Number: **WG26746**

Llywodraeth Cymru
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Consultation Document

A consultation on draft statutory guidance on "Ask and Act" under section 15 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 and section 60 of the Government of Wales Act 2006

Date of issue: **4 November 2015**
Action required: Responses by **27 January 2016**

Overview

Violence against women, domestic abuse and sexual violence are large scale, pervasive problems, which every year causes needless deaths and damage to thousands of lives across Wales.

Whilst the incidence of these issues is high, those who experience violence against women, domestic abuse and sexual violence are known to under report and all current directly reported prevalence figures are likely to be under-estimates.

The experience of violence against women, domestic abuse and sexual violence has serious and negative social impacts on the health of adult victims, with known consequences for mental health, pregnancy, eating disorders, reproductive health and physical wellbeing; it is also linked to homelessness and substance abuse.

Violence against women, domestic abuse and sexual violence can cause physical harm and, in the most serious cases, death. Two women a week are killed by a partner or ex partner and a third of those who experience domestic abuse have considered suicide.

Public services have an important role to play in addressing these issues, by supporting clients and strengthening the services they receive. A more consistent approach to identifying those who experience violence against women, domestic abuse is required across Wales.

The Welsh Government propose the national implementation of a principles based approach to targeted enquiry for violence against women, domestic abuse and sexual violence to increase identification and support for those who experience these issues. The proposal is "Ask and Act" and this document outlines the detail of the approach.

How to respond

This is a written, electronic consultation. Questions are summarised in a questionnaire at the end of this document, please use this questionnaire to provide your feedback. Responses can be e-mailed/posted to the contact details below.

Further information and related documents

Large print, Braille and alternative language versions of this document are available on request.

Contact details

For further information:
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Data protection

How the views and information you give us will be used

Any response you send us will be seen in full by Welsh Government staff dealing with the issues which this consultation is about. It may also be seen by other Welsh Government staff to help them plan future consultations.

The Welsh Government intends to publish a summary of the responses to this document. We may also publish responses in full. Normally, the name and address (or part of the address) of the person or organisation who sent the response are published with the response. This helps to show that the consultation was carried out properly. If you do not want your name or address published, please tell us this in writing when you send your response. We will then blank them out.

Names or addresses we blank out might still get published later, though we do not think this would happen very often. The Freedom of Information Act 2000 and the Environmental Information Regulations 2004 allow the public to ask to see information held by many public bodies, including the Welsh Government. This includes information which has not been published. However, the law also allows us to withhold information in some circumstances. If anyone asks to see information we have withheld, we will have to decide whether to release it or not. If someone has asked for their name and address not to be published, that is an important fact we would take into account. However, there might sometimes be important reasons why we would have to reveal someone's name and address, even though they have asked for them not to be published. We would get in touch with the person and ask their views before we finally decided to reveal the information.

Contents

Executive summary

Violence and abuse in any form is unacceptable. Anyone who experiences violence against women, domestic abuse and sexual violence must be provided with an effective and timely response by relevant authorities.

"Ask and Act" is a process of targeted enquiry to be practiced across the Public Service to identify violence against women, domestic abuse and sexual violence. The term targeted enquiry describes the recognition of indicators of violence against women, domestic abuse and sexual violence as a prompt for a professional to ask their client whether they have been affected by any of these issues.

The aims of "Ask and Act" are:

- to increase identification of those experiencing violence against women, domestic abuse and sexual violence;

- to offer referrals and interventions for those identified which provide specialist support based on the risk and need of the client;

- to begin to create a culture across the Public Service where addressing violence against women, domestic abuse and sexual violence is an accepted area of business and where disclosure is expected supported, accepted and facilitated;

- to improve the response to those who experience violence against women, domestic abuse and sexual violence with other complex needs such as substance misuse and mental health; and

- to pro-actively engage with those who are vulnerable and hidden, at the earliest opportunity, rather than only reactively engaging with those who are in crisis or at imminent risk of serious harm.

"Ask and Act" is one of the most significant practice changes, facilitated through the National Training Framework on violence against women, domestic abuse and sexual violence.

These two Welsh Government policies are integrated, in that local delivery of the National Training Framework also delivers key aspects of "Ask and Act".

The National Institute of Health and Care Excellence (NICE) and the World Health Organisation recommend a system of targeted clinical enquiry across Health and Social Care to better identify and therefore respond to domestic abuse.[1] [2]

The Welsh Government takes this recommendation and identified good practice further by supporting the use of such enquiry across the Public Service (to include those in a safeguarding role, education, Fire and Rescue and those within housing services). It also proposes a slightly wider focus on violence against women, domestic abuse and sexual violence.

It is the role of the entire Public Service to provide an effective response to those experiencing violence against women, domestic abuse and sexual violence. This involves collaboration in its broadest sense to create consistency and standardisation of response, no matter which gateway (housing, health, social care etc.) a client uses to access service provision. Leadership and strategic co-ordination are key in establishing a process which is suitable to the workforce, the organisation and above all, the client.

This guidance provides a detailed process of "Ask and Act" to support implementation. However, the working practices through which to offer a consistent response will, of course, differ depending on organisational structure and client group. **It is not expected that the same process of "Ask and Act" will be implemented by each organisation but each organisation should consider how best to offer "Ask and Act" within their varying functions and professional roles**.

However, one fundamental statement must support every variation of process:

Violence against women, domestic abuse and sexual violence require a Public Service response. Professional confidence to identify these issues, to ask about them and to respond effectively is fundamental for good clinical and social care practice.

Any proposed model of work should be tested against the following four key principles. **No matter how a process of "Ask and Act" is operationalised it should address each of these**.

1. Culture and leadership
2. Clarity and confidence
3. Recognition and response
4. Follow up and monitoring

The diagram below further defines these principles.

The principles of “Ask and Act

Culture and leadership

Aim: A working culture which acknowledges “Ask and Act” as core to the organisational purpose.

Requirements:

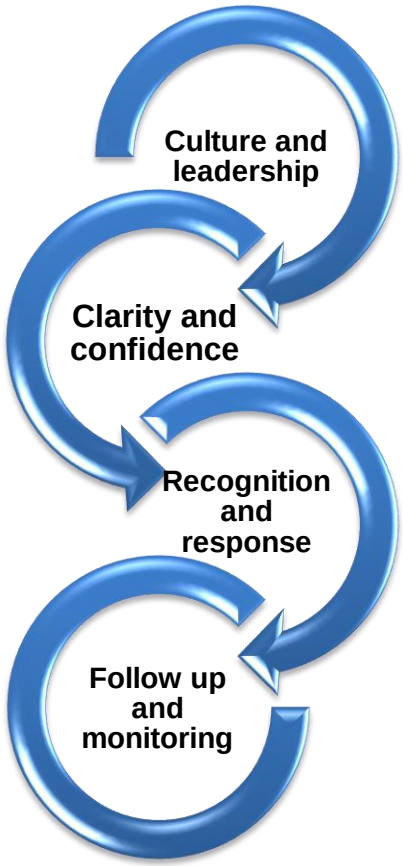
- Identification of leadership and strong management
- Potential barriers to the implementation of “Ask and Act” considered and addressed
- Potential impact to staff recognised and addressed

Clarity and confidence

Aim: A well equipped workforce; confident and accountable, supported by clear policies and procedures.

Requirements:

- Confidentiality and information sharing policies which are fit for purpose
- Clear lines of accountability between staff, management and leaders
- “Relevant” staff identified, trained, with clarity of responsibility



Recognition and response

Aim: An organisationally tailored process involving recognition, targeted enquiry and intervention to those who are experiencing violence against women, domestic abuse and sexual violence.

Requirements:

- Staff aware of the indicators of violence against women, domestic abuse and sexual violence
- A clear internal process which follows recognition and includes targeted enquiry
- A response which ensures efficient, positive intervention for the client
- Partnership and collaborative processes which offer efficient client access to specialist support

Follow up and monitoring

Aim: Strategic oversight and evaluation of a process which maps disclosure to population and uses local data and collaboration to further develop.

Requirements:

- Clear record keeping guidance for disclosure
- The establishment of baseline data from which to monitor disclosure
- Strategic oversight of the process and regular monitoring
- Consideration of process application in relation to equality and diversity

The language used within this guidance

"Ask and Act" is a principles based approach to targeted enquiry for violence against women, domestic abuse and sexual violence.

This should ensure a focus – through delivery - on particular forms of violence and abuse which are disproportionately experienced by women and girls. Evidence shows that women disproportionately experience repeat incidents of domestic abuse, all forms of sexual violence and other forms of violence and abuse such as forced marriage and female genital mutilation.

Whilst it is important that this disproportionate experience is acknowledged and communicated through the implementation and training for "Ask and Act", the purpose of the approach is to ensure that anyone experiencing any form of violence against women, domestic abuse and sexual violence is offered appropriate support and assistance as early in their experience as possible.

References in this guidance to "violence against women, domestic abuse and sexual violence" or "violence and abuse" should therefore be read to capture all forms of violence against women, domestic abuse and sexual violence as defined in section 24 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015.

Some forms of violence and abuse which meet these definitions are experienced within family settings and relationships, including same sex relationships, between family members and by men who are abused by women. As such, the implementation of "Ask and Act" should acknowledge the disproportionate impact of these forms of violence and abuse on women but be inclusive of all potential victims.

The implementation of "Ask and Act" requires a nuanced approach which provides for effective responses to women and men, accounts for their different experiences and properly addresses their needs.

This guidance refers to the relevant authorities named under the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015. The term Public Service is also used both for ease of reading and to demonstrate the broad implementation potential of "Ask and Act". Definitions of both terms are provided in the definitions section of this guidance.

The term "Health and Social Care" is also used within this guidance. Use of this term is limited to references to pre-existing guidance or research relating specifically and only to these sectors.

The purpose of this guidance

This guidance is written for leaders and practitioners working across the Public Service who will have responsibility for the implementation, management and practice related to “Ask and Ask”.

The term “Ask and Act” is used to describe a process of targeted enquiry for use across the Public Service related to violence against women, domestic abuse and sexual violence.

The guidance provides information on the types of activities which should be undertaken to support robust implementation of “Ask and Act”, including the required training, welfare and support and monitoring. It also provides a step by step process which outlines the key considerations required when practicing “Ask and Act” including setting, client confidentiality and asking sensitive questions.

The Welsh Government acknowledge the processes through which to ensure the requirements set out in this guidance will vary and can be arranged in various ways, involving different structures and staff roles. The Welsh Government wish to promote flexibility in applying a process of “Ask and Act” to allow relevant authorities to utilise existing skill sets, structures and partnerships in its development, whilst ensuring confident staff are equipped and ready to identify violence against women, domestic abuse and sexual violence, know how to respond and are supported to do so within each organisation.

This document is split into five parts:

1. an introduction;

2. guidance issued under section 15 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015;

3. a summary of the aims and evidence base for this policy (the rationale);

4. guidance to Public Service leaders; and

5. process models and practical guidance to support the implementation of targeted enquiry across the Public Service.

The case for change – why implement "Ask and Act"?

Asking patients about abuse in some specialised health care settings is considered good practice by professionals in those fields[3]. The National Institute of Health and Care Excellence (NICE) and the World Health Organisation[4] recommend a system of targeted (or clinical) enquiry across health and social care to better identify and therefore respond to domestic abuse.

The Welsh Government takes this recommendation and identified good practice further by supporting the use of such enquiry across the Public Service (to include those in safeguarding roles, Fire and Rescue Authorities, education and housing services). It also proposes a wider focus on violence against women, domestic abuse and sexual violence.

This approach has been taken in consultation with specialist service providers on the basis that where a general question is asked about someone's experience of abuse it may lead to a disclosure of several forms of abuse. It is expected these forms of abuse could include:

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

The aims of "Ask and Act"

- increase identification of those experiencing violence against women, domestic abuse and sexual violence;

- offer referrals and interventions for those identified which provide specialist support based on the risk and need of the client;

- begin to create a culture across the Public Service where the experience of violence against women, domestic abuse and sexual violence is an accepted area of business and where disclosure is supported, accepted and facilitated;

- improve the response to those who experience violence against women, domestic abuse and sexual violence with other complex needs such as substance misuse and mental health; and

- pro-actively engage with those who are vulnerable and hidden, at the earliest opportunity, rather than only re-actively engaging with those who are in crisis or at imminent risk of serious harm.

These aims are explored further below:

Increasing identification of those experiencing violence against women, domestic abuse and sexual violence

The majority of research into the effectiveness of types of screening for violence against women, domestic abuse and sexual violence has focussed on healthcare settings and primarily relate to domestic abuse. Although there is less data available outside of health, similar, innovative projects indicate the effectiveness of such an approach across the Public Service.[5]

Where routine enquiry takes place a greater proportion of abused women are identified by healthcare professionals than where screening does not take place, although not necessarily more than would be identified by clinical enquiry.[6] Enquiry typically results in a doubling of identification rates of domestic abuse and it increases referrals to outside agencies.[7]

Where specialist training and support for the clinician is provided to use a low threshold for clinical enquiry, primary health care clinicians are three times more likely to secure a disclosure of domestic violence than those where no enquiry is made.[8]

Where information about a client is provided or gathered by a professional, which "cues" them to investigate issues of domestic abuse, this improves rates of identification and disclosures of domestic abuse.[9]

Enquiry for domestic abuse in pregnancy, when supported by staff training and organisational support, improves screening practices and documentation of domestic abuse.

