NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

PUBLIC HEALTH DRAFT GUIDANCE

Domestic violence and abuse: how social care, health services and those they work with can identify, prevent and reduce domestic violence and abuse

Introduction: scope and purpose of this draft guidance

What is this guidance about?

This guidance aims to help identify, prevent and reduce domestic violence and abuse. The recommendations cover:

- commissioning
- service delivery
- information sharing
- enquiring about domestic violence and abuse
- equality and diversity
- working with children and young people
- advocacy
- mental health
- perpetrator programmes
- training.

The term 'domestic violence and abuse' is used to mean: any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or are family members. This includes: psychological, physical, sexual, financial and emotional abuse. It also includes 'honour'-based violence and forced marriage.

The majority of this violence and abuse is perpetrated by men on women and girls, although men can also experience domestic violence and abuse, and it can occur in same-sex relationships.

Children and young people can experience domestic violence and abuse:

- When they are exposed to it within their families. This includes fearing, hearing or seeing it, worrying about its effects on someone else or direct involvement.
- Within their own intimate relationships.

Young people may also perpetrate domestic violence and abuse in their own intimate relationships.

See About this guidance for details of how the guidance was developed and its current status.

Who is this guidance for?

The guidance is for:

- Local authority and other commissioners, including clinical commissioning groups.
- Local strategic partnerships and health and wellbeing boards.
- GPs, specialist domestic violence and abuse staff and those working in the health, social care, voluntary, community and private sectors who may come into contact with people who experience or perpetrate domestic violence and abuse.

The guidance may also be of interest to people affected by domestic violence and abuse, including those who perpetrate it, their families and other members of the public.

Contents

1 Draft recommendations

The Programme Development Group (PDG) considers that the recommended measures or interventions are cost effective.

The evidence statements underpinning the recommendations are listed in The evidence.

See also Preventing and reducing domestic violence for the evidence reviews and economic modelling report.

For the research recommendations see Recommendations for research.

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

Introduction

Domestic violence and abuse are complex issues that need sensitive handling by a range of health and social care professionals.

Men are more likely than women to perpetrate this type of violence and abuse (particularly sexual and more severe violence). Given the lack of evidence on men who experience domestic violence and abuse, most of the recommendations are primarily for women. However, men who experience domestic violence or abuse also need support.

The recommendations advise making services available for everyone affected, but providing additional support to those who most need it. It is important to note that initial and ongoing training and organisational support is needed to maximise the effectiveness of all the recommendations.

Whose health will benefit?

Some recommendations highlight groups who are particularly at risk. However, most of the recommendations will benefit all adults and young people who may experience domestic violence and abuse and all children who are exposed to it.

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

Recommendation 1 Commissioning: planning services

Who should take action?

- Local, regional and national commissioners of domestic violence and abuse and related services.
- Strategic partnerships, for example health and wellbeing boards, local domestic violence partnerships.

What action should they take?

- Local commissioners should use a comprehensive mapping exercise to identify all local services that deal with domestic violence and abuse. (For example, housing, the police, health, criminal justice, education, safeguarding, social care and other specialist services.) Services should be mapped against the Home Office's Coordinated Community Response Model and any gaps identified.
- Local commissioners should use the results of the mapping exercise to inform commissioning. They should develop referral pathways that aim to meet the health and social care needs of all those affected by domestic violence and abuse.
- Regional and national commissioners should work with local commissioners to ensure service support extends across local authority boundaries, where appropriate (for example, within prison services).

- Strategic partnerships should use the results of mapping in the joint strategic needs assessment (JSNA) and other strategic planning tools. They should also make the results widely available to all relevant services and the general public. For example, they could produce a directory of services.

Recommendation 2 Participate in a local partnership to prevent domestic violence and abuse

Who should take action?

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

What action should they take?

- Ensure senior officers from the following services participate in a local partnership to prevent domestic violence and abuse, along with front line practitioners and service users or their representatives:
    - health services and the local authority (including the chairs of local safeguarding boards for adults and children
    - housing
    - police and crime commissioners
    - criminal justice agencies
    - the Children and Family Court Advisory and Support Service (CAFCASS)
    - voluntary, community and independent sector organisations.
- Regularly review membership of the partnership to ensure it is relevant and inclusive.

Recommendation 3 Commissioning: develop an integrated strategy

Who should take action?

Local strategic partnership on domestic violence and abuse.

What action should they take?

- Establish an integrated commissioning strategy with input from domestic violence and abuse services and from people who have experienced domestic violence and abuse. The strategy should:
    - meet the needs of both those who experience domestic violence and abuse and the perpetrators (including young people)
    - consider the needs of children and young people who are exposed to domestic violence and abuse
    - meet the needs of all local communities.

- Ensure the strategy is based on the following principles:
    - aligned or, where possible, integrated budgets and other resources
    - one partner takes the strategic lead and oversees delivery on behalf of the local strategic partnership
    - services address all levels of risk and all degrees of severity of domestic violence and abuse
    - services are based on sound commissioning evidence (see recommendation 1).
    - agencies work together to deliver services.

- Monitor implementation of the strategy.

Recommendation 4 Commissioning: establish an integrated care pathway

Who should take action?

Commissioners of services for those who experience or perpetrate domestic violence and abuse.

What action should they take?

- Ensure there is an integrated care pathway for identifying, referring and providing support for both people who experience, and those who

perpetrate, domestic violence and abuse. Ensure resources are available to support it.

- Ensure people who have substance misuse or mental health problems and are affected by domestic violence and abuse are referred to the relevant health, social care and domestic violence and abuse services.

- Ensure all service pathways have robust mechanisms for assessing the risks facing those adults (and their children) who experience domestic violence and abuse.

Recommendation 5 Services: create an environment for disclosing domestic violence and abuse

Who should take action?

- Health and social care service managers in the statutory, voluntary, community and private sectors.

- Specialist domestic violence and abuse services.
- Related services. This includes schools, the police, criminal justice (including prisons), housing, early years and youth services and services for older people.

What action should they take?

- Clearly display information in waiting areas and other suitable places about the support on offer for those affected by domestic violence and abuse and the contact details of relevant helplines. (For example, the number of the National Domestic Violence Helpline.)

- 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. It could also include more discreet ways to convey the information, for example, by providing pens or key rings with a helpline number.

- Establish a referral pathway to specialist domestic violence and abuse agencies (or the equivalent within a health or social care setting). This should include age-appropriate options and options for groups that may have difficulties accessing services, or are reluctant to do so. (The latter may include people from black and minority ethnic groups, people who are disabled, people whose immigration status is insecure, older people, trans people and lesbian, gay or bisexual people.)

- Ensure staff know about the services, policies and procedures of relevant local agencies in relation to domestic violence and abuse.

- Provide ongoing training and regular supervision for staff who may be asking people about domestic violence and abuse. This should aim to sustain and monitor good practice.

- Establish clear policies and procedures for staff who have been affected by domestic violence and abuse. Ensure there are opportunities for addressing both personal issues in relation to domestic violence and abuse and any issues arising from working in this area.

- Establish a process for regular staff supervision that monitors and sustains good practice.

Recommendation 6 Services: tailor support

Who should take action?

- Domestic violence and abuse service managers.

- Staff in all health and social care settings, including the voluntary and community sector, and those they work with. This includes: schools, the police, criminal justice (including prisons), housing, early years and youth services and services for older people.

What action should they take?

- Assess what type of service someone needs – crisis, medium- or long-term support – bearing in mind that these stages can be cyclical.

- For those in need of immediate support, consider referral to specialist domestic violence and abuse services. This includes refuges, floating and outreach support and advocacy. It also includes housing workers, independent domestic violence advocates, or a multi-agency risk assessment conference (MARAC) for high-risk clients.

- For those in need of medium-term support, consider referral to floating or outreach advocacy support or to a skill-building programme.

- For those in need of long-term support (for example, following the end of the relationship or because they have previously experienced domestic violence and abuse), consider referral to local group support programmes. If symptoms indicate they have mental health problems, also refer them to mental health services (see recommendation 13).

Recommendation 7 Information sharing

Who should take action?

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

- Commissioners of services for those who experience or perpetrate domestic violence and abuse.

What action should they take?

- Take note of the Data Protection Act and professional guidelines that address confidentiality and information sharing in health services, such as the Caldicott guidelines. This includes seeking consent from people to share their information and letting them know when, and with whom, information is being shared.

- Develop or adopt clear protocols and methods for sharing information, both within and between agencies about people at risk of, experiencing, or perpetrating domestic violence and abuse. Clearly define the range of information that can be shared and with whom (this includes protocols on

sharing information with health services on the perpetrator's criminal history).

- Ensure information-sharing methods are secure and will not put anyone involved at risk.
- Ensure the protocols and methods are regularly monitored.
- Identify and train key contacts responsible for advising on the safe sharing of domestic violence and abuse-related information.
- Ensure all staff who need to share information are trained to use the protocols so that they do not decline to cooperate from overcaution or fear of reprisal.
- Ensure any information shared is acknowledged by a person, rather than an automatically generated response.

Recommendation 8 Asking about domestic violence and abuse

Who should take action?

Health and social care service managers and professionals.

What action should they take?

- Health and social care service managers should ensure front line staff are trained to recognise the indicators of domestic violence and abuse and to ask relevant questions if the evidence suggests it may be occurring (targeted enquiry).
- Trained staff in services where domestic violence and abuse are commonly seen should ask the people they see, on a one-to-one basis, whether they have experienced such violence and abuse. The enquiry should be made in a kind, sensitive manner and in an environment where the person feels safe. Relevant services where such enquiries should be a routine part of

good clinical practice include: antenatal, postnatal and reproductive care, sexual health, substance misuse and mental health services.

- Ensure staff know, or have access to, information about the services, policies and procedures of all relevant local agencies for people who experience or perpetrate domestic violence and abuse.

- All services should have formal referral pathways in place for people who disclose that they have been subjected to domestic violence and abuse (see recommendation 4).

Recommendation 9 Equality and diversity: overcoming barriers to accessing services

Whose health will benefit?

