NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

PUBLIC HEALTH GUIDANCE

FINAL SCOPE

1 Guidance title

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

1.1 Short title

Preventing and reducing domestic violence.

2 Background

a) The National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) have been asked by the Department of Health (DH) to develop public health guidance on preventing and reducing domestic violence.

b) The current cross-governmental definition of domestic violence is: ‘any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality’ (Home Office 2005).

c) This first piece of guidance will focus on interventions to identify, prevent, reduce and respond to domestic violence between family members or between people who are (or who have been) intimate partners. It will include intimate relationships between teenagers and abuse of parents by children. Note: the latter two issues are not covered by the definition above, but consultation with experts has highlighted the importance of addressing them.

d) Separate guidance will be produced subsequently to cover other aspects of domestic violence. Topics will include female genital

mutilation (FGM) and how to recognise and support workplace colleagues who are the victims of domestic violence. These pieces of guidance will have separate scopes.

e) This guidance will support a number of related policy initiatives and documents including:

- ‘Call to end violence against women and girls: action plan’ (HM Government 2011).
- ‘Commissioning services for women and children who experience violence or abuse: a guide for health commissioners’ (DH 2011a).
- ‘Call to end violence against women and girls’ (HM Government 2010).
- ‘Improving services for women and child victims of violence: action plan’ (DH 2010).
- ‘Safeguarding adults: The role of health services’ (DH 2011b).

f) This guidance will provide recommendations for good practice based on the best available evidence of effectiveness, including cost effectiveness. It is aimed at commissioners, managers and other professionals working in: the NHS, social care, early years, education (primary, secondary and tertiary), youth services, the police, housing departments and associations, local authorities and the wider public, private, voluntary and community sectors. It may also be of interest to people who are experiencing (or who have experienced) domestic violence, or know someone who may be affected by it.

This guidance will be developed using the NICE public health programme process.

3 The need for guidance

a) An estimated 1.2 million females and 677,000 males aged 16 to 65 in England and Wales (8% and 4% respectively of the population as a whole) were victims of domestic violence in the year 2009/10. At least 29% of women and 16% of men in England and Wales (over 7.3 million adults) have experienced it (Home Office 2011). Domestic violence can be sexual, 'non-physical' – comprising emotional or financial threats, or physical (using 'minor' or 'severe' force). 'Honour' violence and forced marriage are examples of domestic violence that particularly affect black and minority ethnic groups in England (Home Office 2010a). These figures are likely to be an underestimate, as domestic violence is under-reported. Eighty per cent of psychological, physical and sexual abuses are perpetrated by men.

b) In England, 1.6% of older people (aged 66 years and over) reported experiencing abuse (psychological, physical, sexual and financial) in the past year from a family member, close friend or care worker[1] (DH 2007). Forty per cent of the abuse was perpetrated by a partner and 43% by another family member. In the UK, 72% of girls and 51% of boys reported experiencing emotional violence, 31% of girls and 16% of boys reported experiencing sexual violence. In addition, 25% of girls and 18% of boys reported experiencing physical violence in a relationship. One in six girls aged 13 to 17 reported some form of severe domestic violence inflicted on them by a partner (Barter et al. 2009).

c) Since 1995, approximately half of all female murder victims aged 16 or over in England and Wales were killed by their partner or ex-partner. Twelve per cent of male murder victims have been killed by their partner or ex-partner since 1995. In 2009/10 that figure reduced to 5% (21 offences) (Home Office 2011; Thompson 2010).

[1] Please note that the latter two categories of perpetrator are outside of this scope.

d) Factors associated with being a victim of domestic violence include:

- being female
- long-term illness or disability (women and men with a long-term illness or disability were almost twice as likely to experience domestic violence as others)
- use of any recreational drug in the last year
- marital status (married people had the lowest risk, while those who had previously been married had the highest risk)
- age (women in younger age groups, in particular, in those aged 16–24 years are at greatest risk)

(All of the above are from: Home Office 2011.)