Offering referrals and interventions for those identified which provide specialist support based on the risk and need of the client

Professionals who are not trained to identify violence against women, domestic abuse and sexual violence may overlook, mislabel and misdiagnose people's problems, leading to inappropriate plans or ineffective remedies.[10] [11] Where the primary issue for seeking treatment is identified as violence against women, domestic abuse and sexual violence, the services offered can relate to this primary issue, rather than the symptoms caused by it.

Referrals to external resources (e.g. police, specialist services and social care) increase as a result of enquiry and this presents an opportunity for advocacy intervention, a strategy linked to decreased violence and isolation, increased safety practices and a cost benefit.[12] The evaluation of the IRIS project (Identification and Referral to Improve Safety) found individuals in the intervention were 22 times more likely to be referred to advocacy services than those in general practices which did not receive the programme.

Studies which have measured rates of domestic abuse as outcomes detect a reduction of physical and non-physical abuse with counselling and advocacy support for women identified in antenatal clinics.[13]

The Independent Domestic Violence Advisor (IDVA) advocacy model (in use across Wales) as a service for those at high risk of serious harm due to their experience of domestic abuse has been found to be effective in improving the lives of those who have been abused and in terms of value for money.[14]

The IDVA forms a crucial element of the Multi Agency Risk Assessment Conference (MARAC) approach which is also well evidenced as an effective means of addressing high risk domestic abuse. The majority of adult victims who engage with these services report improved safety and wellbeing outcomes after receiving support, including a cessation of abuse, feeling safer and an improved quality of life.

- 63% of the victims who engage with IDVAs report a total cessation of abuse at case closure.

- For every £1 spent on MARACs and IDVAs, at least £2.90 of public money can be saved annually on direct costs to agencies such as the police and health services.[15]

Beginning to create a culture across the Public Service where the experience of violence against women, domestic abuse and sexual violence is an accepted area of business and where disclosure is supported, accepted and facilitated

Being asked about abuse can go some way to remove the shame and stigma some associate with the experience. Those who have experienced violence against women, domestic abuse and sexual violence also see being asked as a means of increasing knowledge, developing a sense of self-validation and getting support.[16]

Adopting a clear process of targeted enquiry can remove this sense of stigma by demonstrating the service has an awareness of violence against women, domestic abuse and sexual violence and showing professionals are open to having these discussions as part of routine areas of work which can be a conduit for specialist services.

Research into the acceptability of targeted enquiry has focussed on the experience of women; the majority of whom are in favour of a process of enquiry about domestic abuse in maternity settings, provided it is conducted in a safe confidential environment.[17]

Improving the response to those who experience violence against women, domestic abuse and sexual violence with other complex needs such as substance misuse and mental health

The co-occurrence of domestic abuse, mental health and substance misuse has been referred to as the "toxic trio". Where a parent experiences the three issues they are viewed as indicators of increased risk of harm to children and young people. The combined experience of these issues by a parent can create a "toxic" care giving environment.

Providing and selecting services for these three issues when experienced in combination or as part of a dual diagnosis is challenging for practitioners and can hamper client engagement. Practice based reports emphasise the importance of addressing each issue separately and utilising the expertise of each related profession but also of providing treatment or services in partnership to acknowledge the complexity of the clients situation. In order to do this effectively, each issue must first be identified.

The risk of developing depression, post-traumatic stress disorder (PTSD), substance misuse issues or becoming suicidal is 3 to 5 times higher for women who have experienced violence in their relationships compared to those who [have] not.[18] 70% of women psychiatric in-patients and 80% of those in secure settings have histories of physical or sexual abuse and child sexual abuse is associated with an increased rate of mental disorders in adulthood for men and women. [19] [20]

Whilst substance misuse by either perpetrator or victims of violence against women, domestic abuse and sexual violence is not a causative factor, the two issues do frequently co-occur; requiring knowledge and identification by the professional. 44% of domestic violence offenders are under the influence of alcohol and 12% are affected by drugs when they commit acts of physical violence. A number of studies have found the perpetrators' use of alcohol, particularly heavy drinking, is likely to result in more serious injury to their partners than if they had been sober.[21] [22] Moreover two thirds of those experiencing abuse began misusing substances following this experience.[23]

At least half of all women in touch with mental health services have experienced violence and abuse, despite guidance to the contrary, women are rarely asked about their experience of violence or sexual abuse.[24]

Screening protocols for domestic abuse within screening/entry assessment for alcohol or substance misuse have been found to improve rates of identification of the issue.[25] The Wales In-Depth Integrated Substance Misuse Assessment Toolkit (WIISMAT) includes indirect and direct questions on violence and abuse and encourages use of the Live Fear Free helpline. However, it should be noted, use of WIISMAT is not fully mandated and is not always applied in its entirety.

Undertaking a risk assessment is part of the Mental Health Measure guidance to support developing a care and treatment plan.[26] Asking about violence forms part of all risk assessments in Mental Health services in England and Wales, however this relates to all forms of violence, not violence against women, domestic abuse and sexual violence specifically. Currently this would be explored as appropriate if people admitted to a history or thoughts of violence.

Pro-actively engaging with those who are vulnerable and hidden, at the earliest opportunity, rather than only reactively engaging with those who are in crisis or at imminent risk of serious harm

Early identification and prevention may also help stop violence against women, domestic abuse and sexual violence from escalating and, therefore, reduce future support and criminal justice costs.

Evidence suggests an improved response through non-criminal justice agencies identifies a client group who are not engaging with other services and are therefore hidden from other agencies.[27]

Evidence collected from specialist services which have been situated in acute or maternal health services indicates there is a group of clients, experiencing domestic abuse who make fewer reports to the police than other victims but who attend emergency health services regularly[28].

In identifying violence against women, domestic abuse and sexual violence through health and co-locating hospital based specialists within clinical settings, a more vulnerable group of younger victims are being identified. These clients are experiencing higher severity abuse with additional complex needs, e.g. substance misuse, mental health issues. They tend to still be in a relationship or living with the perpetrator and have been in relationships for shorter periods of time than the client group who access community based services.[29]

In many settings, co-location of violence against women, domestic abuse and sexual violence specialists is not realistic. In those settings, it is essential to have explicit referral protocols between clinicians and these specialists, often based in third sector organisations.

Earlier identification of these issues, through non-traditional methods of engagement, can facilitate an awareness of service availability at the earliest opportunity and safeguard vulnerable people immediately, rather than just at the point of crisis.

Guidance issued under section 15 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015

This section of the guidance is issued under section 15 of the Act. The majority of the guidance is issued to all relevant authorities as defined in section 14 of the Act[1]. Where the guidance is only to apply to a single, or a particular number of relevant authorities, specific reference is made. Where no reference is made, all relevant authorities must adhere to this guidance.

In accordance with section 17 of the Act relevant authorities, or particular relevant authorities to which specific requirements in this section of the guidance are addressed, must follow the course set out in this section of the guidance.

A relevant authority is not however required to follow this section of the guidance if:

- It thinks there is a good reason for it not to follow the guidance in particular categories of case or at all,
- it decides on an alternative policy for the exercise of its functions in respect of the subject matter of the guidance, and
- a policy statement issued by the authority in accordance with section 18 of the Act is in effect.

Section 18 of the Act provides that the policy statement issued by a relevant authority must set out how the relevant authority proposes that functions should be exercised differently from the course set out in this section of the guidance and the authority's reasons for proposing that different course. The policy statement must be published and a copy sent to the Welsh Ministers.

Section 19 of the Act enables the Welsh Ministers to direct relevant authorities to take any action which the Welsh Ministers consider appropriate for the purpose of securing exercise of functions by the authority in accordance with this section of the guidance where the Welsh Ministers consider that the authority's alternative policy (in whole or in part) is not likely to contribute to the pursuit of the purpose of the Act[2].

Nothing in this guidance is to be taken to require a relevant authority or any person to provide, request, record or disclose information, if disclosure of that information is prohibited by law.

Requirement to submit an Information Sharing Protocol

Relevant authorities must prepare and submit to the Welsh Ministers an Information Sharing Protocol in relation to "Ask and Act".

Relevant authorities can achieve this by:

[1] Local Authorities (defined in section 24(1) as councils of a county or county borough in Wales), Local Health Boards, fire and rescue authorities and NHS trusts.

[2] The purpose of the Act is defined in section 1 of the act as: to improve – (a) arrangements for the prevention of violence against women, domestic abuse and sexual violence; (b) arrangements for the protection of victims of violence against women, domestic abuse and sexual violence; and (c) support for people affected by violence against women, domestic abuse and sexual violence.

- preparing and submitting a WASPI assured Confidentiality and Information Sharing protocol in relation to “Ask and Act”; or
- preparing and submitting an Information Sharing Protocol developed by themselves (“local Information Sharing Protocol”).

The WASPI assured Confidentiality and Information Sharing protocol and the local Information Sharing Protocol must (as a minimum), in relation to “ask and act”:

- contain provisions regarding client or patient confidentiality”;
- contain references to the relevant legislation relating to data protection;
- identify when it may be appropriate for persons to share personal and sensitive data relating to individuals under “Ask and Act”;
- provide guidance on recording information including:
  - what information should be recorded;
  - how such information should be recorded;
  - where such information should be recorded; and
  - where such information should be stored.

A person should not share, request, record or disclose information under an Information Sharing Protocol if disclosure of that information is prohibited by law.

“Ask and Act” “lead”

A relevant officer of the relevant authority must be appointed (from within the relevant authority) as the “Ask and Act” lead.

A relevant officer of a relevant authority is listed in the table below:

Relevant authority	**Relevant officer**
Local Health Board	An officer at Band 7 or above
Local Authority	An officer at Grade 11 or above
Fire and Rescue	TBC
NHS Trusts	An officer at Band 7 or above

The “Ask and Act” lead must be a member of the local operational partnership or board relating to violence against women, domestic abuse and sexual violence.

The “Ask and Act” lead is responsible for leading and co-ordinating the implementation of “Ask and Act” within the relevant authority.

The “Ask and Act” lead must (as a minimum):

- develop the “Ask and Act” workplace policy for the relevant authority (in partnership with relevant internal partners)[3];

[3] See **Planning** – point e

- communicate to the relevant authority's staff how "Ask and Act" will be implemented within the authority;

- co-ordinate the training provision for "Ask and Act" within the relevant authority;

- ensure the relevant authority's staff be informed about the potential barriers to the implementation of "Ask and Act";

- address the potential impact to staff of receiving a disclosure of violence against women, domestic abuse and sexual violence;

- ensure the relevant authority's staff are supported to overcome potential barriers to the implementation of "Ask and Act";[4]

- collect feedback from staff regarding "Ask and Act";

- collect and process data in relation to the impact of "Ask and Act"; and

- present to the local operational partnership or board relating to violence against women, domestic abuse and sexual violence the progress of the implementation of "Ask and Act".

  The "Ask and Act" lead must (as a minimum) present:

  - a summary of any staff feedback received;
  - the impact that their authority's "Ask and Act" policy has had;
  - "Ask and Act" training that is available to staff and how successful the training has been; and
  - anything, within the relevant authority that is not complying with "Ask and Act".

Point of Contact

The relevant authority must appoint an officer to be a point of contact for "Ask and Act". The point of contact must (as a minimum):

- enable staff of the authority to contact them regarding "Ask and Act"; and

- consider and respond to any queries from staff of the authority regarding "Ask and Act".

The point of contact can be the "Ask and Act" lead.

Staff Training

The relevant authority must provide training to staff members in accordance with the requirements for group 2 and 3 of the National Training Framework as outlined in the

[4] See appendix 2

guidance issued under section 15 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act on the National Training Framework on violence against women, domestic abuse and sexual violence.

"Ask and Act" Referral Protocol[5]

The relevant authority must have an "Ask and Act" referral protocol.

The "Ask and Act" referral protocol must be followed by all officers of the relevant authority when a disclosure of experience of violence against women has been made.

The "Ask and Act" referral protocol must refer to service level agreements with partner agencies which can offer specialist services in relation to violence against women, domestic abuse and sexual violence.

The "Ask and Act" referral protocol must comply with the Information Sharing Protocol.

Requirement to submit an "Ask and Act" workplace policy

Relevant authorities must have and submit to the Welsh Ministers an "Ask and Act" workplace policy.

The workplace policy must (as a minimum):

- contain the aims of "Ask and Act" as laid out on page 16;
- state which local operational partnership or board relating to violence against women, domestic abuse and sexual violence the "Ask and Act" lead will report the progress of the "Ask and Act" implementation to.
- have a section which refers to the support available to staff in relation to "Ask and Act". The section must (as a minimum):
-
    - outline "Ask and Act" training that is available to staff members under the NTF Guidance;
    - state who the point of contact is in the authority, how staff should contact the point of contact and in what circumstances the point of contact may be contacted;
    - outline the relevant authority's "Ask and Act" referral protocol; and

[5] See **Planning** – point f

    - outline any further provisions that the relevant authority has made in order for staff to be supported in relation to “Ask and Act” implementation.