People who may find services inaccessible or difficult to use, for example, people from black and minority ethnic groups or with disabilities, older people, trans people and lesbian, gay or bisexual people.

Who should take action?

Health and social care commissioners and service providers, including in the voluntary and community sector.

What action should they take?

- Identify any barriers people may face when trying to get help for domestic violence and abuse. Do this in consultation with local groups that have an equality remit (including organisations representing the interests of specific groups) and in line with statutory requirements.

- Introduce a strategy to overcome these barriers.

- Train staff who have direct contact with people affected by domestic violence and abuse in equality and diversity issues. (This includes those working with people who perpetrate this violence and abuse.) Specifically:

- ensure staff assumptions about people's beliefs and values, for example in relation to 'honour', do not stop them identifying and responding to domestic violence and abuse
- ensure interpreting services are confidential (confidentiality is often a concern in small communities where a minority language is spoken)
- ensure professional interpreters are used: do not rely on the use of family members or friends
- ensure people who may be experiencing domestic violence and abuse can be seen on their own (a person may have multiple abusers and friends or family members may be colluding in the abuse).

Recommendation 10 Identifying domestic violence and abuse: children and young people

Who should take action?

- Local safeguarding children boards and other local partnerships with a responsibility for safeguarding children.

- Providers of services where children and young people who experience domestic violence and abuse may be identified. This includes: accident and emergency (A&E), child and adolescent mental health, maternity, sexual health, general practice, dental and other health services; social care; youth services; early years, schools; and voluntary and community sector services.

What action should they take?

- Ensure staff can recognise the indicators of domestic violence and abuse, understand its impact on children and young people, and know when child protection services should be involved.

- Ensure staff are trained and confident to discuss domestic violence and abuse with children when they suspect they are being exposed to it.

- Ensure staff are trained and confident to discuss domestic violence and abuse with young people when they suspect they are being exposed to, experiencing or perpetrating it.

- Put clear information-sharing protocols in place to ensure staff gather and share information to gain a clear idea of the child or young person's circumstances, risks and needs.

- Develop (or adapt) and implement clear referral pathways to local services that can support children and young people affected by domestic violence and abuse. This should include opportunities for consultation with safeguarding leads, senior clinicians or managers and consideration of the appropriateness of a referral to children's services.

- Ensure staff know about the services, policies and procedures of all relevant local agencies for children and young people in relation to domestic violence and abuse.

- Involve children and young people in the development and evaluation of local policies and services.

- Monitor policies and services with regard to children's and young people's needs.

Recommendation 11 Specialist domestic violence and abuse services for children and young people

Who should take action?

- Local safeguarding children boards and other local partnerships with a responsibility for safeguarding children.

- Commissioners and providers of specialist services for children and young people who experience domestic violence and abuse. This includes child and adolescent mental health, sexual health, social care, youth and relevant voluntary and community sector services.

What action should they take?

- Address the emotional, psychological and physical harms arising from a child or young person's exposure to domestic violence and abuse, as well as their safety. This includes the wider educational, behavioural and social effects.

- Provide a coordinated package of care and support that takes individual preferences and needs into account (for example, in terms of where help is provided and what form it takes).

- Ensure interventions are multi-component and include advocacy, therapy and parenting support. They may involve individual or group sessions, or both.

- Ensure support matches the child's developmental stage (for example, infant, pre-adolescent and adolescent). Interventions should be timely and should continue over a long enough period to achieve lasting effects. Recognise that long-term interventions are more effective.

- Provide interventions that strengthen the relationship between the child or young person and their non-abusive parent or carer. Offer them to children and their non-abusive mothers in parallel or joint sessions.

- Include support and services for young people experiencing domestic violence and abuse in their own intimate relationships.

Recommendation 12 Advocacy

Who should take action?

- Health and social care commissioners (including clinical commissioning groups).

- Health and wellbeing boards.

- Front line practitioners in a number of settings, in particular, refuges and outreach services.

- Domestic violence and abuse advocates.

What action should they take?

- Provide all those currently (or recently) affected by domestic violence and abuse with advocacy services tailored to their level of risk and specific needs. For example, provide this support in different languages, as necessary. Also ensure that advocates are aware of how racism, homophobia, ageism or the fact that someone is disabled may have contributed to the situation.

- Ensure advocacy support meets national standards of good practice.

- Ensure advocacy support forms part of a comprehensive referral pathway (see recommendation 4).

- Ensure the support is offered (although not necessarily delivered) in settings where people may be identified or may disclose that domestic violence and abuse is occurring. Examples include: A&E, general practice, refuges, sexual health clinics and maternity, mental health, rape crisis, sexual violence, substance use and abortion services.

Recommendation 13 Mental health interventions

Who should take action?

- Clinical commissioning groups.

- Health and wellbeing boards.

- Health professionals working in primary care, mental health and the voluntary and community sectors.

What action should they take?

- Where people who experience domestic violence and abuse have a mental health condition, provide evidence-based treatment for the condition. This may include psychological interventions (in particular, cognitive behavioural therapy), medication and support, in accordance with national guidelines.

- Ensure psychological interventions are provided by professionals trained in how to address domestic violence and abuse and psychological trauma.

- Ensure the treatment programme also includes an ongoing assessment of risk, collaborative safety planning and the offer of a referral to specialist domestic violence and abuse support services. It must also take into account the person's preferences and whether the domestic violence and abuse is ongoing or historic.

Recommendation 14 Commissioning programmes for people who perpetrate domestic violence and abuse

Who should take action?

- Commissioners of these programmes.

- Health and wellbeing boards.

What action should they take?

- Commission programmes for people who perpetrate domestic violence and abuse, in accordance with national standards and based on the local needs assessment (see recommendation 1).

- Ensure programmes primarily aim to increase the safety of the perpetrator's partner and children. Ensure this is monitored and reported. In addition, programmes should report on the perpetrators' attitudinal change, their understanding of violence and accountability, and their ability and willingness to seek short-term help.

- Link these programmes with specialist support for those experiencing domestic violence and abuse (including children and young people). This should include feedback to those affected on the perpetrator's progress.

See also recommendations 1–4.

Recommendation 15 Training to support different roles

Who should take action?

- Royal medical colleges.
- Professional organisations responsible for setting training and registration standards for clinical, social worker and social care staff.
- Commissioners.
- Heads of health, social care and related services.
- Universities and other providers of health and social care training.

What action should they take?

- Provide different levels of training for different groups of professionals, as follows.
- Training to provide a **universal response** should give staff a basic understanding of the dynamics of domestic violence and abuse and its links to mental health and substance use, along with the legal duties of staff (for example, their duty of care). In addition, it should cover the concept of shame that is associated with honour-based violence and an awareness of diversity and equality issues. It should also ensure they know what to do next:
    - **Level 1** Staff should be trained to respond to a disclosure of domestic violence and abuse sensitively and in a way that ensures people's safety. They should also be able to direct people to specialist services. Typically this is for: non-specialist nurses, physiotherapists, speech therapists, dentists, youth workers, care assistants and non-specialist voluntary and community sector workers.
    - **Level 2** Staff should be trained to ask about domestic violence and abuse in a way that makes it easier for people to

disclose it. They should also be able to offer a referral to specialist services, where necessary. This involves an understanding of the epidemiology of domestic violence and abuse, how it impacts on people's lives and the role of professionals in intervening safely. Typically this is for: A&E doctors, adult social care staff, children's centre staff, children and family social care staff , GPs, midwives, health visitors, health and social care professionals in education (including school nurses), prison staff and substance use workers. In some cases it will also be relevant for youth workers.

- Training to provide a **specialist response** should equip staff with a more specialist understanding and enhanced skills:

  - **Level 3** Staff should be trained to provide an initial response. In addition to the Level 2 response, this should include a risk assessment and continued liaison with specialist support services. Typically this is for: child protection social workers, safeguarding nurses, specialist midwives and health visitors with additional domestic violence and abuse training, MARAC representatives, substance use workers and mental health practitioners.
  - **Level 4** Staff should be trained to give expert advice and support to people experiencing domestic violence and abuse. This is for specialists in domestic violence and abuse. For example, independent domestic violence advocates or sexual violence advocates, domestic violence and abuse and sexual violence counsellors and therapists and children's workers.

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

- All levels of training should include increasing amounts of face-to-face interaction, although level 1training can be delivered mostly online or by distance learning.

- Ensure face-to-face training covers the practicalities of enabling someone to disclose that they are affected by domestic violence and abuse and how to respond.

Recommendation 16 Training: integration of training and a referral pathway into general practice

Who should take action?

- Commissioners and service managers working in specialist domestic violence and abuse services.

- GPs.

What action should they take?

- Commissioners should commission integrated training and referral pathways for domestic violence and abuse. This should include education for clinicians and administrative staff in GP practices on how to monitor disclosures of domestic violence and abuse and how to make referrals to specialist agencies.

- Service managers should work in partnership with voluntary and community agencies to develop training and referral pathways for domestic violence and abuse.

Recommendation 17 Training: pre-qualifying and continuing professional development for health and social care professionals

Who should take action?

- The royal colleges.

- Professional organisations responsible for setting training and registration standards for relevant clinical, social worker and social care staff.
- Heads of health, social care and related services.
- Universities and other providers of health and social care training.

What action should they take?

- Ensure training is part of the undergraduate or pre-qualifying curriculum for health and social care professionals, as relevant. It should also be part of their continuing professional development programme. It should be delivered in partnership with local specialist domestic violence and abuse services and include both face-to-face and online content.
- Implement a rolling training programme that recognises the turnover of staff and the need for follow-up. The training strategy should:
    - be clear about the level of competency required for each role
    - refer, where appropriate, to existing accredited materials from specialist organisations working in domestic violence and abuse
    - ensure the content on domestic violence and abuse is linked to child safeguarding and adult protection services and vice versa
    - follow the recommended content for each level (see recommendation 15).