- alcohol or drug consumption (partner assaults are four to eight times higher among people seeking treatment for substance-dependence) (Murphy and Ting 2010)
- pregnancy (the greatest risk is for teenage mothers and during the period just after a woman has given birth (Harrykissoon et al. 2002)
- being lesbian, gay, bisexual or transgender (Barter et al. 2009; Browne and Lim 2008; Home Office 2010b).

e) Between 4% and 19.5% of women attending healthcare settings in England and Wales may have experienced domestic violence in the past year. A high proportion of women attending accident and emergency, primary care, family planning, reproductive and sexual health settings are likely to have experienced domestic violence at some point (Alhabib et al. 2010; Feder et al. 2009). In addition, between 30% to 60% of female psychiatric inpatients report experiencing domestic violence in their lifetime (Howard et al. 2010).

f) At least 750,000 children and young people are estimated to be exposed[2] to domestic violence every year in England (DH 2002). Approximately 75% of those living in households where domestic violence occurs are exposed to actual incidents (Royal College of Psychiatrists 2004). Many will be traumatised by what they witness – whether it is the violence itself or the emotional and physical effects the behaviour has on someone else in the household (DH 2009). Domestic violence is also associated with an increased risk of abuse, deaths and serious injury for children and young people (DH 2009). Parents can also be the victims of abuse perpetrated by a child or adolescent, although the proportion affected in England is unknown (Kennair and Mellor 2007).

g) Domestic violence cost the UK an estimated £15.7bn in 2008 (Walby 2009). This included:

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

4 The guidance

Public health guidance will be developed according to NICE processes and methods. For details see section 5.

This document defines exactly what this guidance will (and will not) examine, and what the guidance developers will consider. The scope is based on a referral from the DH (see appendix A).

[2] That is, the violence is not perpetrated on them directly, but they witness, hear or experience the domestic violence or its repercussions.

4.1 Who is the focus?

4.1.1 Groups that will be covered

This guidance will cover:

- adults and young people who are experiencing (or have experienced) domestic violence
- those who are perpetrating domestic violence
- children who are exposed to domestic violence (that is, the violence is not perpetrated on them directly, but they witness or experience it), including those who are taken into care
- the general population (for the purposes of prevention generally).

4.1.2 Groups that will not be covered

- People whose violence is directed at children.
- Paid carers who abuse vulnerable older people[3].
- People who endorse, or carry out, female genital mutilation[4].

4.2 Activities

4.2.1 Activities/measures that will be covered

The guidance will cover interventions and systems that focus on preventing, identifying and responding to domestic violence. This includes supporting survivors and preventing re-offending by perpetrators.

It will focus on the following settings:

- Emergency, primary, secondary and tertiary healthcare.
- Local authority, private, community and voluntary social care.

[3] This group will be covered in future NICE guidance.
[4] This group will be covered in future NICE guidance.

- Specialist domestic violence services including refuges, advocacy, outreach, and crisis support in both the statutory and voluntary sectors.

The guidance will focus on a whole-systems approach to provide a seamless response across the above settings and services. It will also include services which may interface with them, for example, the police, criminal justice, education, early years services and youth services.

4.2.2 Activities/measures that will not be covered

- Interventions and activities that take place outside the settings and services detailed in 4.2.1. (For example, interventions involving the activities of the police, criminal justice, education, early years and youth services that are not linked with health and social care).

- Interventions and activities that focus on the prevention of female genital mutilation.

4.3 Key questions and outcomes

Below are the overarching questions that will be addressed, along with some examples of the outcomes that would be considered as evidence of effectiveness:

Question 1: What types of intervention or approach are effective and cost effective in preventing domestic violence from ever happening in the first place (that is, primary prevention)?

Expected outcomes: Qualitative and quantitative outcomes include: raised awareness of domestic violence, reduced incidence of domestic violence, attitudinal change, knowledge of support services and reporting.

Question 2: What types of intervention or approach are effective and cost effective in helping all those working in health and social care to safely identify and, 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.

Expected outcomes: Qualitative and quantitative outcomes including increased detection of domestic violence and increased reporting of it by/among professionals.