- Clarify how statutory safeguarding children and vulnerable adults processes will align to the process of “Ask and Act” to be adopted locally.

- outline how data regarding the impact of “Ask and Act” will be collected and processed.

The “Ask and Act” Workplace Policy must not require a person to provide, request, record or disclose information if disclosure of that information is prohibited by any enactment or other rule of law.

Implementation of “Ask and Act” – planning stages for leaders, co-ordinators and managers

Implementation

The introduction to this guidance sets out the reasons why the Welsh Government are pursuing a policy of 'Ask and Act' and the aims in doing so. This section sets out the stages which need to take place to implement Ask and Act.

Although many organisations already have practice underway which is similar to "Ask and Act", the implementation of this work within the relevant authorities will present significant practice change on a large scale. As such, prior to rollout a significant amount of planning is required to ensure the organisation is prepared and aware of "Ask and Act" and its implications

Implementation of "Ask and Act" requires four phases of work:

1) Phase 1: Pre Planning
2) Phase 2: Planning, including the pre-training phase
3) Phase 3: Training
4) Phase 4: Rollout

Throughout rollout the relevant authority should consider alignment of "Ask and Act" with statutory safeguarding processes and address any impact on staff. These phases are summarised in the following diagram and detailed below.

Pre-planning

- "Lead" role for "Ask and Act" appointed
- Steering group established

Planning

- Communication strategy prepared
- Training needs anlaysis undertaken
- Practitioners who will "Ask and Act" selected
- Training plan developed
- Regional training consortia developed
- "Ask and Act policy developed
- Referral protocol agreed
- Information Sharing Protocl developed, ratified and assured
- Basline data established
- Data collection plan developed

Training

- Delivery of Train the trrainer course takes place

Rollout

- Implementation of training plan
- Regional training consortia deliver ongoing "Ask and Act" training
- Staff implementing "Ask and Act" are supported to manage the impact of disclosures
- Safeguarding procedures monitored to ensure alignment
- Impact of "Ask and Act "monitored

Pre-planning

In order to ensure that the planning for implementation of ”Ask and Act” is robust the following structures and individuals need to be in place at an organisational and regional level:

a. organisational - the selection of a “lead” for the work.

Each relevant authority must select a “lead” for “Ask and Act” within the organisation. Relevant authorities have flexibility over who this lead will be although they must be of a suitable level of seniority within the organisation. Suitable leads are likely to be those who already have a lead for safeguarding (such as head of any of the safeguarding teams, domestic abuse co-ordinators or regional co-ordinators). The work should be overseen and “held” by a senior manager such as the Director of Social Services or the lead for Women and Child Health.

The “lead” will have responsibility for establishing “Ask and Act” within their organisation and co-ordinating the actions outlined below.

Whilst each relevant authority should have a lead in place, it is important that all organisational leads working within a region are co-ordinated. The training for “Ask and Act” (further outlined below) will be delivered regionally and therefore regional co-ordination is important.

Learning from the pilots

In the ABMU Health Board the work was led by the Named Nurse for Safeguarding and the Lead for Adult Safeguarding.

In the South East Wales Local Authorities this work was led by the Regional Adviser.

b. Regional - The establishment of a steering group to lead and oversee implementation of “Ask and Act”.

The steering group should work on a regional basis to share learning between relevant authorities and to ensure that the training programme is included within their oversight. It should bring together those with responsibility for delivering “Ask and Act” within the relevant authorities and those accountable for compliance with this guidance.

The steering group should be integrated with local governance arrangements to ensure strong communication, robust leadership and an embedded approach. Via the lead for “Ask and Act”, the steering group should feed into local governance measures, aligned to multi agency collaboration arrangements, as outlined in the Welsh Government statutory guidance on Multi Agency Collaboration. Relevant boards are likely to include the Regional Safeguarding Board but relevant authorities have flexibility to select appropriate boards locally.

Planning

a. Communication

Organisational wide implementation of “Ask and Act” should transform the response to those experiencing or at risk of all forms of violence against women, domestic abuse and sexual violence.

A communication plan for “Ask and Act” should be drafted early in the planning phase to ensure timely communication which outlines the purpose of this practice change and the plan to implement. This will be crucial in ensuring that both staff and leadership are engaged in the work and feel prepared for implementation.

The communication plan should include strategic and leadership engagement, include relevant boards and partnerships in addition to staff wide bulletins. Workforce development, HR and learning and development teams should be included in such planning at the earliest possible stage as these teams tend to control the systems and processes through which other training is shared.

b. A local training needs assessment based around the requirements of each group within the National Training Framework.

The training needs assessment in relation to “Ask and Act” should consider whether any existing training, which meets the requirements of groups 2 and 3 of the National Training Framework on violence against women, domestic abuse and sexual violence has been delivered within the relevant authorities in the past two years and formally record those professionals who are already trained to the requirements of groups 2 and 3. The analysis should also consider the professional roles suitable for the training and the numbers of these roles within the Relevant Authority.

The Welsh Government encourages careful consideration of professionals within the following groups for prioritisation for “Ask and Act”.

Local Health Board
Midwifery and Health Visiting General Practitioners and primary care teams Emergency Department Substance misuse Mental Health District and community nursing Ambulance Service School nursing
Local Authority
Safeguarding Safeguarding in Education Housing, Housing options and Homelessness officers Youth Offending Team

Fire and Rescue Authority
All firefighters with community based responsibilities

In order to select the professional roles most suitable to “Ask and Act” the Relevant Authority should consider how the role meets the following selection criteria:

The professional works:

- In a public facing role, coming into contact with patients/clients in which either an assessment is made and/or care is delivered and which provides an opportunity to “ask”.

  This may be one off contact or as part of an ongoing relationship with a client/patient.

and;

- In a role where the client group is likely to have experienced a form of violence against women, domestic abuse and sexual violence.

  This experience complicates and impacts on the nature of the client’s engagement with the service offered in that role.

or;

- In a setting or location which is reason alone to “Ask and Act” (midwifery, mental health, child maltreatment)

The following matrix was developed in one of the pilot sites to apply these criteria in practice

Learning from the pilots

Matrix developed with ABMU Health Board and used following prioritisation of sites for pilot, by each team lead to plot roles within their teams against the criteria for “Ask and Act”

Key:

Group 1 training requirement (Awareness)

Group 2 training requirement (Ask and Act)

Group 2 at Managers discretion

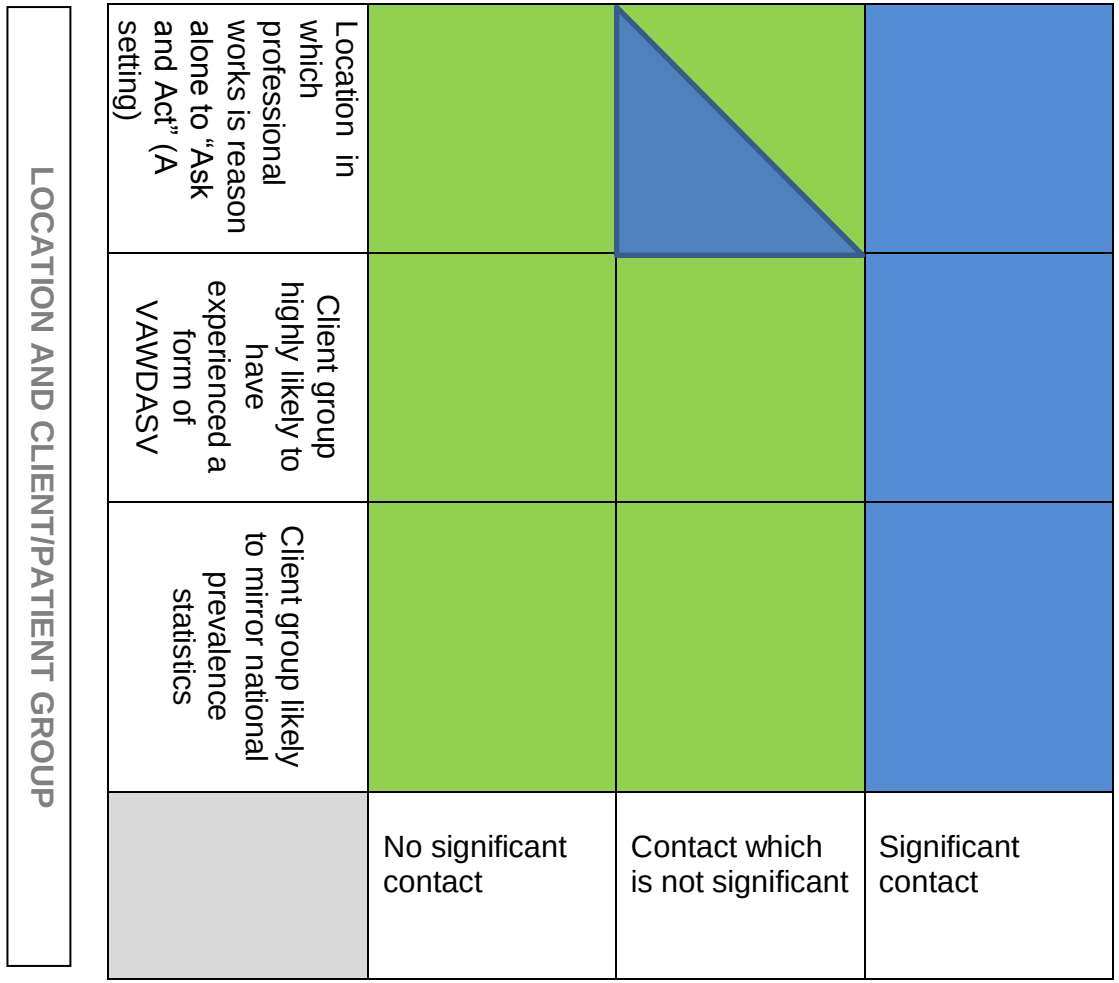
Significant Contact:

An incident of professional contact with a patient/client in which an assessment and/or care is delivered and which provides an opportunity to “ask”.

This may be one off contact or as part of an ongoing relationship with a client/patient.

Evidence Setting:

Based on research relating to screening and enquiry for forms of violence against women, domestic abuse and sexual violence.



These criteria are provided as it is not possible to provide an exhaustive list of professionals who should be able to "Ask and Act", nor is it possible to train such a large group of professionals in a short period time.

The criteria and its application will enable relevant authorities to consider where they would like to prioritise training for "Ask and Act" whilst planning longer term to meet the training needs of a broader group of professionals.

Relevant authorities, as employers of these professionals, should ensure they are:

- adequately trained (through the National Training Framework);
- supported to implement "Ask and Act" in an empathic and safe way; and
- able to ensure practice is monitored to promote the client's safety and wellbeing as central to all work.

c. An organisational training plan which outlines how the groups of professionals within each site will be trained and the timeframe in which this will happen.

This plan should form part of the wider regional training plan required as part of the Statutory Guidance on the National Training Framework on violence against women, domestic abuse and sexual violence.

This plan should set out how the training needs identified through the training needs assessment will be met. The plan should be drafted over a five year forecast, although annual review and detail will be required.

The plan should also include an assessment of capacity through which to meet the training need and this should include consideration of the training consortia membership required to meet the need.

Regional training consortia are required by the Statutory Guidance on the National Training Framework on violence against women, domestic abuse and sexual violence to deliver training for groups 2 and 3. This is the training for "Ask and Act". Depending on the training plan for the coming year the relevant authorities will need to nominate representatives for the regional training consortia and ensure they have undertaken the required accredited Train the Trainer course. For further information see **training.**

d. Convene a regional training consortia based upon local training priorities and the professionals prioritised for training through the training plan.

The training model for "Ask and Act" is a "train the trainer" model; a regional training consortia will roll out a nationally developed training programme to colleagues. The training roll out will be supported by a central provider.

Calls for nomination of local professionals, who are representative of region, specialist knowledge and audience will be issued. These nominated professionals will be trained on the Train the Trainer programme which will cover the key

messages of the “Ask and Act” training and support and skills training on how to deliver these messages regionally.

This approach allow regions and organisations to take a flexible approach to training local professionals whilst addressing the needs of the targeted priority audiences.

Opportunity will be provided for membership of the consortia to be refreshed on an annual basis. This will ensure capacity remains sufficient to meet training demand and that membership of the consortia is adjusted to the needs of the audience. It is expected that the organisational training plans will prioritise audiences over a five year forecast period and that refreshment of the consortia memberships allows representatives of the audiences prioritised for any particular year to be included in the consortia on an ongoing basis.

e. An “Ask and Act” policy which outlines the approach to be undertaken within the relevant authority and can be submitted to the Welsh Government to evidence compliance with this Guidance.