2 Public health need and practice

Introduction

At least 1.2 million women and 784,000 men aged 16 to 59 in England and Wales experienced domestic abuse in the year 2010/11 – 7.4% of women and 4.8% of men. (Domestic violence and abuse here is defined as: physical abuse, threats, non-physical abuse, sexual assault or stalking perpetrated by a partner, ex-partner or family member.) At least 29.9% of women and 17.0% of men in England and Wales have, at some point, experienced it (Smith et al. 2012).

These figures are likely to be an underestimate, because all types of domestic violence and abuse are under-reported in health and social research, to the police and other services.

Although both men and women may perpetrate or experience domestic violence and abuse, it is more commonly inflicted on women by men. This is particularly true for severe and repeated violence and for sexual violence.

It reflects, and is reinforced by, social norms, roles and expectations relating to gender in intimate partner relationships and in wider family and social structures. It is often part of a system of fear and coercive control. This means that a focus on specific incidents and episodes is of limited value in understanding the experience of domestic abuse.

Associated risk factors

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

- is female
- is aged 16–24 (women) or 16–19 (men) (Smith et al. 2011)
- has a long-term illness or disability – this almost doubles the risk (Smith et al. 2011)
- has a mental health problem (Trevillion et al. 2012)

- is a woman who is separated (Smith et al. 2011): there is an elevated risk of abuse around the time of separation (Richards 2004).

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

The majority of transgender people (80%) experience emotional, physical or sexual abuse from a partner or ex-partner (Roch et al. 2010).

Just under 40% (38.4%) of bisexual, gay and lesbian people class themselves as having experienced domestic violence and abuse. However many more respondents reported behaviours that could be classed as domestic violence and abuse (Donovan et al. 2006).

Alcohol or drug misuse is another risk factor: 21% of people experiencing partner abuse in the past year thought the perpetrator was under the influence of alcohol and 8% under the influence of illicit drugs (Smith et al. 2012). In addition, partner assaults are 4 to 8 times higher among people seeking treatment for substance dependency (Murphy and Ting 2010). However, there is no clear pattern between the frequency of drinking and perpetrating abuse.

Partner abuse among adults

Partner abuse is the most prevalent form of domestic abuse. At least 26.6% of women and 14% of men have, at some point, experienced this since they were 16 (Smith et al. 2012).

Women are more likely than men to experience repeated partner abuse, partner abuse over a longer period of time, violence and more severe abuse (Smith et al. 2010). Women's reports of partner abuse are also more likely to indicate that it is part of a system of fear and coercive control (Hester and Westmoreland 2005; Hester 2009).

Men are less likely to report abuse to the police, and more likely to say this is because they consider it too trivial or not worth reporting (Smith et al. 2010).

Each year since 1995, approximately half of all women aged 16 or older murdered in England and Wales were killed by their partner or ex-partner. Around 12% of men murdered each year from 1995 were killed by their partner or ex-partner. But by 2010/11 that figure had reduced to 5% (21 offences) (Smith et al. 2012; Thompson 2010).

Partner abuse among young people

Partner violence is also prevalent in young people's relationships. In the UK in 2009, 72% of girls and 51% of boys aged 13 to 16 reported experiencing emotional violence in an intimate partner relationship, 31% of girls and 16% of boys reported sexual violence, and 25% of girls and 18% of boys experienced physical violence (Meltzer et al. 2009). One in six girls reported some form of severe domestic violence and abuse inflicted on them by a partner (Barter et al. 2009).

In line with research among adults, girls described more abuse, and more severe abuse, more direct intimidation and control, and more negative impacts.

Young people in same sex relationships were at greater risk than those in heterosexual relationships.

Domestic violence and abuse between parents

Domestic violence and abuse between parents is the most frequently reported form of trauma for children (Meltzer et al. 2009). In the UK, 24.8% of those aged 18 to 24 reported that they experienced domestic violence and abuse during their childhood. Around 3% of those aged under 17 reported exposure to it in the past 12 months (Radford et al. 2011).

The impact of living in a household where there is a regime of intimidation, control and violence differ by children's developmental age. However, whatever their age, it has an impact on their mental, emotional and

psychological health and their social and educational development. It also affects their likelihood of experiencing or becoming a perpetrator of domestic violence and abuse as an adult, as well as exposing them directly to physical harm (Stanley 2011; Holt et al. 2008).

There is a strong association between domestic violence and abuse and other forms of child maltreatment: it was a feature of family life in 63% of the serious case reviews carried out between 2009 and 2011 (Brandon et al. 2012).

'Honour-based' violence and forced marriage

It is difficult to estimate the prevalence of so-called 'honour-based' violence and forced marriage, but we do know that the incidences of both are under-reported. Both can occur in Christian, Jewish, Sikh, Hindu, Muslim and other communities. They are probably more common in some cultural groups, for example, some Pakistani, Kurdish and Traveller-Gypsy communities. They reflect a patriarchal ideology of oppression (Home Affairs Select Committee 2008; Brandon and Hafez 2008).

Both often involve wider family members and affect men, as well as women: 22% of the 1468 cases looked at by the Forced Marriage Unit involved a male being forced to marry. It is estimated that between 5000 and 8000 cases of forced marriage were reported to local and national organisations in England in 2008. In 41% of cases reported to local organisations the person forced to marry was aged under 18 (Kazmirski et al. 2009).

Abuse of older people

More than 250,000 older people (aged 66 years and older) living in England in private households reported experiencing maltreatment from a family member, close friend or care workers in the past year (O'Keefe et al. 2007). Maltreatment included neglect and psychological, physical, sexual and financial abuse.

Of those experiencing maltreatment, 51% experienced it from a partner, 49% from another family member, 5% from a close friend and 13% from a care worker. Women were more likely to experience maltreatment than men (3.8%

of women and 1.1% of men in the past year), and men were more often the perpetrators.

Abuse of parents by children

The prevalence of abuse of parents by their children is very difficult to ascertain and 'still lies in a veil of secrecy' (Kennair and Mellor 2007). It is 'a pattern of behaviour that uses verbal, financial, physical or emotional means to practise power and exert control over a parent' (Holt 2012). It is more commonly experienced by mothers than fathers – and is more common among single parents.

It can bring stress, fear, shame and guilt, as well as physical, emotional and psychological harm to the person who experiences it. Those inflicting the abuse may feel inadequate, hopeless and alone (Holt 2012; Kennair and Mellor 2007). A large proportion of those inflicting the abuse will themselves have been physically or sexually abused or have witnessed abuse.

Public sector costs

The public service burden of domestic abuse is considerable. A high proportion of women attending A&E, primary care, family planning, reproductive and sexual health settings are likely to have experienced domestic violence and abuse at some point (Alhabib et al. 2010; Feder et al. 2009).

Between 25 and 56% of female psychiatric patients report experiencing domestic violence and abuse in their lifetime (Oram et al. 2013).

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

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

3 Considerations

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

General

3.1 The PDG was clear that men are more likely to perpetrate domestic violence and abuse than women. Members were also clear that men are much more likely to be the ones who carry out severe attacks and sexual abuse. However, the Group stressed that men could also experience such violence and abuse.

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

3.3 Although the main focus of domestic violence and abuse research and services is on that occurring between intimate partners, domestic violence and abuse takes many forms. Examples include: forced marriage, violence connected to 'honour', violence against adults by their children, abuse of older people and other abuse among adults. However, evidence of effective interventions in these areas is lacking.

3.4 The PDG agreed that family violence, including so-called 'honour'-based violence and forced marriage, occurs among all ethnic groups.

3.5 The PDG agreed that, rather than use the terms 'victim' or 'survivor', they would refer to 'people who have experienced domestic violence and abuse'.

3.6 The PDG thought it likely that domestic violence and abuse services could also benefit the extended family and friends of

people who directly experience domestic violence and abuse. However, these effects have not been studied.

3.7 The PDG was aware that much of the expertise and support for people who experience domestic violence and abuse lies in the voluntary and community sector, where funding and capacity is generally limited.

3.8 The PDG was aware that domestic violence and abuse is often one of several problems that a couple or family have. For example, it may be combined with substance use or mental health problems. Such cases are more complex and difficult – and the outcomes tend to be worse – than for families where there are no other major problems.

3.9 Most of the evidence relates to male violence against women and children in heterosexual relationships. However, the PDG noted that intimate partner relationships take many forms. This includes: bisexual, gay, lesbian and transgender partnerships, reconstituted (or step) families or more complex families. In such cases, the Group noted that people may face particular barriers to accessing support and may have specific needs.

3.10 The PDG noted that all domestic violence and abuse is about abuse of power and may have consequences for the wider family.

Children who experience domestic violence and abuse

3.11 The PDG recognised the wide range of ill-effects that exposure to domestic violence and abuse can have on children and young people, including the effect on their social, emotional, psychological and educational wellbeing and development. It also recognised that the provision of effective interventions and support may reduce the likelihood of them being affected by, or perpetrating, domestic violence and abuse in adulthood.

3.12 The PDG noted the importance of working concurrently with both the non-abusive parent or carer and child, rather than just focussing on the parent.

3.13 The PDG noted that domestic violence and abuse – and children's exposure to it – often continues beyond the end of the adults' relationship.

3.14 Although the evidence relating to the length of interventions is unclear, it appears that longer interventions are more effective. This may be particularly true in complex cases.

3.15 The PDG noted the importance of ensuring services are appropriate to the age, gender and developmental stage of the child or young person. For example, teenagers may not want to be seen at the same time as their non-abusive parent or carer.

Identifying domestic violence or abuse

3.16 The PDG was aware that the distinction between a routine and a targeted (or selective) enquiry about domestic violence and abuse was not always clear. The guidance makes recommendations that cover the broad spectrum of settings and the most appropriate method of identifying, or enabling someone to disclose, incidences of domestic abuse.

3.17 The PDG acknowledged that people experiencing domestic violence and abuse may choose not to disclose it when asked by a healthcare or other professional. Or, if they do disclose, they do not want to be pressurised to give more details of the abuse or take a specific course of action (Feder 2006).

3.18 The PDG noted that healthcare professionals not trained to identify domestic violence and abuse may mislabel and misdiagnose people's problems, leading to inappropriate plans or ineffective remedies. (For example, specialists may be ordering unnecessary

and expensive investigations and GPs may be prescribing inappropriate anxiolytics and antidepressants.)

