition in section 21(2) or (3) of the Violence against women, domestic abuse and sexual violence (Wales) Act.

Female Genital Mutilation: An act that is an offence under sections 1, 2 or 3 of the Female Genital Mutilation Act 2003 (c. 31).

“Gender-based Violence”

- (a) violence, threats of violence or harassment arising directly or indirectly from values, beliefs or customs relating to gender or sexual orientation;
- (b) female genital mutilation;
- (c) forcing a person (whether by physical force or coercion by threats or other psychological means) to enter into a religious or civil ceremony of marriage (whether or not legally binding);

Harassment: A course of conduct by a person which he or she knows or ought to know amounts to harassment of the other; and for the purpose of this definition:
(a) a person ought to know that his or her conduct amounts to or involves harassment if a reasonable person in possession of the same information would think the course of conduct amounted to or involved harassment of another person, and

(b) “conduct” includes speech;

Independent Domestic Violence Adviser: Trained specialist worker who provides short to medium-term casework support for high risk victims of domestic abuse.

Independent Sexual Violence Adviser: Trained specialist worker who provides short to medium-term casework support for victims of sexual abuse

Local Authority: A county or county borough council.

Practitioner: a professional employed to work directly with a client group; a proportion of whom are likely to be experiencing a form of violence against women, domestic abuse or sexual violence, whose role and relationship to the client provides an opportunity to “Ask and Act”.

Public service: Public services are services delivered for the benefit of the public. This can include services delivered through the third sector, through social enterprise or through services that are contracted out.

In the context of the National Training Framework (of which “Ask and Act” is an element) the public service is defined based on an estimate of ‘devolved public sector workers’ in Wales – this includes the devolved civil service, local authorities, health, education authorities and WGSBs. Although not devolved, Police Authorities are included as they are partly funded by WG. ‘Devolved public sector workers’ excludes non-devolved civil servants (such as those working for HMRC and the DVLA), military personnel and people employed by Public Corporations (such as S4C and Cardiff Bus etc) in Wales.

Region: Local authorities are expected to work with neighbouring local authorities and across Local Health Board areas for the purposes of dissemination of the VAWDASV Services Grant (from March 2018). Local authorities will have the autonomy to align as they see best for this purpose. For the purposes of this guidance the partnership with other Local Authorities and Local Health Boards is referred to as a region. The Train the Trainer course which supports “Ask and Act” will be delivered within this region.

Relevant authorities: county and county borough councils, Local Health Boards, fire and rescue authorities and NHS trusts.

Sexual exploitation: Something that is done to or in respect of a person which
(a) involves the commission of an offence under Part 1 of the Sexual Offences Act 2003 (c. 42), as it has an effect in England and Wales, or
(b) would involve the commission of such an offence if it were done in England and Wales.

Sexual Violence: Sexual exploitation, sexual harassment, or threats of violence of a sexual nature.

The Act: The Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015.

Violence against women: The experience of gender based violence by women.

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- ¹⁸ www.caada.org.uk

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- ¹⁹ This is captured in a separate tool (known as the severity of abuse grid) which is used by specialist practitioners to assess the severity of the abuse.
- ²⁰ <http://www.scotland.gov.uk/Resource/Doc/1032/0099922.pdf>.
- ²¹ http://www.caada.org.uk/Young_People/YP_RIC.htm
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