The “Ask and Act” policy should set out the approach the relevant authority will take to “Ask and Act”. It must evidence each of the requirements outlined above (see **guidance issued under section 15 of the Violence against Women, Domestic Abuse and Sexual Violence Act (2015**) and offer clarity to both employees and the Welsh Ministers about how the approach is to be implemented.

The “Ask and Act” policy should include:

f. An agreed and simply presented referral protocol which clarifies the referral options for those who disclose the experience of any form of violence against women, domestic abuse and sexual violence.

The policy should involve formal arrangements with local and national specialist service providers who can offer expert support to those who disclose abuse. The protocol should be simply presented and include minimum action on behalf of the Relevant Authority employee.

Whilst for some clients this support will require statutory services provided through the Local Authority (see **Aligning “Ask and Act” with statutory safeguarding processes)**, it should also include support and advice provided through a specialist service.

The majority of specialist support services are based in the third sector and this is also where most of the expertise on violence against women, domestic abuse and sexual violence sits. An effective Public Service response to violence against women, domestic abuse and sexual violence through “Ask and Act” will therefore need partnership and collaborative working with the third sector. They offer clients access to expertise, provide options where statutory thresholds are not met, widen capacity for support and offers choice to the client group.

In order to offer such services to clients it is important that referral protocols are established between the relevant authorities and the specialist violence against

women, domestic abuse and sexual violence sector. These protocols should be formal and based on a service level agreement. The referral protocol should also be simple to ensure it is easy to follow. Ideally relevant authority staff should only have to undertake one action (such as phoning a number or completing on short referral form) to "Act".

There may be a variety of local services available in an area and, therefore, a variety of options to offer the client. In such cases it may be appropriate to establish a referral protocol with one organisation who disseminates referrals to other partner organisations based on their specific needs and choices.

In most cases a local referral protocol is preferential to a national protocol as it utilises local expertise, is more likely to mean face to face contact for a client and improves local working relationships and multi agency work. However, relevant authorities should also consider establishing a national protocol with the Live Fear Free helpline to ensure that where a local protocol cannot be followed (due to the operating hours of the service, risk thresholds or capacity) an option can always be provided to the client.[6]

A list of the types of services most often available for referral is provided below. This list is not exhaustive and local service provision will differ.

Floating support

Domestic violence service providers have developed a range of services to reach out and offer support and help to women whether or not they are staying in refuge accommodation. Floating support is a specific type of outreach service which is designed to support women who wish to remain in their own homes (regardless of the type of tenancy they have), or who are in emergency or other temporary accommodation.

Independent Domestic Violence Advisors

The main purpose of independent domestic violence advisors (IDVA) is to address the safety of victims at **high risk** of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients **from the point of crisis** to assess the level of risk, discuss the range of suitable options and develop safety plans.

They are **pro-active** in implementing the plans, which address immediate safety, including practical steps to protect themselves and their children, as well as longer-term solutions. These plans will include actions from the MARAC as well as sanctions and remedies available through the criminal and civil courts, housing options and services available through other organisations. IDVAs support and work over the short- to medium-term to put them on the path to **long-term safety.** They receive specialist accredited training and hold a nationally recognised qualification.

[6] ***www.gov.wales/livefearfree***

Since they work with the highest risk cases, IDVAs are most effective as part of an IDVA service and within a multi-agency framework. The IDVA's role in all multi-agency settings is to keep the client's perspective and safety at the centre of proceedings.

Studies have shown when high risk clients engage with an IDVA, there are **clear and measurable improvements in safety**, including a reduction in the escalation and severity of abuse and a reduction or even cessation in repeat incidents of abuse[30].

Outreach support

Outreach services provide a range of new initiatives including information services in rural areas, and specialist outreach services for women from minority ethnic communities.

Refuge

A refuge is a safe house where those who are experiencing domestic abuse can stay. Refuge addresses (and sometimes telephone numbers) are confidential. There are over 50 refuges and support services in Wales, the majority of which are women only. A small proportion of the available units are accessible to men.

Some refuges are specifically for women from particular ethnic or cultural backgrounds (for example, Black or Asian women). Many refuges have disabled access and staff and volunteers who can assist women and children who have special needs.

Sexual Assault Referral Centre

Sexual Assault Referral Centres provide specially trained, experienced professionals to support and advise men, women, children and young people who have experienced sexual violence. SARCs have been developed in partnership with the police, health and voluntary services.

The SARC often employs **Independent Sexual Violence Advisors (ISVAs)** who can offer specialist support and advocacy to those who have experienced sexual violence from anyone. They offer expertise in the Criminal Justice System and can support those whose perpetrators are prosecuted support through the Court process.

Risk identification and assessment

Risk assessment is a "process of looking at what possible outcomes might be from any identified hazard or threat, using a combination of known information and judgment.[31] This is also referred to as making 'a structured clinical judgment" of the client's situation[32] or "actuarial assessment" and professional judgement.

Risk identification and assessment is a commonly used process in parts of the violence against women, domestic abuse and sexual violence sector. It relates

specifically to the risk of a victim of violence and abuse being subjected to further violence and abuse and the potential severity of that abuse.

The guidance issued under section 15 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 does not require the adoption of a risk identification process or tool within the relevant authorities as part of "Ask and Act". However, such a process is an integral part of existing practice (especially within the domestic abuse field) and, as such, the development of a referral protocol should consider how and when a process of risk assessment can be offered to a client who discloses abuse. It is the choice of the relevant authority whether the process is completed "in house" or whether this forms part of the formal referral protocol agreement (i.e. following referral the partner agency will undertake formal risk assessment).

A Risk Identification Checklist enables identification and recording of commonly recognised risks, rather than a thorough assessment of the client's individual situation. The purpose of the Checklist is to give a consistent and simple tool to practitioners who work with victims in order to help them to begin to identify the risk faced by their client and offer appropriate, relevant services. Professionals who practice "Ask and Act" should be able to use the tool in a skilful way to offer a service based on risk at the earliest opportunity.

Consistent use of a Risk Identification Checklist across a locality increases the likelihood of the victim being responded to appropriately and therefore of addressing the risks they face through the use of common criteria and a common language of risk. The Risk Identification Checklist also forms the referral tool which supports the Multi Agency Risk Assessment Conference (MARAC) process for those at high risk of serious harm as a result of domestic abuse.

Addressing the immediate safety of the client and any risk generated by the disclosure and subsequent involvement of services must be addressed either by the professional to whom the disclosure is made or by appropriate colleagues.

It is important for the client to be offered the opportunity to participate in detailed assessment of the risk posed to them by their abuser. This opportunity should be provided to the client efficiently and immediately if possible, to utilise client engagement most effectively.

Relevant authority leaders should consider whether they plan for their staff teams to incorporate risk identification into their internal process of "Ask and Act" (i.e. the person who undertakes targeted enquiry also completes a Risk Identification Checklist) or to establish a referral protocol to specialist services who can offer this service with accompanying risk management planning.

Options to consider within and to support such protocols should include:

- co-location of services to include specialist professionals within non specialist teams;

- a “champion” or “lead” role within teams who has received enhanced training in violence against women, domestic abuse and sexual violence and has time set aside to support colleagues in risk identification;
- local specialist agencies providing drop in services, clinics or surgeries within Public Service organisations;
- clear referral processes to local specialist services, with outlined expectations of contact parameters (e.g. guaranteed contact attempted within 24 hours); and
- utilisation of the Live Fear Free Helpline – either through providing immediate access to a phone in order to call or arranging for convenient call back to client.

The referral protocol should include age-appropriate options and options which support those who may have difficulties accessing services, or are reluctant to do so. In many cases this will require assertive and pro-active engagement with clients.

g. A WASPI assured Information Sharing Protocol which outlines how sensitive, personal information, obtained through the implementation of “Ask and Act” will be managed and stored.

Submission of the Information Sharing Protocol must also be submitted to the Welsh Ministers under section 15 of the Violence against Women, Domestic Abuse and Sexual Violence Act (2015).

A process of “Ask and Act” will inevitably lead to disclosures of personal and sensitive information and, in turn, a requirement of a professional to decide whether this information should be shared further. These can be challenging decisions, which require an effective and caring individual response, supported by clear referral and interagency protocols, effective leadership, managerial support, and a good understanding of the Data Protection Act 1998.

The managerial requirement in relation to client confidentiality, data protection and information sharing is twofold;

1. creating an environment where the legal framework and decision making requirements are clarified in process, protocol and guidance; and

2. providing “on the spot” management support to those practicing “Ask and Act” and considering individual decisions.

Relevant authorities must process information in accordance with the relevant legal framework. In addition, relevant authorities may wish to consider any sector specific documentation (E.g. the Caldicott guardian principles) which may provide assistance in understanding the legal requirements relating to processing information.

The Wales Accord on the Sharing of Personal Information (WASPI) is a framework designed to facilitate the lawful sharing of personal information. It does this by establishing agreed requirements and mechanisms for the exchange of personal information between all relevant agencies.

The WASPI framework provides two core outputs; a common set of principles and standards under which organisations will share information (known as the Accord), and the creation of Information Sharing Protocols (ISPs) which can be accessed and utilised for specific purposes.

The WASPI framework is compliant with the Information Commissioner's Data Sharing Code of Practice and with other legislative requirements, standards and policies. Significant work has taken place in relation to violence against women, domestic abuse and sexual violence and the framework therefore provides a useful resource for leadership across the public sector.

Those with line management or supervision responsibilities may be called upon to support professional decision making in individual cases. In these cases, the relevant legal requirements must be followed and should be reflected in organisational policy and procedure. Managers and supervisors should be available to support and advise a colleague through a decision making process in accordance with the law, particularly the Data Protection Act 1998.

Organisational policies on data protection, information sharing and confidentiality should be up to date, reflect the relevant legal framework and be reviewed regularly. The requirements of these policies should be communicated clearly to staff to ensure they understand the duty of confidentiality and its limitations. Close liaison with legal and information sharing teams will be required to ensure appropriate processes are in place to manage personal data safely and legally.

j. A baseline data set relating to disclosure of violence against women, domestic abuse and sexual violence within the early adopter sites prior to implementation.

Such a data set will help to understand the current levels of disclosure within the organisation. This data will illustrate where improvement is required and provide a baseline from which the organisation can assess rates of disclosure as a result of "Ask and Act".

The steering group should also seek to establish:

k. A data collection and monitoring plan to collect data through the pilot, to include (wherever possible) the following:

- The number and percentage of client group who were identified as demonstrating an indicator of the experience of violence against women, domestic abuse and sexual violence.

- The number and percentage of client group who were asked if they were experiencing a form of violence against women, domestic abuse and sexual violence.

- The number and percentage of those asked who disclosed the experience.

- The number and percentage of those asked who did not disclose the experience.

- The referral or service outcome for those asked who disclosed the experience.

- The referral or service outcome for those asked who did not disclose the experience.

A process of "Ask and Act" should be evaluated against the aims outlined earlier in this guidance. This will involve monitoring relevant data and reviewing wider outcomes and outputs.

Identification of any issue of violence against women, domestic abuse and sexual violence must result in appropriate interventions and levels of support and, <u>over a longer period of time,</u> decrease further cases of violence and abuse and associated health consequences.

In the immediate term, strengthening the response of frontline professionals within relevant authorities to "Ask and Act" should achieve the following:

- **Increased identification of those experiencing violence against women, domestic abuse and sexual violence.**

  Monitoring considerations

  - ✓ Can baseline data on disclosures of this type be established?
  - ✓ Does each organisation have a suitable case management system through which to record disclosure, count how often indicators are recognised, how often targeted enquiry is implemented and what percentage of questions result in disclosure?

- **Increased referrals and interventions for those identified which provide specialist support based on the risk and need of the client.**

  Monitoring considerations

  - ✓ How is action taken following disclosure recorded
  - ✓ Are referral options taken monitored and how will outcomes for the client be monitored thereafter?
  - ✓ How can local Multi Agency Risk Assessment Conferences (MARAC), and any other local fora, data be used to assess whether referrals into the process are increasing from all Public Sector organisations?

- **A culture across the Public Service where the experience of violence against women, domestic abuse and sexual violence is an accepted area of business and where disclosure is supported, accepted and facilitated.**

  Monitoring considerations

- ✓ Do all local services have a workplace policy on violence against women, domestic abuse and sexual violence?
- ✓ Is anonymised data of disclosures made under these policies being monitored?

- **An improved response to those who experience violence against women, domestic abuse and sexual violence with other complex needs such as substance misuse and mental health.**

  Monitoring considerations

  - ✓ At the point of disclosure is any co-occurrence of violence against women, domestic abuse and sexual violence with substance misuse and mental health issues noted?
  - ✓ Is the engagement of substance misuse and mental health agencies within multi agency fora and referrals from such agencies to fora monitored?

- **Pro-active engagement with those who are vulnerable and hidden, at the earliest opportunity, rather than only reactively engaging with those who are in crisis or at imminent risk of serious harm.**

  Monitoring considerations

  - ✓ Is the length of relationship at point of disclosure being noted?
  - ✓ Is the risk level at point of disclosure being noted?
  - ✓ Is repeat access to service related to violence against women, domestic abuse and sexual violence being monitored?

j. Equality and diversity

The collection of demographic information will also be important to inform future planning.