Advocacy and skill building

3.19 There is no universally accepted understanding of what 'advocacy' means in the context of domestic violence and abuse. The PDG kept the term because it has been applied to a range of interventions that have been evaluated in research studies. A definition was agreed for the purposes of this guidance (see Advocacy in section 6).

3.20 The PDG noted that skill-building approaches might be of particular use in refuge settings, although they are also an intrinsic part of the advocacy and support role.

Programmes for people who perpetrate domestic violence and abuse

3.21 There is a lack of consistent evidence on the effectiveness of programmes for people who perpetrate domestic violence and abuse. The PDG noted that some evaluations take account of the partner's health and wellbeing and include their perception of any changes in the perpetrator's behaviour. However, these tend to be small-scale uncontrolled studies.

3.22 The PDG noted that national programmes dealing with behaviour-change among perpetrators are aimed at heterosexuals. Members were unclear whether or not these programmes would also be effective for non-heterosexuals.

Prevention

3.23 The review did not find sufficient evidence to make recommendations on primary prevention programmes. This was partly because it looked only at health and social care settings (most of these interventions are delivered in education settings.)

However, the PDG agreed that this is an important area for future research.

Health economics

3.24 The economic modelling showed that effectiveness and cost-effectiveness in the medium to long term was less certain than in the shorter term. This was due to the short follow-up period applied to the studies used as the basis of the model and due to the lack of longitudinal studies. However, even using conservative assumptions, it seems likely that the interventions will be cost-effective in the long term by stopping the violence and improving the mental health of all those involved.

3.25 The PDG was aware that lack of evidence meant the economic models would underestimate the cost effectiveness of interventions. For example, a reduction in the incidence of post-trauma-related stress disorder is likely to lead to additional benefits, such as being less depressed or having improved self-esteem. However, these benefits were not estimated in the model because of limited evidence.

3.26 Although the economic modelling focused on 2 interventions, the findings are also relevant for interventions with similar benefits and similar (or lower) costs. The PDG noted that the potential health and non-health benefits of these interventions would outweigh the costs when the positive impacts on people experiencing the violence and abuse, their families and wider society were considered.

This section will be completed in the final document.

4 Recommendations for research

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

4.1 How effective are programmes that aim to prevent domestic violence and abuse from ever happening in the first place? This includes media-based public health awareness campaigns. It also includes social movements to establish people's rights, community-building and primary prevention activities that tackle underlying assumptions in society about, for example, the role and status of women.

4.2 How effective are combinations of interventions to deal with domestic violence and abuse in the short, medium and long term? Are the outcomes sustainable and do they have a beneficial effect on quality of life and health in the longer term?

4.3 What are the longitudinal effects of the following interventions, across various levels of risk and including diverse (including marginalised) groups:

- advocacy
- domestic abuse recovery programmes
- perpetrator programmes
- psychological or social interventions
- interventions for primary carers, apart from mothers (for example, fathers, grandparents)
- interventions for other family members and friends of people experiencing domestic violence and abuse?

4.4 What are the most appropriate ways to collect and manage data about domestic violence and abuse across the health, social care

and criminal justice sectors? Is there value in collecting anonymised aggregate data, or is there a more useful method of data capture?

More detail identified during development of this guidance is provided in Gaps in the evidence.

5 Related NICE guidance

- Common mental health disorders. NICE clinical guideline 123 (2011)
- Depression in adults (update) NICE clinical guideline 90 (2009)
- Psychosis with coexisting substance misuse. NICE clinical guideline 120 (2011)
- Alcohol dependence and harmful alcohol use. NICE clinical guideline 115 (2011)
- Pregnancy and complex social factors. NICE clinical guideline 110 (2010)
- Looked-after children and young people. NICE public health guidance 28 (2010)
- Alcohol-use disorders: preventing harmful drinking. NICE public health guidance 24 (2010)
- When to suspect child maltreatment. NICE clinical guideline 89 (2009)
- Antisocial personality disorder. NICE clinical guideline 77 (2009)
- Antenatal care. NICE clinical guideline 62 (2008)
- Antenatal and postnatal mental health. NICE clinical guideline 45 (2007)
- Postnatal care. NICE clinical guideline 37 (2006)
- Post-traumatic stress disorder (PTSD).NICE clinical guideline 26 (2005)

6 Glossary

Advocacy

In general, advocates working with people who have experienced domestic violence provide:

- legal, housing and financial advice

- access to and use of community resources such as refuges or shelters, emergency housing, and psychological interventions
- safety planning advice.

The activities may differ according to the level of risk facing the person. Crisis advocacy involves working with the person for a limited period of time (they may then be referred on to more specialised agencies). Advocates can also provide ongoing support and informal counselling. The intensity of the advocacy provided may vary. It may last for a year – or longer, if the person is particularly vulnerable.

Coercive behaviour

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

Controlling behaviour

Controlling behaviour involves a range of acts designed to make a person subordinate or dependent. This could range from isolating them from sources of support to exploiting them for personal gain. It can also involve depriving them of the means to be independent including stopping them from leaving and regulating their everyday behaviour. (Home Office [2012] New definition of domestic violence, published18 September 2012)

Disclosure

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

Elder abuse or maltreatment

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

Floating support

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

- Keeping safe/Security measures
- Accessing legal advice and options
- Welfare Benefits
- Budgeting/Debts
- Life Skills
- Resettlement/Re-housing
- Accessing Community Services
- Form Filling
- Pre-tenancy Support
- Training/Education/Employment

Forced marriage

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

Honour-based violence or honour violence

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

Independent domestic violence advisers (IDVAs)

Also known as independent domestic violence advocates, IDVAs work primarily with people at high risk of domestic violence and abuse, independent of any one agency, to secure their safety and the safety of their children. Serving as the primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the options and develop plans that address their immediate safety, as well as longer-term solutions. These plans will include action by the MARAC, the criminal and civil courts, housing and other statutory and voluntary services. IDVAs help people over the short- to medium-term. In many areas they are funded by the local community safety partnership, in some areas they are funded by the police or local authorities.

Indicators

Presenting problems or conditions that are associated with domestic violence abuse. These include:

- symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders
- suicidal tendencies or self-harming
- alcohol or other substance use
- unexplained chronic gastrointestinal symptoms
- unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- adverse reproductive outcomes, including multiple unintended pregnancies or terminations, delayed pregnancy care, adverse birth outcomes
- unexplained genitourinary symptoms, including frequent bladder or kidney infections or other
- repeated vaginal bleeding or sexually transmitted infections
- chronic pain (unexplained)
- traumatic injury, particularly if repeated and with vague or implausible explanations
- problems with the central nervous system – headaches, cognitive problems, hearing loss

- repeated health consultations with no clear diagnosis
- intrusive partner or husband in consultations.

(Adapted from Black 2011.)

Multi-agency risk assessment conferences (MARACs)

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

Parenting support

Interventions that aim to improve parents' understanding of how domestic violence and abuse affect children and how to protect them.

Refuge or shelter

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

Routine enquiry

In this guidance, routine enquiry is used to mean ask all women in specific health care settings whether they are affected by domestic violence or abuse and raise awareness of the help available , as part of good clinical practice.

Safety planning

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

Skill building

Training and education to improve the skills of people who have experienced domestic violence and abuse. Typically it covers: problem solving and

decision making, resilience and coping, financial skills, and understanding the dynamics of domestic violence and abuse. Sometimes it also includes other components; for example, relaxation and parenting skills.

Targeted enquiry

Asking about domestic violence and abuse based on indicators that raise the likelihood of the person experiencing (or having experienced) it. In contrast to a routine enquiry, this does not involve asking everyone the professional sees.

Therapy

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

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8 Summary of the methods used to develop this guidance

Introduction

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

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

All supporting documents are listed in About this guidance.

Guidance development

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

1. Draft scope released for consultation

2. Stakeholder meeting about the draft scope

3. Stakeholder comments used to revise the scope

4. Final scope and responses to comments published on website

5. Evidence reviews and economic modelling undertaken and submitted to PDG

6. PDG produces draft recommendations

7. Draft guidance (and evidence) released for consultation and for field testing

8. PDG amends recommendations

9. Final guidance published on website

10. Responses to comments published on website

Key questions

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

- What types of intervention or approach are effective and cost effective in preventing domestic violence from ever happening in the first place (that is, primary prevention)?

- What types of intervention or approach are effective and cost effective in helping all those working in health and social care to safely identify and, where appropriate, intervene to prevent domestic violence? Examples may

include collaborative partnerships, advice and information-sharing protocols and specialised training, both on-the-job and pre-entry.

- What types of intervention or approach are effective and cost effective in helping all those working in health and social care to respond to domestic violence? This may include interventions and approaches to assess and improve someone's safety, reduce the risk of harm, support their recovery and prevent a perpetrator reoffending. It may also include collaborative partnerships and advice and information-sharing protocols.

- What types of intervention and approach are effective and cost effective in identifying and responding to children who are exposed to domestic violence in the various settings identified? (That is, the violence is not perpetrated on them directly but they witness or experience it.) Interventions could include collaborative partnerships and advice and information-sharing protocols.

- What are the most effective and cost-effective types of partnership and partnership approaches for assessing and responding to domestic violence?

These questions were made more specific for each review (see review for further details).

Reviewing the evidence

Effectiveness reviews

One review of effectiveness was conducted.

Identifying the evidence

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

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

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

Selection criteria

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

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

Studies were excluded if they:

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

See the review for details of the inclusion and exclusion criteria.

Quality appraisal

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

Study quality

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

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

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

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

Summarising the evidence and making evidence statements

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

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

Cost effectiveness

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

Review of economic evaluations

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

- full economic evaluations of relevant types of intervention

- high quality costing studies relevant to the UK.

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

Economic modelling

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

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

Fieldwork

This section will be completed in the final document.

How the PDG formulated the recommendations

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

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

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

- Strength (type, quality, quantity and consistency) of the evidence.
- The applicability of the evidence to the populations/settings referred to in the scope.