Question 3: What types of intervention or approach are effective and cost effective in helping all those working in health and social care to respond to domestic violence? This may include interventions and approaches to assess and improve someone's safety, reduce the risk of harm, support their recovery and prevent a perpetrator reoffending. It may also include collaborative partnerships and advice and information-sharing protocols.

Expected outcomes:

Quantitative outcomes include: improved referral mechanisms, increased use of services, a reduction in domestic violence, improved health and quality of life outcomes.

Qualitative outcomes include: victims and survivors feeling safe and in control, improvements in their psychological health and respectful and/or improved relationships.

Question 4: What types of intervention and approach are effective and cost effective in identifying and responding to children who are exposed to domestic violence in the various settings identified? (That is, the violence is not perpetrated on them directly but they witness or experience it.) Interventions could include collaborative partnerships and advice and information-sharing protocols.

Expected outcomes:

Quantitative outcomes include: improved behavioural, developmental, educational and mental health outcomes.

Qualitative outcomes for victims and survivors may include: improved self-confidence and better long-term outcomes for children (being healthy, keeping safe, improved school attendance, developing positive behaviours).

Question 5: What are the most effective and cost-effective types of partnership and partnership approaches for assessing and responding to domestic violence?

Expected outcomes: Improved levels of coordination between services, increased numbers of appropriate referrals, comprehensive communication strategies.

4.4 Status of this document

This is the final scope, incorporating comments from a 4-week consultation.

5 Further information

The public health guidance development process and methods are described in 'The NICE public health guidance development process: An overview for stakeholders including public health practitioners, policy makers and the public (second edition, 2009)' and 'Methods for development of NICE public health guidance (second edition, 2009)'.

6 Related NICE guidance

Common mental health disorders. NICE clinical guideline 123 (2011)

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)

Appendix A Referral from the Department of Health

The Department of Health asked NICE and the Social Care Institute for Excellence (SCIE) to:

'Produce public health programme guidance for the police[5], social services and health services on interventions for the prevention and reduction of domestic violence.'

[5] The police will be covered in these pieces of guidance as one of the agencies who work closely with health and social care on domestic violence issues.

Appendix B Potential considerations

It is anticipated that the Programme Development Group (PDG) will consider the following issues:

- Whether the definition of domestic violence used in this scope is appropriate for this guidance
- Whether ‘incidents’ are an appropriate way to measure and respond to domestic violence in health and social care.
- The role of individuals and organisations in healthcare, social care, education, early years services, youth services, housing, local authority, police, criminal justice and specialist settings. Specifically, the action they should take to prevent, reduce or respond to domestic violence, at what level, with whom, how often and for how long.
- Limitations of available evidence and information, both in terms of the under-reporting of domestic violence and in terms of effective interventions for perpetrators.
- The fact that domestic violence cuts across social class, economic status, ethnicity and cultural background and has a social, financial and health impact on victims.
- The needs of specific groups of victims, in particular:
    - people with a long-term illness or disability
    - older people
    - people with a mental health problem
    - pregnant and postnatal women
    - separated women.
    - refugees and asylum seekers
    - young adults (aged up to 24 years)
    - children who experience domestic violence

  - lesbian, gay, bisexual and transgender people.

- The effectiveness and cost effectiveness of different interventions and activities aimed at victims (including children experiencing domestic violence) and perpetrators, and whether this varies according to:
  - the diversity of the population (for example, in terms of age, gender, sexual orientation or ethnicity)
  - the status of the person delivering it and the way it is delivered
  - its frequency, length and duration
  - where it takes place and whether it is transferable to other settings
  - its intensity.

- The impact of the guidance on equity and the extent to which it promotes equality and diversity.

- The perceived barriers to, benefits of, and opportunities for implementing the guidance (including the capacity of the existing workforce).

- Any adverse or unintended effects of interventions or activities.

- The accessibility and acceptability of interventions and approaches for the victims and perpetrators of domestic violence and for those who deliver them.

- The need to cater for everyone at risk (of becoming a victim of violence or perpetrating it), as lower-risk situations often become high risk over time – and it always damages people's health and wellbeing.

Appendix C References

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