It is important data related to disclosures is monitored carefully to ensure it is representative of the local population. Consider gaps in disclosure- for example, in relation to minority groups, and implement support measures for the workforce to increase reporting of these issues within identified groups.

Learning from the pilots

The planning section of the work took around six months in both sites.

Training

The Welsh Government will introduce a National Training Framework on violence against women, domestic abuse and sexual violence in the Spring of 2016.

Guidance will be issued under section 15 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act (2015) to assist the relevant authorities to access and fully benefit from the National Training Framework.

Training to support the implementation of "Ask and Act" will be provided to groups 2 and 3 of the National Training Framework.

Group 2 describes the group of professionals who will "Ask and Act". This section of the National Training Framework outlines the learning outcomes and competencies to support the principle of "Ask and Act".

Group 3 of the Framework describes those who are working closely with families experiencing forms of violence against women, domestic abuse and sexual violence in their current job role (but who do not specialise in this area) and those who perform a champion role for their organisation (see appendix 4 for a definition of this role).

Aim

The aim of the two groups is to ensure that a large group of professionals are skilled and confident to "Ask and Act" and that a smaller group of professionals hold enhanced knowledge to support those who will "Ask and Act" around decision making, case reviews and assessment of whole families.

Delivery

"Ask and Act" training will be offered to approximately 35,000 professionals between 2015 and 2020.

Welsh Government funded training will be offered through a regional dissemination model which utilises the skill and expertise of local practitioners and provides a sustainable model for ongoing provision.

A Welsh Government commissioned training programme and package of supporting materials will be procured. The package will contain generic content on core practice related to "Ask and Act" and tailored materials which are audience specific. The commission to create a training programme and package of supporting materials will also include a separate requirement to write and deliver a "Train the Trainer" programme.

Forming the regional training consortia

The regional training consortia should form part of a sustainable model of training which can be embedded in ongoing practice within each relevant authority. It is therefore important that those who form the membership of the regional training

consortia are recruited to criteria and that both the membership and their management are clear as to the commitment they make through such membership.

The following are provided as a good practice example of regional training consortia membership criteria:

1. The prospective trainer has specialist knowledge of domestic abuse, sexual violence or other forms of violence against women gained through practice in this area or;
2. The prospective trainer has a strong working knowledge of the area of work of one of the prioritised audiences and will champion the approach within that profession and;
3. The prospective trainer has experience of training delivery.

All training for "Ask and Act" should be delivered by two trainers; one who represents point one above, the other who represents the second point. At least one of the two should have experience of training delivery.

In order to ensure that those within the regional training consortia deliver training regularly enough to ensure they retain the required knowledge and maintain a level of confidence, it is recommended that members of the training consortia are released from their core duties to deliver "Ask and Act" training between 3 and 6 times per year and that those trained to deliver training to group 3 of the National Training Framework are released to deliver training 5 times per year. It is important that those who manage members of the regional training consortia are aware of this and share the commitment of their staff.

Regional Advisers or local Domestic Abuse co-ordinators will develop and implement regional training plans, staggered over five years through which to reach an agreed number of professionals, organisation training plans should be incorporated into these. Progress and outcomes will be monitored by the Welsh Government, through the National Adviser.

Such an approach is being piloted during 2015-2016. Learning from these pilots will inform future versions of this guidance.

Separate guidance on the National Training Framework has been published by the Welsh Government. Please refer to this for further information on the training on "Ask and Act".[7]

[7] http://gov.wales/consultations/people-and-communities/national-training-framework-on-violence-abuse/?lang=en

Rollout

The implementation of “Ask and Act” will require the delivery of the organisational “Ask and Act” training plan through the regional training consortia. This work should commence shortly after the Train the Trainers course has been delivered to the initial consortia membership.

The training programme should be managed by the lead for the work and monitored through the steering group. It is recommended that workforce development or learning and development teams are engaged from the outset in the planning of the rollout as they will own the processes through which such training can be delivered and can ensure rollout is embedded within organisational systems.

It will often be the case that professionals prioritised for “Ask and Act” training will need sufficient notice of training dates in order to plan attendance and for their managers to monitor capacity within their teams. As such the organisational training plan and potential training dates should be circulated in advance of training roll out and include dates throughout the year. It may also be useful to consider how “Ask and Act” training can be integrated with other related learning and development opportunities such as safeguarding training, development, practice or skills days.

The consortia and regional dissemination models of training allow for flexibility related to delivery. It is recommended that as part of the delivery of the organisation training plan, departments, divisions and teams are permitted the flexibility to either participate within organisation-wide roll out or utilise their own members of staff (trained as part of the regional consortia) to bring the training “in house” and disseminate in a way which best meets the availability and capacity of that team.

Training reach should be monitored quarterly by the steering group to ensure that the commitments of the organisation training plan are met and to adjust delivery plans where necessary.

Monitoring the impact of “Ask and Act”

The implementation of “Ask and Act” should lead to increased identification of those experiencing violence against women, domestic abuse and sexual violence. It should also lead to positive outcomes for those identified, linked to earlier identification, violence prevention, safeguarding, effective referral and risk reduction.

It is important that such outcomes are monitored and that, wherever possible, the client/patients experience forms part of such monitoring. Although in the short term some separate data collection may be required to measure the impact of “Ask and Act” whilst monitoring systems are updated, in the longer term consideration should be given to how the outcomes linked to “Ask and Act” can be integrated into wider outcomes measurement systems such Patient Reported Experience Measures and Patient Reported Outcomes Measures.

Aligning "Ask and Act" with statutory safeguarding processes

Addressing an immediate risk of harm to the adult client

As stated above, all efforts should be exhausted to establish one simple local care pathway to one service to ensure the referral protocol is as simple to follow as possible. However there will be some cases where the referral protocol is superseded by an immediate need to safeguard the person who has disclosed. A client's risk, and that of their children, is also something which must be considered alongside a professional's duty of confidentiality.

Should a client disclose the experience of violence against women, domestic abuse and sexual violence, relevant authority staff will need to consider whether the person who has disclosed is at immediate risk of harm; is there an immediate threat to the life of the person who has disclosed or a strong possibility that they are at risk of serious immediate harm?

Should a professional consider that the information provided to them demonstrates that the client is in immediate danger they should follow their safeguarding procedures. This should involve contacting the police on 999 and initiating child protection/adult safeguarding procedures.

How should "Ask and Act" and statutory processes to safeguard vulnerable adults align?

All staff have an ethical and professional duty of care to act if they:

- witness abuse;
- receive information about abuse, suspected abuse or concerns about the care or treatment of a vulnerable adult; or
- have concerns or suspicions about possible abuse or inappropriate care.

Vulnerable adults have the right to be fully involved throughout the adult protection process and to make decisions about their safety and welfare, unless it has been assessed that they do not have the mental capacity to make any particular decision.

The experience of violence against women, domestic abuse and sexual violence by vulnerable adults.

The experience of violence against women, domestic abuse and sexual violence can become more complex with increased severity of impact when experienced by those with additional vulnerabilities.

Older people with dementia are more likely to experience abuse than older people who do not have this condition.[33] A link between dementia and a higher risk of abuse of older people has been established. It is well accepted that the effect of dementia can render older people more susceptible to exploitation by others and can severely impair their ability to seek help, advocate for themselves or remove

themselves from potentially abusive situations. This vulnerability is further reinforced by the cognitive impairment, depression, behavioural difficulties, social isolation and dependency associated with dementia.

Emerging Domestic Homicide Review (DHR) data indicates an increasing number of older people (aged 60+) are victims of domestic homicide. In 2013/14 there were 20 female and 5 male victims in England and Wales aged 60+, representing 21.3% of all DHR's.

Disability is also known to increase the likelihood of a person experiencing abuse. Disabled women are twice as likely to experience violence and sexual abuse as non-disabled women.[34]

The experience of violence against women, domestic abuse and sexual violence has serious and negative social impacts on the health of adult victims, with known consequences for mental health, pregnancy, eating disorders, reproductive health and physical wellbeing; it is also linked to homelessness and substance abuse.

Vulnerable adults who are also experiencing violence against women, domestic abuse and sexual violence require a multi-agency response to ensure that positive action is taken in providing support for victims whilst at the same time dealing effectively with offenders. This requires alignment and communication between Safeguarding Vulnerable Adults Processes and multi agency processes commonly used for forms of violence against women, domestic abuse and sexual violence (such as Multi Agency Risk Assessment Conferences or Multi Agency Safeguarding Hubs).

Where the person suspected of committing domestic abuse is a vulnerable adult, the Police, whilst leading the criminal investigation, should work in close collaboration with Social Services and other partner agencies including specialist third sector organisations.

The Social Services and Well-being (Wales) Act 2014

The Social Services and Well-being (Wales) Act 2014 strengthens safeguards through the introduction of new duty to report to the local authority someone suspected to be an adult at risk of abuse or neglect. The Act defines children and adults "at risk" and introduces a duty on relevant partners to report suspicions to the local authority.

Safeguarding children

The All Wales Practice Guidance on Safeguarding Children and Young People Affected by Domestic Abuse talks specifically to child protection linked to concerns of direct or witnessed domestic abuse.

The Children Act 1989 imposes a duty on local authorities to safeguard and promote the welfare of children in need by providing a range and level of services appropriate to those children's needs and where they have cause to believe that the child is

suffering, or is at risk of suffering, significant harm, to provide an initial assessment of risk and need.

The Practice Guidance also outlines the four central imperatives of any intervention for children living with domestic abuse:

- protect the child/ren;
- support the non-abusive parent to protect themselves and their child/ren;
- hold the abusive partner accountable for their actions and provide them with opportunities to change; and
- promote resilience in children by nurturing the relationship between the non-abusive partner and the child.

These imperatives should be considered as part of all services' interaction with children and staff should be trained and skilled to provide for these, this includes child protection training to a level commensurate with their role and responsibilities.

Young people in abusive relationships

"Partner violence" has been identified as a significant concern for young people's wellbeing. A substantial number of young people will experience some form of violence from their partner before they reach adulthood.

- Three-quarters of girls in a relationship experience emotional violence;
- a third report sexual violence;
- a quarter experience physical violence;
- Half of boys in a relationship report emotional violence;
- 18 per cent experience physical violence; and
- 16 per cent report sexual violence.[35]

Thus, a substantial number of young people will experience some form of violence from their partner before they reach adulthood and for a significant number of young women, this abuse will be severe.[36]

Young women aged 16 to 24 years are most at risk of being victims of domestic abuse, one in six girls report some form of severe partner violence. Those young women who are under eighteen are legally defined as children and as such fall within the support, care and protection that are provided by local authorities under the Children Act 1989. However, these young women will be in relationships which are likely to be "adult" in nature - they may be in an intimate relationship, they may be mothers and they may be living with their partner. Moreover, research suggests the severity and escalation of the abuse they experience will be severe.[37]

These young people may therefore need coordinated support from a wide range of local agencies. Joint intervention between Children's Social Care and the specialist sector can provide an effective means of addressing the potentially complex needs of the young person and meeting their statutory duty to protect them. This should be

considered when adopting a process of “Ask and Act”. Specifically relevant authorities’ leaders should:

- consider the needs of young people in strategic needs assessments and planning;
- formalise close and effective joint working between the collaborative fora on violence against women, domestic abuse and sexual violence and those which safeguard children;
- include young people’s services in violence against women, domestic abuse and sexual violence based partnerships and forums to include expertise on the behaviour and needs of this separate client group and to engage consideration of wider issues which disproportionately affect young people, such as gangs, sexual exploitation, cyber based abuse and ‘honour’-based violence; and
- ensure referral protocols focussed on violence against women, domestic abuse and sexual violence include services specific to young people.

How should “Ask and Act” and statutory processes to safeguard children align?

The evidence which supports the introduction of “Ask and Act” is based mainly on the experience of adults, rather than children. However there is evidence available which highlights the links between child abuse and parental domestic abuse and which aids understanding of the dynamics of intimate partner abuse occurring in young people’s own relationships.

There are also existing statutory responsibilities relating to risk of harm to children. Any process of “Ask and Act” which is applied to children must be based on existing safeguarding duties, with consideration of the following points:

- Violence against women, domestic abuse and sexual violence are issues which directly affect young people.
- All forms of violence against women, domestic abuse and sexual violence are safeguarding issues which must be treated as such.
- Joint intervention between Children’s Social Care and the specialist violence against women, domestic abuse and sexual violence sector can provide an effective means of addressing the potentially complex needs of the young person and meeting the statutory duty to protect them.

Existing statutory duties related to safeguarding children.

Section 47 of the Children Act 1989 places a duty on local authorities to investigate when they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm. As a result of this they must make an enquiry as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child’s welfare.

The Social Services and Well-being (Wales) Act 2014 strengthens existing safeguarding arrangements for children by placing on relevant partners a new "duty to report" where they have reasonable cause to suspect that a child is at risk. Partners including Health, Police, Probation and youth offending teams will be required to inform the local authority where they have reasonable cause to believe a child to be at risk. The "duty to report" is scheduled to come into force in April 2016. The existing duty under section 47 of the Children's Act will remain.