- Effect size and potential impact on the target population's health.
- Impact on inequalities in health between different groups of the population.
- Equality and diversity legislation.
- Ethical issues and social value judgements.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of harms and benefits.
- Ease of implementation and any anticipated changes in practice.

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

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

9 The evidence

This section lists the evidence statements from the review and the expert reports provided by the external contractor (see What evidence is the guidance based on?) and links them to the relevant recommendations. (See Summary of the methods used to develop this guidance for the key to quality assessments.)

This section also sets out a brief summary of findings from the economic analysis.

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

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

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

- Recommendation 1: ER1
- Recommendation 2: evidence statement 30–33
- Recommendation 3: evidence statements 30–33
- Recommendation 4: evidence statements 9, 30–-33
- Recommendation 5: evidence statements 3, 8, 9; ER2–5
- Recommendation 6: evidence statements 11–14
- Recommendation 7: evidence statements 3, 33
- Recommendation 8: evidence statements 8–10, 31
- Recommendation 9: evidence statement 33; ER2–5
- Recommendation 10: evidence statements 8, 9, 30–33
- Recommendation 11: evidence statements 27–29
- Recommendation 12: evidence statements 10–12, 27, 28
- Recommendation 13: evidence statements 13, 14
- Recommendation 14: evidence statements 15, 17; ER2
- Recommendation 15: evidence statements 8–10, 30
- Recommendation 16: evidence statements 8,9, 31–33
- Recommendation 17: evidence statements 8, 9, 30

Evidence statements

Please note that the wording of some evidence statements has been altered slightly from those in the evidence review(s) to make them more consistent with each other and NICE's standard house style.

Evidence statement 3 Prevention interventions/ approaches implemented in health settings

There is weak evidence from 2 studies (1 individual RCT[+][1], 1 cross-sectional study [+][2]) that prevention interventions delivered to patients in healthcare settings (emergency departments in both studies) are associated with exposure (reports of noticing, reading or retaining of materials), or changes in knowledge and attitudes related to domestic violence. The RCT (+)[1] reported overall improvements in knowledge, attitudes and practices (willingness to intervene in a bystander scenario) related to intimate partner violence following a computer based intimate partner violence prevention presentation, with somewhat greater improvements for the intervention condition, and no differences in outcomes noted between women and men or identified perpetrators and people who have experienced domestic violence. The cross-sectional study (+)[2] reported modest indicators of exposure (noticing, reading, retaining materials) to domestic violence materials posted in A&E department lavatories, and women were more likely to report that they noticed the materials presented.

[1] Ernst et al. 2011

[2] Edwardsen and Morse, 2006

Evidence statement 8 Provider education

There is inconsistent evidence from 4 studies (2 RCTs, both [++][1,2]; 1 before-and-after study [+][3]; 1 RCT [+][4]) that provider education interventions are effective in improving screening practices or clinical enquiry. The strongest evidence comes from an RCT (++)[1] that compared focus group with full training interventions. It found modest improvements in awareness of and identification of domestic violence for both conditions, but they were greater in the full training condition. Another RCT (++)[2] found improvements in referrals and an increase in disclosures of domestic violence following an education and advocacy intervention. A before-and-after study (+)[3] found a modest increase in women's self-reports of screening following a multimodal education programme for healthcare providers. One RCT (+)[4] found that a

training programme for medical residents increased knowledge about domestic violence but did not significantly increase rates of diagnosis.

[1] Lo Fo Wong et al. 2006

[2] Feder et al. 2011

[3] Bonds et al. 2006

[4] Coonrod et al. 2000

Evidence statement 9 Policy/organisational change

There is inconsistent evidence from 2 before-and-after studies (1 [+][1]; 1 [−][2]) that the implementation of policy or organisational changes to screening for domestic violence improves screening rates, referral rates and/or provider comfort with and ability to screen. One study (+)[1] reported modest improvements in screening following augmentations to a routine inquiry strategy. The other (−)[2] reported improvements in referral rates and providers' self-reports of awareness and efficacy of domestic violence screening following implementation of a routine screening programme within an emergency department.

[1] Shye et al. 2004

[2] Power et al. 2011

Evidence statement 10 Identification in pregnancy/postpartum

There is moderate evidence from 5 before-and-after studies (1 [++][1]; 4 [+][2,3,4,5]) and 1 interrupted time series study (+)[6], that universal screening or routine enquiry for domestic violence in pregnancy, when supported by staff training and organisational support, improves identification practices and documentation of domestic violence. Two studies examined the impact of a routine comprehensive screening protocol during postpartum home visits; 1[1] found significant improvements in the protection of women's privacy during screening (++)[1]; the other was supported by a year-long professional development strategy and found improvements in documentation of abuse

inquiry (+)[2]. One study (+)[3] examined the effect of providing repeated individualised feedback to obstetric and gynaecology residents on their screening performance, compared with that of other residents, and found significant increase in rates of screening. Two studies examined policy and organisational changes to support implementing universal screening protocols in settings serving pregnant and postpartum women (+)[4,5] and found substantial improvements in screening rates. Another study (+)[6] examined the implementation of an antenatal routine enquiry programme but found only modest improvements, with most midwives reporting assessment of only a proportion of clients.

[1] Vanderburg et al. 2010

[2] Grafton et al. 2006

[3] Duncan et al. 2006

[4] Janssen et al. 2002

[5] Garcia and Parsons, 2002

[6] Price et al. 2007

Evidence statement 11 Advocacy interventions for people who have experienced domestic violence

There is moderate evidence from 10 studies (5 RCTs, 2 [++][1,2] and 3 [+][3,4,5]; 3 before-and-after studies, all [+][6,7,8]; 1 cross-sectional study [+][9]; 1 qualitative study [+][10]) that advocacy services may improve women's access to community resources, reduce rates of intimate partner violence, improve safety, decrease depression, reduce various stressors, and improve parenting stress and children's wellbeing. A cluster-RCT (++)[1] revealed a significant decrease in intimate partner violence before adjustment for propensity score for pregnant and postpartum women involved in a community-based mentorship programme. One RCT (++)[2] reported improvements in mothers' depression and self-esteem and children's wellbeing following participation in home visitation advocacy services. A before-and-after study (+)[6] evaluated

the effect of independent domestic violence adviser services, demonstrating improvements in women's safety and a decrease in abuse. An RCT (+)[3] found a decrease in intimate partner violence rates for mothers involved in a home visiting programme. A cluster RCT (+)[5] observed a decrease in depressive symptoms and suicidal thoughts for rural women receiving advocate services, but found no difference in self-perceived mental health or accessing of hotline services. A cross-sectional study (+)[9] reported improvements in perceived safety and safety planning for participants provided with emergency department advocacy counselling services. An RCT (+)[4] revealed improvements in women's access to community resources regardless of presenting need, following post-shelter advocacy services. A before-and-after study (+)[7] found a decrease in various stressors (partner, housing, mental health, legal and physical health) for women using substances who were accessing shelter services. A before-and-after study (+)[8] found that women receiving support services reported improvements in their safety and quality of life and their children's safety, and caseworkers also reported improvements in women and children's safety. Finally, a qualitative study (+)[10] revealed that a 24-hour helpline service helped abused women understand abuse and making changes to their lives, and provided links to available support and services.

[1] Taft et al. 2011

[2] Sullivan et al. 2002

[3] Bair-Merritt et al. 2010

[4] Allen et al. 2004

[5] Coker et al. 2012

[6] Howarth et al. 2009

[7] Poole et al. 2008

[8] Price et al. 2008

[9] Kendall et al. 2009

[10] Cath Gregory Consulting, 2008

Evidence statement 12 Skill building interventions for people who have experienced domestic violence

There is moderate evidence from 6 studies (4 RCTs, 1 [++][1] and 3 [+][2,3,4]; 1 before-and-after study [+][5]; 1 quasi-experimental study [+][6]) that skill building (teaching, training, experiential or group learning) on a range of topics with people who have experienced partner violence has positive effects on the coping, wellbeing, decision-making abilities of people who have experienced partner violence, and their safety and reduction of coercive and violent behaviour toward them. A cluster RCT (++)[1] found that coping skills training reduced physical violence against women in relationships with men with untreated problem drinking. An RCT (+)[2] found that educating women about forms of reproductive coercion and harm-reduction in the reproductive context resulted in a reduction in the odds of pregnancy coercion, compared with women in the control groups. A before-and-after study (+)[5] found that a computerised danger assessment and a decision aid tool resulted in women feeling more supported and less conflicted about improving their safety. A quasi-experimental design (+)[6] found that an educational programme on economic issues improved financial efficacy or the ability to make financial decisions among women who have people who have experienced abuse. An RCT[3] found that a 9-week cognitive behaviour group intervention improved anxious, depressive and internalising or externalising behaviours in children, and improved women's sense of isolation and health. Finally, an RCT (+)[4] found that music therapy decreased anxiety in women in shelters.

[1] Rychtarik and McGillicuddy, 2005

[2] Miller et al. 2011

[3] Sullivan et al. 2004

[4] Hernandez-Ruiz et al. 2005

[5] Glass et al. 2009

[6] Sanders 2007

Evidence statement 13 Brief psychological interventions for people who have experienced domestic violence

There is moderate evidence from 9 studies (5 RCTs, all [+][1,2,3,4,5]; 1 qualitative study [+][6]; 1 non-randomised controlled trial [+][7]; 2 before-and-after studies, both [+][8,9]) that counselling interventions may improve: PTSD symptoms, depression, anxiety, self-esteem, stress management, independence, support, reoccurrence of violence, birth outcomes for pregnant women, motivational level, readiness to change, and/ or forgiveness. An RCT (+)[1] demonstrated a decrease in reoccurrence of violence (that differed by severity of violence) and some birth outcomes (birth weight, preterm delivery and gestational age) for pregnant African–American women following a cognitive behavioural intervention. An RCT (+)[2] revealed reductions in PTSD severity and specific symptoms, and re-abuse for women who completed a shelter-based cognitive behavioural intervention. An RCT (+)[3] found no significant reduction in PTSD or intimate partner violence from an interpersonal psychotherapy intervention for pregnant and postpartum women at follow-up, although there was a moderate reduction in PTSD and depression symptoms during pregnancy. An RCT (+)[4] did not find differences between an expressive writing and neutral writing intervention for PTSD symptoms, but did find that women with depression at baseline benefited from the expressive writing condition. A qualitative study (+)[6] found that Hispanic immigrant women attending support groups for abuse reported improvements in self-esteem, stress management, independence and feelings of support. A non-randomised controlled trial (+)[7] found that motivational interviewing enhanced shelter counselling was associated with greater motivational level and readiness to change. An RCT (+) [5] reported improvements in women's forgiveness, self-esteem and several emotional and recovery outcomes following participation in forgiveness therapy. A before-and-after study (+)[8] revealed that women who participated in a brief educational intervention reported a decrease in several forms of violence. Finally, in a before-and-after

study (+)[9] rural women's PTSD and depressive symptoms improved following participation in videoconference counselling.