The Welsh Government has issued statutory guidance[8] to professionals on what to do when they have concerns about a child.

Addressing safeguarding concerns for children.

The suspected abuse of a child must be reported to social services or the police, to investigate suspected abuse in line with statutory guidance. Agencies must not undertake their own internal child protection enquiries, but refer their concerns.

Where a staff member has concerns, but wishes for further advice, this should be available from their own agency or from social services. Any discussion about a child's welfare should be recorded in writing, including a note of the date and time and the people who took part in the discussion. At the end of a discussion, there should be clear and explicit agreement about what actions will be undertaken and by whom. If the decision is that no further action is to be taken, this should also be recorded in writing with the reasons for the decision. Any member of staff with concerns about a child's welfare should document their concerns, whether or not further action is taken.

The need to seek advice should never delay any emergency action needed to protect a child.

These concerns can and should be shared with social services through a referral. While concerns will not necessarily trigger an investigation, they help to build up a picture, along with concerns from other sources, which suggests that a child may be suffering harm. Many local authorities have developed protocols establishing arrangements for conducting initial assessments by local services and defining the circumstances and thresholds under which a child should be referred to social services.

In cases of alleged or suspected abuse by a professional or individual employee, the action should also be guided by the agency's own procedures on professional abuse and whistle blowing.

Referrals should be made to social services as soon as a problem, suspicion or concern about a child becomes apparent, and certainly within 24 hours. Outside office hours, referrals should be made to the social services emergency duty service or the police.

[8] Safeguarding Children: Working Together Under the Children Act 2004 will be replaced by revised guidance issued under Part 7 of the Social Services and Well-being (Wales) Act 2014

Female Genital Mutilation (FGM)

A new mandatory reporting duty for FGM is being introduced via the Serious Crime Act 2015, following a public consultation.

The duty will require regulated health and social care professionals and teachers in England and Wales to report known cases of FGM in under 18-year-olds to the police.

It will come into force on **31 October 2015**.

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

Managing the impact of "Ask and Act" on the workforce

It is well acknowledged working with traumatised people, even if this is sporadic, can impact on those in a "helper" role. This impact is often termed Vicarious Trauma/tisation or compassion fatigue.[38]

Vicarious Trauma describes helper distress arising from emotional stressors at work; it is a transformation in the self of a trauma worker or helper.[39] Central to the experience is the empathic relationship between the professional and client. Over time and cumulatively, professional empathy with another person's experience can blur emotional boundaries and lead to changes in a professionals' own cognitive perspective and belief system.[40] This can lead to feelings of:

- being overwhelmed or exhausted;
- isolation and alienation;
- pessimism and negativity;
- anger and sadness;
- becoming over-involved with a client;
- self-doubt and concerns about competence and guilt; and
- hyper vigilance - an over stimulated sense of threat.

For a period of time these feelings may persist and tend to parallel those of direct trauma.

Some experience of Vicarious Trauma due to work with victims of abuse is inevitable although the symptoms will not always be the same.[41] A number of contributing factors to the development of Vicarious Trauma have been identified:

Organisational	Personal
Lack of resources, time, personnel and overwork	Lack of experience/junior position
Lack of workplace support (peer support, supervision)	Personal trauma history
Professional isolation	Current personal stress
Differing ethos of agencies/culture clashes	Unrealistic expectations of role and 'making good'

Many Public Service workers will already be in roles which increase susceptibility to Vicarious Trauma (Social Workers, Police Officers etc.) and relevant authorities have a responsibility to limit the impact of this difficult work on professionals.

The implementation of a process of "Ask and Act" is likely to lead to more of those in the relevant authorities working with clients who have been open about their experience of violence against women, domestic abuse and sexual violence.

There is no expectation for relevant authorities' employees to develop a specialist working role in relation to violence against women, domestic abuse and sexual violence. However, it is inevitable a disclosed experience of abuse will impact on the working relationship and therefore the professional. As an employer, therefore, relevant authorities' leaders should ensure (if they are yet to implement such practice) a series of mitigating factors to limit the impact of Vicarious Trauma on staff.

As leaders:

- acknowledge Vicarious trauma and make clear the experience is not a sign of poor professional practice;
- ensure less experienced staff have more support;
- formalise a buddy/safety net provision;
- ensure team meetings address the emotional consequences of work, and spend time reviewing particularly difficult cases/processes;
- consider clinical supervision for staff;
- advocate good self-care and maintenance of professional networks; and
- encourage staff to self-assess their levels of stress as part of case management[42]

As employees:

- acknowledge distress, see it as normal, consider further support if it persists;
- review coping strategies/ask for support/obtain supervision;
- review workload;
- take breaks and use leave; and
- ensure time for social activities, relaxation, sleep[43].

The majority of staff who experience Vicarious Trauma will experience factors which are uncomfortable but manageable and which will generally resolve over time.

Active workplace acknowledgment of the potentially distressing nature of the work and provision for those who find it more troubling, can lead to greater awareness of potential for distress and the activation of coping strategies which increase resilience.

Vicarious trauma is not an endpoint or an inevitable negative experience and should not be presented as such within the workplace. Whilst the potential impact of work with troubled, abused and vulnerable people should be acknowledged, where this is managed well, with strong staff support, Vicarious trauma can lead to Vicarious Transformation; a process of transforming vicarious trauma into professional development. Vicarious transformation is a process of active engagement with the negative changes which come about through trauma work and can lead to deepened commitment to work and to vulnerable client groups.[44]

Recognising violence against women, domestic abuse and sexual violence as an issue affecting the workforce

It is important leadership and management teams within the Public Service recognise violence against women, domestic abuse and sexual violence as an issue

affecting the workforce as well as the client group. Each Local Authority, Local Health Board and Fire and Rescue Authority have established workplace policies and procedures for staff who have been affected by violence against women, domestic abuse and sexual violence. These policies should ensure staffs have the opportunity to address issues relating to their own personal experiences, as well as those which may arise after contact with clients and colleagues.

Awareness raising activities and education linked to the National Training Framework should be available to all staff. This should include references to services which can support them as victims, whether these are available internally or externally.

Delivering “Ask and Act” – the role of the frontline practitioner

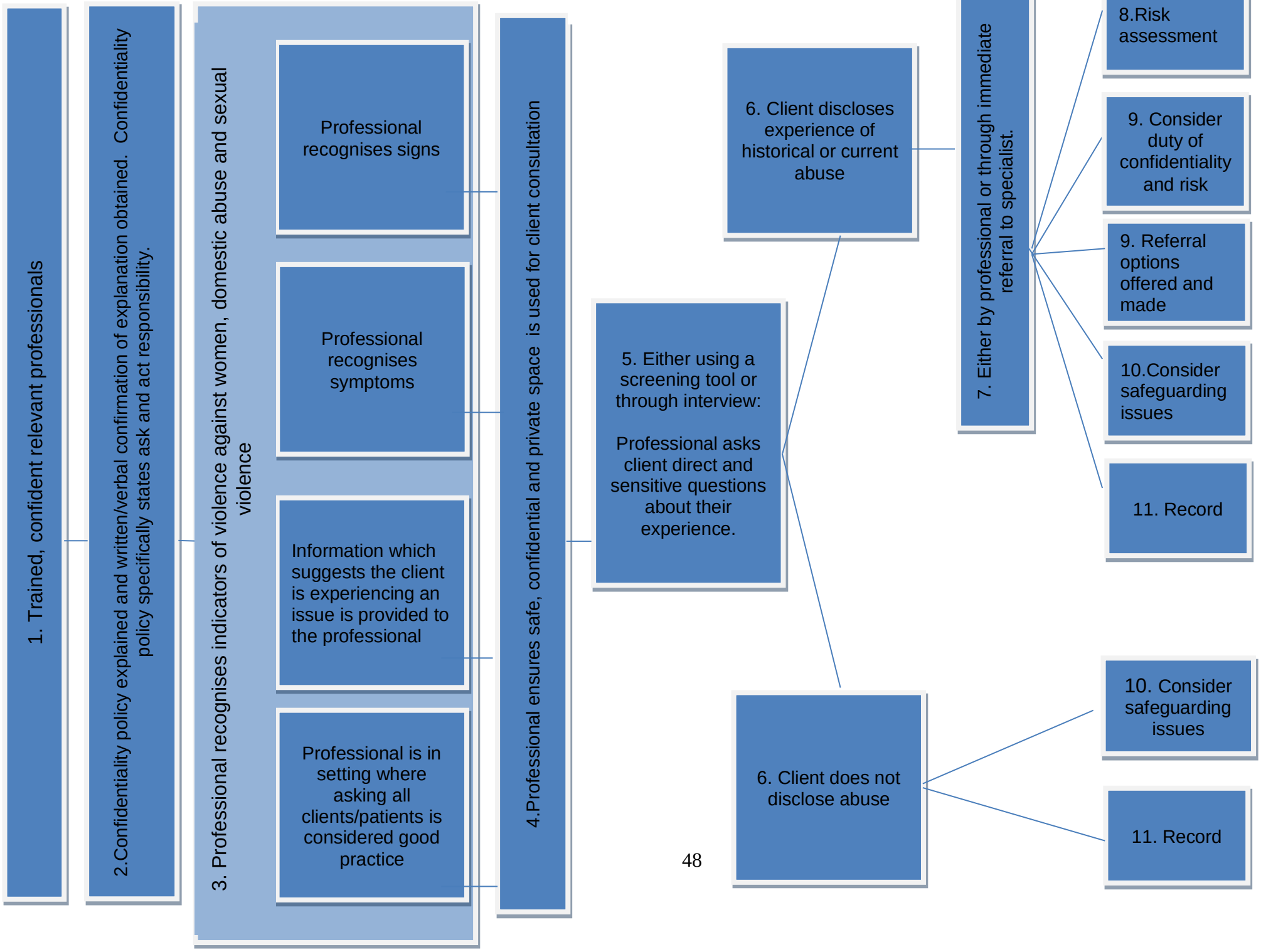
The process

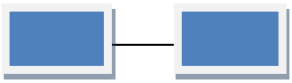
The following section of the guidance provides practice based information for the delivery of “Ask and Act” by frontline practitioners.

This section provides general process implementation advice and specific guidance for professionals. It outlines the fundamental steps related to asking a patient/client about a potential experience of violence and abuse and for taking appropriate action based on their response. Each step includes practice points to support implementation.

As outlined at the beginning of this document, amended processes may be implemented to suit organisational need, utilise partnerships and specialist support. However the process is implemented, each stage here will still require careful consideration.

Ask and Act: A process





1. Trained, confident relevant professionals

To “Ask and Act” requires listening skills, an ability to respond calmly and empathically to a client who may be distressed and a basic knowledge of local services accessed via referral protocols.

For those professions who already work with a client group, where these skills have been taught as part of pre-qualifying education and honed through client relationships, completing the actions required by a process of “Ask and Act” should not differ greatly from those already undertaken as part of their role. These professionals will be expected to practice “Ask and Act” and be prioritised for access to “Ask and Act” training in order to formalise what should already be good practice.

There are other professions within relevant authorities who do not work consistently with a client group and who may find the process of “Ask and Act” new and perhaps intimidating. The process of “Ask and Act” should, however, be simple and evidence suggests undertaking such a process is acceptable to service users.

The “Ask and Act” process is not aimed at those professions who are not in existing client facing roles.

Through a regional training programme delivered through the National Training Framework on violence against women, domestic abuse and sexual violence, there will be an intensive offer of Welsh Government funded “Ask and Act” training between 2016 and2020. Thereafter, it is intended “Ask and Act” training forms an ongoing part of regional training plans to meet locally identified needs, to sustain staff turnover within trained professions and to allow flexibility to meet local and organisational need.

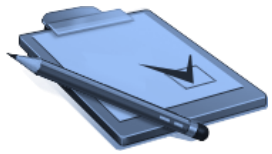
2. The confidentiality policy

Patients and clients have a right to confidentiality, however this right is not absolute and there may come occasions where disclosures are made, as a result of targeted enquiry, where a professional will have to make a judgement about whether to share information and if so, what information to share.

In some cases, such as those where a Local Authority believes a child is likely to suffer harm, and that child lives or proposes to live in the area of another authority, there is a duty on Local Authority to inform the other authority. In other cases, such as where a single adult with no additional vulnerability is potentially at risk, it is not mandatory to share this information.

It is imperative each client is aware of the confidentiality policy of the organisation with which they are engaging and is therefore able to make informed decisions about what information they choose to share with the professional they are working with and have reasonable expectations of how this information will be treated.

Those from minority backgrounds, with diverse needs stress the importance of transparent and clear information on how their personal information will be treated in order to improve their experience of services.[45]



In practice

Confidence to apply local information sharing protocols and specifically, the Data Protection Act 1998 is key in relation to “Ask and Act”.

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

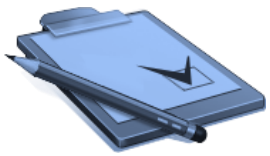
“Ask and Act” is a form of targeted rather than routine enquiry.