[1] Kiely et al. 2011

[2] Johnson et al. 2011

[3] Zlotnick et al. 2011

[4] Koopman et al. 2005

[5] Reed et al. 2006

[6] Morales Campo et al. 2009

[7] Rasmussen et al. 2008

[8] Laughon et al. 2011

[9] Hassija et al. 2011

Evidence statement 14 Psychological therapy interventions for people who have experienced domestic violence

There is moderate evidence from 8 studies (4 RCTs, 1 [++][1] and 3 [+][2,3,4]; 1 non-RCT [+][5]; 3 before-and-after studies, all [+][6,7,8]) that therapy interventions may be effective for improving various PTSD symptoms, depression, trauma symptoms, psychological and social outcomes, parenting or family-related outcomes and in some cases may reduce likelihood of future intimate partner violence or re-abuse. An individual RCT (++)[1] found improvements in PTSD and depression among women in all conditions (cognitive processing alone, with writing account, or writing alone); however, women in the cognitive processing alone group demonstrated a greater reduction on PTSD measures. An RCT (+)[2] demonstrated reductions in PTSD and depressive symptoms that were associated with reductions in physical intimate partner violence at 6 months following either cognitive processing or written account therapies. A non-RCT (+)[5] found improvements in social support measures for women attending a professional development intervention, and improvements

in self-efficacy for women in a homeless shelter involved in cognitive behavioural therapies (CBT). An RCT (+)[3] compared CBT, including either exposure or communication components; it found reductions in post-traumatic stress, anxiety, anger and depression in both conditions, but greater effects for the exposure condition. An individual RCT (+)[4] reported improvements in various emotional, family and change-related outcomes for mothers and children participating in emotion-focused and goal-focused group therapies; women in the goal-focused intervention reported greater improvements in family conflict and decreased alcohol use, and women in the emotion-focused condition reported greater improvements in social support. A before-and-after study (+)[6] found improvements in mothers' psychological and trauma symptoms, and sense of coherence following psychosocial group therapy. A before-and-after study (+)[7] found improvements in women's depressive symptoms, hopelessness, distress and social adjustment following dialectical behavioural therapy. Finally, a before-and-after study (+)[8] demonstrated significant improvements in PTSD symptoms, and women's reports of healing, following a holistic group therapy.

[1] Resick et al. 2008

[2] Iverson et al. 2011

[3] Crespo et al. 2010

[4] McWhirter et al. 2011

[5] McWhirter 2006

[6] Grip et al. 2011

[7] Iverson et al. 2009

[8] Allen et al. 2011

Evidence statement 15 Individual interventions for abusers

There is moderate evidence from 8 studies (3 non-RCTs, all [+][1,2,3]; 2 before-and-after studies, both [+][4,5]; 2 RCTs, both [+][6,7]; 1 qualitative study [+][8]) that

individual interventions for abusers may improve aggressive feelings towards partner, attitudinal change, understandings of violence and accountability, and short-term help seeking. Some interventions also reported improvements in violent behaviours or recidivism, but others demonstrated no effect. The types of individual interventions employed varied. A non-RCT (+)[1] found that individual case management did not significantly improve batterer programme dropout, re-assault, and re-arrests, or women's perceptions of safety. A before-and-after study (+)[4] examining batterer interventions in 3 sites found that programme completion was associated with a reduction in re-assault, and programme length was not significantly associated with programme completion. A non-RCT (+)[2] found that an individual-level intervention on its own was less effective in reducing recidivism among male offenders than when combined with indirect community outreach services. In a before-and-after study (+)[5], all male and female abusers who completed a brief solution focused therapy were reported to be violence free. Evidence from several studies suggests that motivational interviewing-based feedback may not affect aggression or violence, but may affect some attitudinal outcomes. A non-RCT (+)[3] found no significant differences in partner violence among men who received motivational interviewing-based feedback at intake, compared with those who did not, although the intervention did improve men's receptivity to the intervention. An RCT (+)[6] demonstrated improvements on some attitudinal outcomes (action and external attributions of violence when outliers were excluded) but not all (pre-contemplation and contemplation) for a small sample of male abusers following motivational interviewing-based assessment feedback. In an individual RCT(+)[7] that also compared motivational interviewing-based feedback at assessment with a control, a significant difference was found among a small sample of alcohol dependent men for short term help seeking, with no differences in anger, reports of aggression or alcohol outcomes. Finally, in a qualitative study[8] a small sample of male physical abusers demonstrated changes in understandings of violence and accountability following involvement in an educational intervention.

[1] Gondolf 2008

[2] DeLeon-Granados et al. 2005

[3] Musser et al. 2008

[4] Gondolf and Jones 2001

[5] Milner and Singleton 2008

[6] Kistenmacher et al. 2008

[7] Shumacher et al. 2011

[8] Morgan et al. 2001

Evidence statement 17 Short duration group interventions for abusers measuring attitudinal, psychological and interpersonal outcomes

There is moderate evidence from 9 studies (5 before-and-after studies, all [+][1,2,3,4,5]; 1 cluster RCT [+][6]; 1 quasi-RCT study [+][7]; 1 non-RCT [+][8]; a follow up of study 5 [+][9]) that short duration (16 weeks or less) group interventions improve attitudinal, psychological and interpersonal outcomes among abusers. The majority of studies reported improvements on various measured outcomes. A before-and-after study[1] that examined a family-of-origin group therapy treatment reported improvements among male batterers on all psychological, attitudinal and interpersonal measures. A cluster RCT (+)[6] that compared a guidance session based on Duluth model with one including counselling treatment for male abusers reported differences in the attitudinal and interpersonal improvements achieved by each group. Findings from a before-and-after study (+)[2] revealed that a solution- and goal-focused group treatment programme was associated with improved relational skills and self-esteem among male and female offenders. A quasi-RCT study (+)[7] compared structured CBT with unstructured supportive group therapy for partner-violent men, and found improvements for both groups in self-esteem, efficacy to abstain from verbal abuse and stage of change. A before-and-after study (+)[3] found that a group counselling programme was associated with improvements on all psychological, interpersonal and attitudinal outcomes, and improvement

was sustained in the follow up group. A before-and-after study (+)[4] found that a cognitive behavioural intervention resulted in improvements in passive aggressiveness and likelihood to use force, with similar effects for African–American and white participants. A non-RCT (+)[8] reported that group therapy for abusive men was associated with improvements in restrictive emotionality and restrictive affectionate behaviour. Two studies[5,9] found improvements on some, but not all psychological measures. A before-and-after study[5] revealed that a group treatment programme for women batterers was associated with improvements in self-esteem, general contentment, stress, and adult self-expression, but no improvements on depression. In a later study of the same programme (+)[9] improvements were found among female batterers in measures of depression and stress, but there was a reduction in self-esteem.

[1] Tutty et al. 2001

[2] Lee et al. 2004

[3] McGregor et al. 2000

[4] Carney et al. 2006

[5] Tutty et al. 2006

[6] Waldo et al. 2007

[7] Morrel et al. 2003

[8] Schwartz et al. 2003

[9] Tutty et al. 2009

Evidence statement 27 Multi-component advocacy interventions

Four studies in a systematic review (+)[1] evaluated multi-component interventions with advocacy as a primary intervention focus[2,3,4,5] . One individually assessed RCT also evaluated a multi-component advocacy-based intervention (+)[6].

There is moderate evidence that multi-component interventions with a focus on advocacy are effective in reducing the trauma symptoms and stress in both children and families, and in improving child behaviours such as aggression.

[1] Rizo et al. 2011

[2] Blodgett et al. 2008;

[3] Crusto et al. 2008;

[4] McFarlane et al. 2005a,

[5] McFarlane et al. 2005b

[6] Whiteside-Mansell et al. 2009

Evidence statement 28 Multi-component therapy and advocacy interventions

Two studies in a systematic review (+)[1] evaluated multi-component interventions including therapy and advocacy components[2,3], in addition to 2 individually assessed studies – 1 before-and-after (+)[4]; and 1 non-RCT (+)[5].

There is moderate evidence of effectiveness for multi-component interventions including both therapy and advocacy among diverse populations of women and children, some with co-occurring issues of substance use and mental health issues. These interventions increased knowledge and awareness about violence and safety planning, improved self-esteem and self-competence and improved interpersonal relationships.

[1] Rizo et al. 2011

[2] Ernst et al. 2008

[3] Sullivan et al. 2002

[4] Finkelstein et al. 2005

[5] Noether et al. 2007

Evidence statement 29 Multi-component parenting and therapy interventions

A systematic review (+)[1] reported on 8 studies that evaluated multi-component interventions focused on therapy and parenting[2,3,4,5,6,7,8,9]. Two additional studies evaluating a multi-component intervention including parenting and therapy components were identified: 1 before-and-after (+)[10] and 1 qualitative (+)[11].

There is moderate evidence of effectiveness of multi-component interventions focused on therapy and parenting aimed at diverse populations of mothers and children. These interventions showed moderate improvement in children's behaviour and emotions, knowledge about violence and reductions in mothers' stress and improvements in their ability to manage children.

[1] Rizo et al. 2011

[2] Carter et al. 2003

[3] Dodd 2009

[4] Graham-Bermann et al. 2007

[5] Jouriles et al. 2009

[6] Jouriles et al. 2001

[7] MacMillan and Harpur 2003

[8] McDonald et al. 2006

[9] Sullivan et al. 2004

[10] Puccia et al. 2012

[11] Sharp et al. 2011

Evidence statement 30 Effectiveness of partnerships for increasing referrals and addressing violence

There is moderate evidence from 11 studies (4 before-and-after studies, all [+][1,2,3,4]; 3 cross-sectional and qualitative studies, all [+][5,6,7]; 1 cross-sectional study [+][8]; 2 before-and-after study and qualitative report, both [+][9,10]; 1 qualitative study [+][11]) that partnerships to address domestic violence were effective at: increasing referrals, reducing further violence, or supporting people who have experienced violence.

Ten quantitative studies and mixed methods studies[1–10] examining partnerships to address domestic violence evaluated the impact on referrals, reducing violence or providing support for people who have experienced domestic violence. A before-and-after study (+)[1] examining a collaboration between child welfare and domestic violence agencies reported an increase in referrals for domestic violence and increase in batterer referrals. A before-and-after study (+)[2] revealed that a woman's 'door' (source of referral) to service (domestic violence, substance misuse or integrated services) did not significantly affect self confidence in managing abuse, experience of battering, or substance use outcomes at follow up. A before-and-after study (+)[3] found that having a single case coordinator who collaborated across service providers was effective with court-referred participants and their families for increasing family intimacy and child wellbeing and decreasing family conflict. A before-and-after study (+)[4] comparing a team case management model with a standard single social worker model of risk assessment of seniors in adult protection found that the standard model was significantly more likely to confirm cases of mistreatment, including financial exploitation, physical abuse and neglect by others; but for measures of risk reduction, the team approach significantly reduced risk of physical abuse, neglect, and environmental risks. A cross-sectional and qualitative study (+)[5] of a multi-agency approach to protect vulnerable adults from abuse based on 'No Secrets' and 'In Safe Hands' found that service users reported difficulties in accessing social services when needed, communication issues and negative experiences with existing adult protection services. A cross-sectional study (+)[8] evaluated the Women's Safety Unit (WSU), which offers a central point for a range of

support services for people who have experienced domestic violence and their children. It found that: the majority of clients were referred by the police to the WSU and received referrals from the WSU to other agencies; a decrease in repeat experiences of abuse and people who have experienced domestic violence refusing to provide a complaint and an increase in concern for children reports submitted by officers; and WSU clients reported high satisfaction with the WSU. A cross-sectional and qualitative study (+)[6] evaluating a sample of multi-agency risk assessment conference (MARAC) cases revealed that the majority of people who have experienced domestic violence did not have any new domestic violence complaints or police call outs for domestic violence at the end of the evaluation period, although interviews with people who have experienced domestic violence revealed potentially higher rates of repeated abuse than police files. A before-and-after study and qualitative report (+)[9] found that fewer than half of women reported no violence 1 year after being referred to a MARAC, and women reported valuing the support from multiple agencies. A cross-sectional and qualitative study (+)[7] found that the majority of respondents perceived the MARAC they were involved with to be either ‘very effective’ or ‘fairly effective’ in improving outcomes for people who have experienced domestic violence; and performance monitoring data suggest that the average repeated abuse rate in a 1-year period was 22%, although the authors caution that the quality of these data is a concern. A before-and-after and qualitative study (+)[10] found that a specialised domestic violence unit including collaboration between police officers and advocates for people who have experienced domestic violence performed significantly better than a comparison district in rates of arrests, prosecutions and convictions for domestic violence. In addition, people who have experienced domestic violence perceived their experience with the domestic violence unit positively and reported improved safety; and prosecutors, judges and domestic violence unit personnel reported that the collaboration improved their response to people who have experienced domestic violence.

There is evidence from 1 qualitative study (+)[11] examining the Dyn project, an advocacy service for gay, bisexual, transgender and heterosexual men who

have experienced domestic violence. It found that gay men who have experienced domestic violence were less likely to report their experiences as abusive but more willing to use Dyn services than heterosexual men who have experienced domestic violence; and that 3 out of 4 men interviewed reported that the Dyn services helped reduce violence or threat of violence, and all reported satisfaction with services received.

[1] Banks et al. 2008a

[2] Bennett and O'Brien 2010

[3] Coll et al. 2010

[4] Ernst and Smith 2012

[5] Penhale et al. 2007

[6] Robinson 2006a

[7] Steel et al. 2011

[8] Robinson 2003

[9] Robinson and Tregidga 2007

[10] Whetstone 2001

[11] Robinson and Rowlands 2006

Evidence statement 31 Effectiveness of partnerships for increasing interagency information sharing and policy development

There is moderate evidence from 9 studies (1 before-and-after study [+][1]; 3 cross-sectional study and qualitative evaluation [+][2],[4,5]; 1 cross-sectional study [+][3];; 4 qualitative studies, all [+][6,7,8,9]) that partnership approaches have been effective in improving relationships, practices and policies of partner agencies to address domestic violence.

Five quantitative and mixed methods studies provide evidence on the effectiveness of partnerships for improving relationships, policies and

practices to address domestic violence. A before-and-after study (+)[1] examining collaboration between child welfare and domestic violence agencies found that stakeholders reported improved collaboration, staff training, introduction of written guidelines, and sharing of agency resources. A cross-sectional study and qualitative evaluation (+)[2] of a multi-agency approach to protect vulnerable adults from abuse based on 'No Secrets' and 'In Safe Hands' found that stakeholders perceived partnership working as effective in developing new ideas and improving policy making and implementation. But they disagreed on the effect of partnerships on creating unrealistic expectations among partners, benefiting providers over consumers of services, and the status of partner agencies. A cross-sectional study (+)[3] evaluating the Women's Safety Unit (WSU), which offers a central point for a range of support services for people who have experienced domestic violence and their children, reported the following successes: developing protocols with the police and Crown Prosecution Service, improving court procedures for domestic violence, providing domestic violence training, developing relationships and providing support to prosecutors on domestic violence cases, and collaborating with the police and other agencies in receiving and providing referrals. A cross-sectional and qualitative study (+)[4] evaluating a sample of MARAC case outputs found that key informants saw the main outputs as information sharing and the identification of key agency contacts. A cross-sectional and qualitative study (+)[5] examining the experiences of a national sample of MARAC members reported that their MARAC was effective, particularly in improving information sharing, agency representation and the involvement of the independent domestic violence adviser services in representing people who have experienced domestic violence. The majority of survey respondents reported that their MARAC was familiar with and followed the CAADA principles for effective MARAC, and quality assurance data revealed that some principles (information sharing and administration) were more consistently followed than others (action planning).

One qualitative study (+)[6] found that coordinating councils were effective at improving knowledge of other partner members and relationships and facilitating institutional change (including creating new procedures, protocols

and policies). An evaluation (+)[7] of a partnership between voluntary and criminal service sectors to offer support services to people who have experienced domestic violence with a partner attending a domestic abuse court revealed that the partnership was regarded as having strong relationships, partner commitment, and effective advocacy for people who have experienced domestic violence and the court. A study (+)[8] evaluating the Dyn project, an advocacy service for gay, bisexual, transgender and heterosexual men who have experienced domestic violence reported improvements in information-sharing, knowledge of the needs and availability of services for men who have experienced domestic violence. Finally, 1 study (+)[9] found that a multi-agency model of service delivery for children, young people and mothers who experience violence was beneficial in improving knowledge, awareness, and communication of staff and partner agencies.

[1] Banks et al. 2008a

[2] Penhale et al. 2007

[3] Robinson, 2003

[4] Robinson, 2006a

[5] Steel et al. 2011

[6] Allen et al. 2008

[7] Robinson, 2006b

[8] Robinson and Rowlands, 2006

[9] Sharp and Jones, 2011

Evidence statement 32 Enabling factors to partnership working

There is moderate evidence from 6 studies (1 cross-sectional study [+][1]; 1 before-and-after and qualitative study [+][2]; 1 cross-sectional and qualitative study [+][3]; 1 qualitative report [+][4]; 2 qualitative studies, both [+][5,6]) that various enabling factors, such as leadership and management, active membership, community involvement, strong relationships and

communication, training and resources, are associated with effective partnership working.

Three quantitative and mixed methods studies provide information on enabling factors to partnership working. A cross-sectional study (+)[1] found that domestic violence coordinating councils were more likely to be rated as effective by council members if they had efficient and inclusive leadership and a diverse breadth of active membership. Conflict resolution, breadth of formal membership and presence of formal structures were not significantly related to perceived effectiveness. A before-and-after and qualitative study (+)[2] found that several themes emerged as important for the success of the Greenbook initiative to address the co-occurrence of domestic violence and child maltreatment, including: institutional empathy, effective leadership, reaching out to the community, needs assessment, and the maintenance of collaborative relationships. Several factors were also rated as important facilitators to collaboration, including (scored in decreasing importance): partners having the needs of women and children in mind, involvement of key agencies and groups, having the right people at the table, strong leadership, and commitment of key leaders. At follow-up, stakeholders were significantly less likely to agree that the involvement of key agencies and groups was a facilitator. A cross-sectional and qualitative study (+)[3] examining the experiences of a national sample of MARAC members reported key factors to support effective practices, including: strong partnership links, strong leadership facilitated by the MARAC chair, good coordination from the MARAC coordinator, and the presence of training and induction.

Three qualitative studies also provide evidence on enabling factors for partnerships to address domestic violence. A qualitative report (+)[4], examining 2 multi-agency partnerships for addressing domestic violence, revealed that strong developmental factors (including strong multi-agency working relationships; strong domestic violence infrastructure; processes for development, management, and monitoring of the new initiative; and manageable size and scope of the new initiative) contributed to more effective multi-agency working relationships and the capacity to manage issues related

to power, communication and resources during the operational phase. A qualitative study (+)[5] examining a working group to improve collaboration between domestic violence and mental health service sectors revealed the following facilitators to collaboration: commitments that build trust and have a shared sense of purpose; relationship building; developing 'institutional empathy'; and fair leadership and neutrality by the research team (team leading the project). Finally, a qualitative study (+)[6] reported the following factors associated with the success of a community-government collaborative workgroup that aimed to improving income support services for people who have experienced intimate partner violence: leadership by the host department; willingness to be measured risk takers; small group size and strong group composition; provision of resources and focus on departmental policy issues; trust, respect, open communication, and equity within the group; and purposeful consideration of responsiveness and feasibility.