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

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

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

It is crucial the process of “Ask and Act” is based on consistent application of known indicators of violence against women, domestic abuse and sexual violence, rather than judgments, personal perspectives or any form of stereotyping. The recognition of known indicators requires the application of informed, open minded discretion on the part of the professional and as such, training to recognise the indicators of abuse and to respond appropriately is vital.



In practice

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

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

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

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

No matter the other characteristics of the client, where one of the four indicators is observed, this is an indicator of the potential experience of violence against women, domestic abuse and sexual violence and the professional should follow the continued stages of the process of “Ask and Act” as outlined below.

The four types of indicator

Signs:

The potential outward and physical signs someone is experiencing violence against women, domestic abuse and sexual violence will be both physical and linked to the demeanour and behaviour of the client. They may include attitudinal change.

Socio cultural signs	Physical signs
Changes in attitude or behaviour: becoming very quiet, anxious, frightened, tearful, aggressive, distracted, depressed etc. Constant accompaniment by partner, even where this seems supportive and attentive Partner exerting unusual amount of control or demands over interactions with service, including constant accompaniment Reliance on partner for decision making-lack of free will and independence Obsession with timekeeping Secretive regarding home life Worried about leaving children at home with partner or family Partner or ex-partner exerting unusual amount of control or demands over clients schedule Social isolation from family/friends	Unexplained injuries Change in the pattern or amount of make-up used Change in the manner of dress: for example, clothes which do not suit the climate which may be used to hide injuries Substance use/misuse Fatigue/sleep disorders

Symptoms:

As the term would indicate it is expected the identification and subsequent enquiry based on symptoms will be rooted within clinical and medical practice. Symptoms which should trigger an enquiry include (this list is not exhaustive):

- Depression
- Anxiety
- Medically unexplained Chronic pain
- Tiredness
- Medically unexplained chronic gastrointestinal symptoms
- Medically unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Gynaecological problems[46]
- Alcohol or other substance use
- Self harm
- Suicide attempts
- Eating disorders
- Medically unexplained genitourinary symptoms, including frequent bladder or kidney infections or other
- Repeated vaginal bleeding and sexually transmitted infections
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis or medically unexplained symptoms
- Intrusive or controlling partner in consultations

Cues:

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

To "Ask and Act" is not to interrogate, but where a cue is observed or received a professional should make appropriate enquiry.

Settings:

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

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

- **Mental health**

The risk of developing depression, post-traumatic stress disorder (PTSD), substance use issues or becoming suicidal is 3 to 5 times higher for women who have experienced violence in their relationships compared to those who [have] not.[47]

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

- **Maternal and post partum settings**

30% of domestic violence starts in pregnancy and is associated with low birth weight and pregnancy complications including miscarriage and still-birth[48] [49].

A process of "Ask and Act", with additional training will further strengthen the existing maternity care pathway which uses an evidence based approach to asking all women about domestic abuse in the antenatal period.

- **Concerns about child maltreatment**

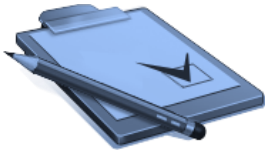
Nearly three quarters of children on the child protection register live in households where domestic violence occurs and 52% of child protection cases involve domestic violence.[50]

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

4. Provision of a safe, confidential and private space for client consultation

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

- the creation of a service which promotes the safety of the client as a priority and provides transparency in relation to confidentiality; and
- the creation of internal processes whereby private spaces can be utilised efficiently to ask required questions in settings which the client deems safe and confidential.



In practice

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

- the environment; and
- their rapport with the client.

Environment

The space you provide in which to ask the client about their experience of violence against women, domestic abuse and sexual violence must be safe. Whether it is safe is down to the judgment of the client. Ensure they feel secure in the space you provide and ask them what would make them feel more comfortable to have the discussion.

Do not broach the subject of the experience of violence against women, domestic abuse and sexual violence if other people are around or if your conversation can be overheard. The client must be completely alone.
Clearly display information in waiting, communal areas and other suitable places about the support on offer for those affected by violence and abuse. This should include contact details of relevant local and national helplines.

Ensure materials are displayed which indicate inclusivity of those clients who may identify as minority or with diverse needs (see **Applying “Ask and Act” to those with additional diverse needs).**

Ensure the information on where to get support is available in a range of formats and locally used languages. The former could include Braille and audio versions and the

use of large font sizes. There may also be more discreet ways of conveying information, for example, by providing pens or key rings with a helpline number.

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

A client is less likely to disclose if their children are present as they may try and protect them from this information, minimise the violence and will be aware their children are being used by a perpetrator to keep a tab on their action.

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

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

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

Rapport

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

Talking about violence against women, domestic abuse and sexual violence can be an emotionally charged event for both the person being abused and the confidante and needs to be handled sensitively.
The professional must appear confident to ask the question. A professional who appears nervous to ask may convey to the client they are not able to deal with the answer.

The professional should be aware of their non verbal communication to ensure they appear “open” to receiving the answer to their question.

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

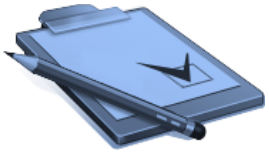
5. Professional asks client direct and sensitive questions about their experience

The questioning style

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

Targeted enquiry typically results in a doubling of identification rates of domestic abuse and it increases referrals to outside agencies.[51] As such it has the potential to provide a positive impact on the lives of many victims of violence against women, domestic abuse and sexual violence and those of their children. The priority of all services engaged with "Ask and Act" should be to address the needs and the safety of these victims.

The majority of those surveyed on this issue are in favour of a process of enquiry about domestic violence, provided it is conducted in a safe, confidential environment.[52] Practice based feedback indicates those who experience violence against women, domestic abuse and sexual violence want professionals to ask them about their experience and it is easier for a client to respond to a direct question than to offer the information up independently.



In practice

It is generally best practice to "ask" in a conversational style, provide full attention to the client and listen carefully to their answers. However, questioning techniques should be adapted to best suit the needs of the professional setting and client group. In some work areas it may be preferential to utilise a screening tool due to time and capacity pressures within this area. If tools are used, these should be brief, yet comprehensive and tested across a diverse population. Partnerships between healthcare providers and local specialist organisations should be solidified in order to provide more comprehensive delivery of policy and practice.[53]

Screening tools should not be confused with risk identification or assessment tools which serve a different purpose than the identification of the issue and provide a subsequent step in a process of "Ask and Act". Please see **Screening tools** for further information on commonly utilised tools for this purpose).

The question

The information below provides guidance for practitioners on how to begin a conversation with a client following an observation of an indicator that they may be experiencing violence against women, domestic abuse and sexual violence.

- explain to the client what you have observed;

- explain to the client you are concerned about what the observation/s you have made could be linked to.

Indirect questions

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

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

> *"I have noticed these signs/symptoms"*
>
> *"I have been provided with this piece of information"*

Which are then followed with an indirect question such as:

> *Are there any problems or reasons which may be contributing to these signs and symptoms?*
>
> *Is there anything going on for you which may be causing these signs and symptoms?*

These questions may prompt disclosures of violence against women, domestic abuse and sexual violence or of other issues requiring support and in such cases provide a gentle, conversation based approach to targeted enquiry.

However, for some clients, such an approach will lack the required clarity for understanding or will not be enough to overcome their personal barriers to disclosure. It is therefore important professionals also follow up indirect questioning with direct questioning where necessary. The professional must be certain they have asked the question required of "Ask and Act" and this question has been understood by the client.

Direct questions

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

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

> *"Abuse at home is very common and can sometimes result in people behaving or feeling the way you have described today. Abuse is a term used to describe a partner or family member hurting or upsetting you - this might mean physically hurting you, it might mean controlling finances or it might mean calling you names or being hurtful through the things they say. It might also mean pushing you to do things you don't want to sexually. Is this happening to you"?*
>
> *Some of the things you have told me today have worried me and I am concerned about what you might be experiencing in your personal life. Is somebody hurting you in any way or are you afraid somebody might hurt you in the future?*
>
> *"Some of the things you have described are indicators a person is suffering harm or abuse by a partner or family member. Is it happening to you"?*

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

Below are some examples of behaviour based questions:

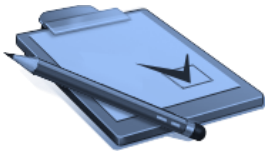
> *Does your partner/ family member(s) get jealous of you seeing friends, talking to other people, going out? If so, what happens?*
>
> *Does your partner/ family member lose their temper with you? If so, what happens as a result?*
>
> *Has anyone in your family threatened to hurt you or make you do anything you don't want to do?*
>
> *Do you feel frightened of anyone in your life?*
>
> *Who makes decisions in your family/about what you can and can't do?*
>
> *Do you have access to your own money and free choice about how to spend it?*

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

Where a client makes some reference to violence against women, domestic abuse and sexual violence or partly acknowledges their experience, it is important the professional does not pressurise them to fully disclose if the client is uncomfortable with this.

6. Dealing with disclosure

The response which is provided by the professional is as important as the question which is asked. This may be the first time the client has disclosed and they are likely be fearful for the implications of doing so. The professional response will be crucial in reassuring the client.



In practice

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

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

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

> *"It takes huge strength to share what you have today"*
>
> "*No-one deserves to be abused. There is no excuse for violence and you deserve better"*
>
> *"I am concerned about your safety and well-being but there are options and resources available to you"*
>
> *"You are not alone"*
>
> *"The abuse / violence is not your fault"*

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

It is also important the professional considers the following:

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

- **Client does not disclose abuse**

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

"Ask and Act" is not an interrogation

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

Do not dismiss your professional judgement

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

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

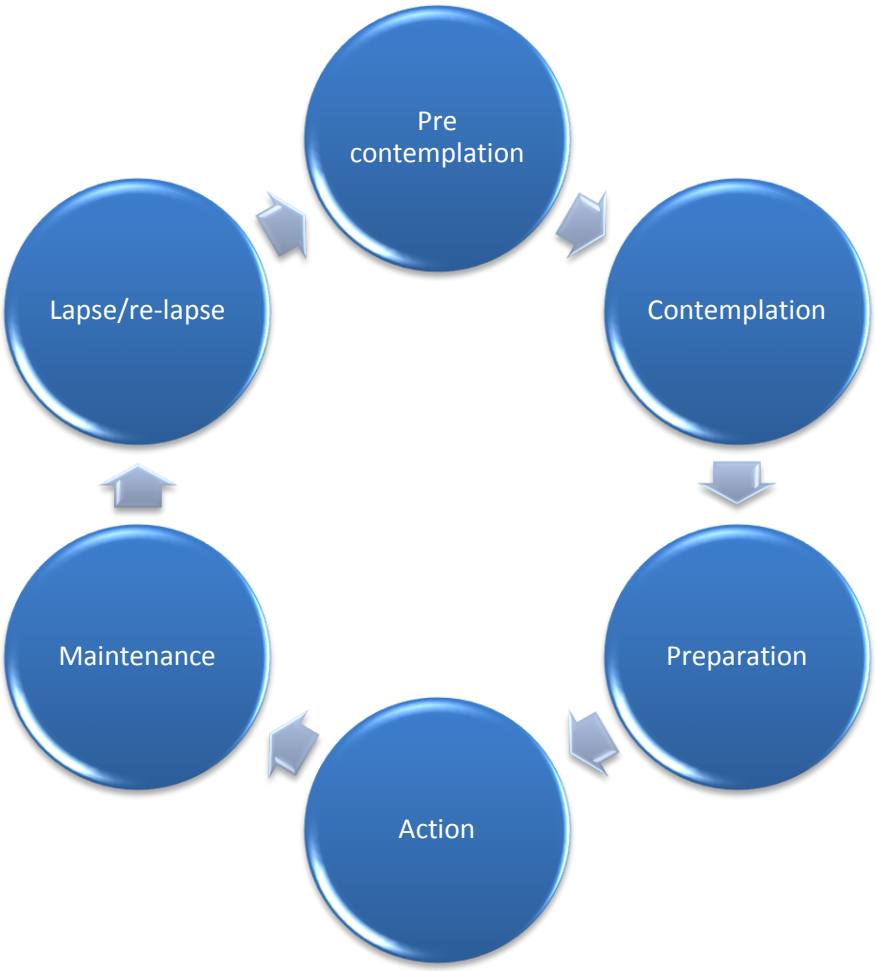
It is important to remember the experience of the client may not relate to violence against women, domestic abuse and sexual violence, but could be a sign of another vulnerability. A follow up question as to whether there is anything else the client would like to share could be effective as will a general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

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

Above all, it is crucial "Ask and Act" is not considered a single intervention. Those who experience violence against women, domestic abuse and sexual violence are often described as moving through **Stages of Change** in their view of their situation.[54] The stages determine how able and ready a client feels to make a change in their life, in relation to violence against women, domestic abuse and

sexual violence this may mean their readiness to recognise their situation, to disclose information or to take action to escape the abuse they are experiencing.