[1] Allen, 2005

[2] Banks et al. 2008b

[3] Steel et al. 2011

[4] Donovan et al. 2010

[5] Laing et al. 2012

[6] Woodford, 2010

Evidence statement 33 Barriers to partnership working

There is moderate evidence from 9 studies (A before-and-after study [+][1]; 1 before-and-after and qualitative study [+][2]; 4 cross-sectional and qualitative studies, all [+][3,4,5,6]; 1 cross-sectional study [+][7]; 2 qualitative studies, both [+][8,9]) regarding the barriers and challenges to effective partnership working, including: lack of resources (financial and human), differences in the culture of agencies and organisations, leadership and management issues, lack of commitment, limited monitoring, and addressing diverse populations.

Seven quantitative and mixed methods studies provide evidence on barriers and challenges to partnerships to address domestic violence. A before-and-after study (+)[1] examining a collaboration between child welfare and domestic violence agencies found that stakeholders reported inconsistent use of screening tools for domestic violence, along with confidentiality issues among multi-disciplinary case review teams. A before-and-after and qualitative study (+)[2], examining the Greenbook initiative to address the co-occurrence of domestic violence and child maltreatment, found that over time respondents were less likely to cite accessibility of data as an obstacle but more likely to agree that lack of resources, burnout of participants, conflicting organisational cultures, lack of leadership buy-in, and lack of accountability were obstacles to success. A cross-sectional and qualitative study (+)[3] of a multi-agency approach to protect vulnerable adults from abuse based on 'No Secrets' and 'In Safe Hands' guidance noted the following challenges: lack of resources, lack of specific legislation to protect vulnerable adults, a concern that some agencies view the guidance as optional, and ambiguous commitment from agencies at local levels. A cross-sectional study (+)[7] evaluated the Women's Safety Unit (WSU), which offers a central point for a range of support services for people who have experienced domestic violence and their children, and noted the need for further work to address 'hidden' populations, including: women who have experienced sexual abuse by an intimate partner; women from minority ethnic groups and women who have sex with women and men who have sex with men. A cross-sectional and qualitative study (+)[4] evaluating a sample of MARAC case outputs found that key informants reported concerns about administrative responsibilities and cooperation with people who have experienced domestic violence. A cross-sectional and qualitative study (+)[5] evaluating police notifications of child protection services in cases of domestic violence where a child was present revealed inconsistencies in police reporting, and limited knowledge of the roles and expectations of the other partner agency. The study provides new approaches to improve information sharing. Finally, a cross-sectional and qualitative study (+)[6] examining experiences of a national sample of MARAC members reported the following limitations and areas for improvement: improving clarity regarding the links between MARACs and other multi-agency procedures

working with people who have experienced domestic abuse, developing links with services aimed at responding to perpetrators, monitoring and evaluation of MARACs, verifying that MARACs reflect the community context (specifically, the need for representation from black and minority ethnic agencies and lesbian, gay, bisexual and transgender agencies), and providing ongoing local and national training.

There is also evidence from 2 qualitative studies regarding barriers to partnership approaches to domestic violence. One study (+)[8] found that self-interest as a motivation for participation, leadership and dominance of the process by law enforcement, organisational ambiguity, and an absence of key players were challenges to the effectiveness of a multi-level collaborative public-private partnership to address domestic violence. Finally, a study (+)[9] evaluating a collaborative intervention for children and young people who have experienced violence reported the need for to clarify the roles and expectations of partner agencies and to include diverse co-facilitators.

[1] Banks et al. 2008a

[2] Banks et al. 2008b

[3] Penhale et al. 2007

[4] Robinson 2006a

[5] Stanley et al. 2011

[6] Steel et al. 2011

[7] Robinson 2003

[8] Giacomazzi and Smithey 2001

[9] Sharp and Jones 2011

Expert reports

Report 1: Current health and social care interventions on domestic violence.

Report 2: Men as perpetrators and victims.

Report 3: Honour-based violence and forced marriage.

Report 4: Broken Rainbow (UK) National LGBT domestic violence service.

Report 5: Elder abuse.

Review of economic evaluation

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

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

Economic modelling

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

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

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

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

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

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

10 Gaps in the evidence

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

1. There is a lack of research on:

    a) 'honour'-based violence or forced marriage

    b) Interventions to prevent elder abuse

    c) lesbian, gay, bisexual and transgender experiences of domestic violence and abuse

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

    e) dating violence and intimate partner violence among adolescents

    f) tailored approaches for women facing different levels of risk

    g) whole-family interventions in response to domestic violence.

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

3. There is a lack of evidence on prevention interventions due to methodological issues including: short follow up, lack of comparisons of different interventions, lack of behavioural measures and reliance on self-reporting. In addition, most studies measured attitudes and knowledge, or exposure to educational materials and messages, rather than behavioural outcomes. Many included women who were already using refuge or shelter services, so the findings may not be applicable to those who are not using them.

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

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

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

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

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

Programme Development Group

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

Zlakha Ahmed Chief Executive, Apna Haq Ltd

Rahila Ameen, Integrated Domestic Abuse Programme Facilitator, London Probation Trust

Diana Barran, Chief Executive, Co-ordinated Action Against Domestic Abuse

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

Bushara Bostan, Health Improvement Specialist, NHS Leeds

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

Lori Busch, Charity Manager, The ManKind Initiative

Linda Davies, Domestic Abuse Trainer, Cheshire West and Chester Council

Gene Feder (Chair), Professor of Primary Care, University of Bristol

Chris Green, Executive Director, White Ribbon Campaign

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

Louise Howard, Professor in Women's Mental Health, Kings College London

Davina James-Hanman, Director, Against Violence & Abuse

Jane Lewis, Director of Implementation Support, Colebrooke Centre for Evidence and Implementation

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

Maureen Noble, Independent Consultant – Safeguarding and Public Protection

Federico Podeschi, Chief Executive, Broken Rainbow UK

Pamela Richardson, Chief Executive, Women's Aid Leicestershire Ltd

Amanda Robinson, Senior Lecturer in criminology, Cardiff University

David Sloan, Independent Public Health Consultant

Nicky Stanley, Professor of Social Work, University of Central Lancashire

Karen Williams, Managing Director, Karen Williams Associates

NICE project team

Mike Kelly CPHE Director

Antony Morgan Associate Director

Chris Carmona Lead Analyst

Una Canning Analyst

Charlotte Hayes Analyst

Andrew Hoy Analyst

Jennifer Francis Research Analyst, Social Care Institute for Excellence

Kim Jeong Technical Adviser Health Economics

Victoria Axe Project Manager

Rukshana Begum Coordinator

Sue Jelley Senior Editor

Susie Burlace Editor

12 About this guidance

Why is this guidance being produced?

The Department of Health (DH) asked the National Institute for Health and Care Excellence (NICE) to produce this guidance.

The guidance should be implemented alongside other guidance and regulations (for more details see Implementation and Related NICE guidance respectively).

How was this guidance developed?

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

Members of the PDG are listed in Membership of the Programme Development Group and the NICE project team.

For information on how NICE public health guidance is developed, see the NICE public health guidance process and methods guides.

What evidence is the guidance based on?

The evidence that the PDG considered included:

- Evidence review: Review of interventions to identify, prevent, reduce and respond to domestic violence and abuse was carried out by the British Columbia Centre of Excellence for Women's Health. The principal authors were: Nancy Poole, Lorraine Greaves, Natalie Hemsing, Eliza Seaborn, Renee O'Leary, Rose Schmidt and Tricia Yu.

- Review of economic evaluations and economic modelling: Economic analysis of interventions to reduce the incidence and harm of domestic violence and abuse was carried out by Matrix Evidence. The principal authors were: Jacque Mallender, Meena Venkatachalam, Obina Onwude and Tracey Jhita.

- Expert reports:
  - Report 1: Current health and social care interventions on domestic violence, by Davina James-Hanman
  - Report 2: Men as perpetrators and victims by Thangam Debbonaire
  - Report 3: Honour-based violence and forced marriage, by Hannana Siddiqui
  - Report 4: Broken Rainbow (UK) National LGBT Domestic Violence Service, by Rita Hirani
  - Report 5: Elder abuse, by Gary Fitzgerald
  - Report 6: Sexual health, by Susan Bewley
  - Report 7: Prevention – mass media, by David Gadd
  - Report 8: Prevention – schools, by Hannah Wharf
  - Report 9: Offenders, by Angela Everson and Clare Jones
  - Report 10: Domestic violence services and sex workers, by Catherine Stephens.

In some cases the evidence was insufficient and the PDG has made recommendations for future research.

Status of this guidance

This is draft guidance. The recommendations made in section 1 are provisional and may change after consultation with stakeholders (listed on our website) and fieldwork.

This document does not include all sections that will appear in the final guidance. The stages NICE will follow after consultation (including fieldwork) are summarised below.

- The Group will meet again to consider the comments, reports and any additional evidence that has been submitted.
- After that meeting, the Group will produce a second draft of the guidance.
- The draft guidance will be signed off by the NICE Guidance Executive.

The key dates are:

Closing date for comments: 27 September 2013

Next PDG meeting: 12–13 November 2013.

Implementation

NICE guidance can help:

- Commissioners and providers of NHS services to meet the quality requirements of the DH's Operating framework for 2012/13. It can also help them to deliver against domain 1 of the NHS outcomes framework (preventing people from dying prematurely).

- Local health and wellbeing boards to deliver on their requirements within Healthy lives, healthy people (2010).

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

NICE will develop tools to help organisations put this guidance into practice. Details will be available on our website after the guidance has been issued.

Updating the recommendations

This section will be completed in the final document.