The stages of change



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

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

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

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

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

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

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

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

6. Risk Identification

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

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

For a number of these experiences a process of risk identification has been established. **This process does not identify who is most likely or at risk of experiencing these issues, it is to be used when <u>it is known</u> someone is experiencing these issues**. The risk being assessed relates to particular types of behaviour which are linked to serious harm and death and the escalation of abuse.

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

The Welsh Government training on "Ask and Act" will cover risk identification.

Risk identification tools

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

This tool is known as the DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence) Risk Identification Checklist. It is published by the charity Safelives and was developed in partnership with Laura Richards on behalf of the Association of Chief Police Officers and in consultation with CAFCASS, Respect and independent subject experts.[55]

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

- To help frontline professionals to identify risk in cases of domestic abuse, stalking and 'honour'-based violence.
- To decide which cases should be referred to the Multi Agency Risk Assessment Conference (MARAC) and what other support might be required. A completed

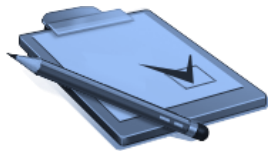
form becomes an active record which can be referred to in future for case management.
- To offer a common tool to agencies which are part of the MARAC process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based abuse.
- To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

In order to build on current good practice, should a process of risk identification be introduced as part of a relevant authorities process of "Ask and Act"it is this tool which should be considered for use..

The DASH Checklist was introduced as a multi agency risk assessment tool in 2009 and **combines a number of pre-existing risk assessment models,** including the integrated tool used by the police.

The Checklist has been designed **for use by both domestic abuse specialists and practitioners working across the Public Service**. The Welsh Government is keen to see consistency of use of an agreed Checklist across Wales.

The DASH Checklist is **evidence based**. The risk factors included are drawn from extensive research by leading academics in the field into domestic homicides and 'near misses'. The research base for each factor can be found in the tool's practice guidance, a link to which is provided in the useful links section of this guidance. The listed indicators can be organised into factors relating to the behaviour and circumstances of the alleged perpetrator(s) and to the circumstances of the victim. Most of the available research evidence, upon which the risk factors are based, is focused on male abusers and female victims in a current or previous intimate relationship. Generally the risk factors refer to the risk of further assault, although some are also linked to the risk of homicide.



In practice

When to use the checklist

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

Someone is a victim of 'current' abuse where there has been any form of abuse (including psychological, financial, sexual and physical abuse) occurring within the last three months. However this is not an absolute; risk can change and each client's situation will differ. Therefore it is essential professionals consider each case based on its own circumstances.

The checklist includes questions about static and dynamic risk factors:

- the static risk factors are those which will not change. For example, if the perpetrator has *ever* threatened to kill the victim or someone else or have they *ever* threatened or attempted suicide.
- the dynamic risk factors, such as pregnancy, financial issues or sexual abuse.

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

Who should the checklist be used with?

The checklist is designed for use with adult victims of domestic abuse, stalking and 'honour'-based violence (those who are over eighteen). A specific, amended form for use with young people is also available.[56]

When using the checklist:

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

Applying the Risk Identification Checklist in practice.

Confidentiality policy of organisation explained

Policy to “Ask and Act” explained

Indicator of abuse identified

Safe space provided

Question asked

Disclosure made

Prior to completing the checklist a professional should establish:

How much time the client has to talk to them.

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

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

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

And:

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

Option 1 – refer for risk identification

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

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

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

Explain service which can be offered through Public Service

Option 2: offer risk identification process “in house”

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

Introduce and explain the Risk Identification Checklist

Ask client if questions on the form can be asked

Go through form

Explain results of form

Consider service options with client

Explain service which can be offered by specialist service

Specialist service provision

Professional judgment and escalation

9 ticks or less*	10 ticks or more	14 ticks or more
Specialist services	IDVA services Specialist services	IDVA and MARAC

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

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

Professional judgment

The practitioner's professional judgment is crucial in all cases; the results from a checklist are not a definitive assessment of risk. The results provide a structure to inform judgment and act as prompts to further questioning, analysis and risk management. The checklist does not demonstrate any scale of risk.[57]

If a professional has serious concerns about a victim's situation, they should refer the case to MARAC and to the Independent Domestic Violence Advisor service attached to MARAC.

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

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

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

Potential escalation: the number of known incidents of abuse experienced by a victim as a result of domestic abuse in the past 12 months. This criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information.

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

Service generated risk

The term "service generated risk" is used in the Caledonian System's Women's Services' Framework for Safety Planning as part of this perpetrator programme in Scotland.[58] The term is used to name the scenario in which systems or practice of professionals creates or increases the perpetrator's risk to the client, or creates additional obstacles for the client.

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

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

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

Explaining risk and confidentiality

A professional should remind their client of their organisation's confidentiality policy prior to completion of the checklist. This will create transparency and clarity for the client about how and when the information they disclose might be used and shared. It can also be useful to explain completion of the checklist will help to understand their situation better and make decisions on the most appropriate services to offer them.

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

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

Explaining the results of risk identification

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

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

Provide your evidence

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

Be clear about the action you will take

It is important you explain what the next steps are to be, i.e. risk management, safety plans, referrals to MARAC and child protection agencies.

Ensure you address the client's immediate safety concerns

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

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

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

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

'Honour' based violence

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

A professional's judgement will be crucial in identifying risks in relation to 'honour'-based violence as many of the questions in the checklist cover wider criminal behaviour which may be absent in these cases. In such cases the score on the checklist is unlikely to meet the actuarial threshold for referral to MARAC despite the situation being gravely serious. In such cases professional judgement should still prompt a referral to MARAC.

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

Stalking

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

In cases where stalking is identified as part of the domestic abuse, this should be taken very seriously. The Checklist guidance also lists additional questions to

consider where stalking is identified and specialist services will utilise additional stalking risk assessment tools upon receipt of referral.

LGBT victims

Lesbian, Gay, Bisexual or Transgender (LGBT) individuals accessing services will have to disclose both their experience of violence against women, domestic abuse and sexual violence and their sexual orientation or gender identity. Creating a safe and accessible environment where victims feel they can do this and by using gender neutral terms such as partner/ex-partner is essential.

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

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

Family violence

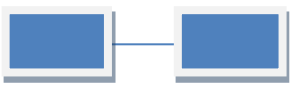
As risk, identified through use of the Risk Identification Checklist, relates to the risk faced by an adult victim, based, in part, on their perception of the risk posed by their abuser, the checklist is suitable for use in cases of adolescent to parent violence where the victim is over 18 (even if the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

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

Young people and children

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

Specific tools are available to understand the risk faced by young people who are the direct victims of abuse within their own relationships or as part of child sexual exploitation. Where a young person is identified as in this situation, their risk should be taken very seriously and specialist services should be alerted immediately.[59]

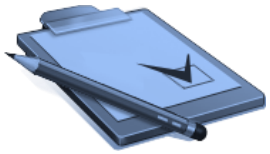


Consider whether risk requires the sharing of client information

Personal and sensitive information related to the client should only be shared with their consent, subject to practice policy on child protection and adult safeguarding. In exceptional circumstances information may be shared without the patient's consent

as ‘consent’ is just one of the methods under the Data Protection Act 1998 by which personal data may be shared. The 1998 Act recognises and allows for situations where data may be legitimately shared where a professional does not have the explicit consent of the client.

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



In practice

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

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

    - The client consents to their information being shared
    - The client does not consent to their information being shared

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

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

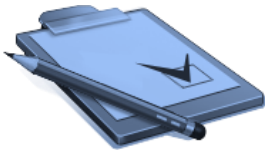
Each of these scenarios will require different considerations and each decision must be based on the detail of the individual case. As required by the guidance issued under section 15 of the Violence against Women, Domestic Abuse and Sexual Violence Act, information shared following the implementation of “Ask and Act” should be compliant with a local Information Sharing Protocol.

Referral options offered and made

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

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

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



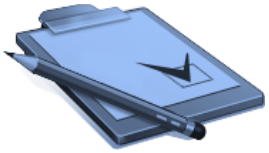
In practice

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

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

Consider safeguarding issues

The experience of forms of violence against women, domestic abuse and sexual violence by adults with additional vulnerabilities such as disability, mental health, substance misuse or age related vulnerability can increase the risk of harm and neglect. Moreover children who live in households where there is domestic abuse are exposed to a significant risk of harm (Working Together under the Children's Act 2004). Section 120 of the Adoption and Children Act 2002 expands the definition of harm in section 31 of the Children Act 1989 (care and supervision orders) to include 'impairment suffered from seeing or hearing the ill treatment of another'.



In practice

Every professional with a responsibility to “Ask and Act” should:

- Understand their role and responsibilities to safeguard and promote the welfare of children and vulnerable adults;
- Be familiar with and follow their organisation’s procedures and protocols for safeguarding and promoting the welfare of children and vulnerable adults and know who to contact in their organisation to express concerns in relation to this;
- Be alert to indicators of abuse and neglect;
- Understand the principles and practice contained in *Safeguarding Children: Working Together under the Children Act 2004;*
- Know when and how to refer any concerns about abuse and neglect to social services or the police;
- Know a child, parent, caregiver, relative or member of the public who expresses concerns about a child’s or vulnerable adult’s welfare to a professional and /or agency employee must never be asked to make a self referral to social services or the police. The professional and/or agency employee must make the referral.

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

This is not a matter for individual choice.
60

Recording

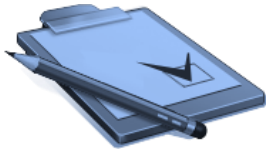
All professionals should record the questions they ask the client and the response accurately in relevant case notes or files. Clients have a general right of access to

their own personal data under the Data Protection Act 1998 so it's vital that the records are relevant and accurate.

These records should be:

- ✓ Concise yet detailed enough for it to be useful to manage and progress the case
- ✓ Legible so others within the team can access them in your absence or in emergencies.
- ✓ Accurate distinguishing between fact and opinion
- ✓ Relevant to your case work[61]

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



In practice

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

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

   The client consents to their information being shared

   The client does not consent to their information being shared

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

Where children are at risk of harm, individual choice is subordinate to safeguarding the child. : If any person has knowledge, concerns or suspicions a child is suffering, has suffered or is likely to be at risk of harm, it is their responsibility to ensure the concerns are referred to social services or the police. It is good practice to gain parental consent to this referral, but a judgement should be made whether this could increase risk to the child. Additional advice can be taken if needed, from either the Health Board or NHS Trust named or designated professionals for child safeguarding, or Local Authority Emergency Duty Teams.

However where children are not involved, or not considered to be at risk, the decision is more complex. in cases such as these, information sharing is not mandatory but is permitted".[62] In these cases a professional will need to make a judgment about whether, and what information can be shared legally, and with

whom. In practice, gaining the client's consent to share information is the simplest route. However it is important to remember:

"It cannot be ethically justified if we hold information that we know could prevent serious harm to others and yet knowingly decide not to share it."[63]

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

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

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

- Seek managerial advice
- Record their decision and their reasons for it
- Make decisions/enquiries about the information to disclose, how and to whom
- Discuss with the client, if appropriate and safe
- Note when and whether the client was informed and reasons why, if not.

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

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

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

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

- The professional should record the assessment of risk and actions on file
- Reassure client of ongoing offer of services.
- Mark/flag the client file to ensure a sensitive, heightened response is provided, should the client return to the service for any purpose.

Applying "Ask and Act" to those with additional diverse needs

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

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

Partnership between specialist and Public Services offers an effective response to minority communities.

Consideration of the diverse needs of a client should not be an "add on" to service provision, nor should assumptions be made as to the experience of any client-each should be treated individually. However in order to ensure the typical considerations required by professionals are set out, this chapter summarises some of the barriers to disclosing an experience of abuse. The content is not exhaustive, nor is their any suggestion the experience of these barriers will be inevitable. It is hoped the observation of them will influence a professional's likelihood to trigger enquiry:

Those at risk of "honour" based abuse[64]

The terms "Honour" or "izzat" relate to issues of family honour, reputations and personal reputations. One could bring shame to one's family through behaviour which is judged by one's family or community to damage reputation.

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

An additional barrier for those who are at risk of "honour" based abuse is fear that professionals will not keep confidentiality or that records will not be kept securely enough to maintain confidentiality.[65]

Black, Asian, Minority Ethnic, Refugee individuals[66]

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

- language barriers - interpretation;
- immigration status and no recourse to public funds;

- racism (either a perception or fear of a racist response or an actual racist response from a service provider);
- cultural beliefs and practices; fear of rejection by their community; and
- mistrust of authorities.

Violence in the country of origin - Asylum-seeking and refugee people may have experienced abuse or violence prior to their arrival in the UK.

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

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

Divorce or separation may seem impossible to contemplate and concern about family “honour” may particularly influence some people from BAMER communities.

Male victims

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

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

Young people at risk of forced marriage

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

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

Older people[67]

Older people may find it particularly difficult to disclose given a traditional notion people should hide their problems, particularly if they involve family members.[68] Some older people will be experiencing abuse by their children for example. This dynamic may make it harder to speak out and ask for help.

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

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

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

Young people

Younger women (aged 16-24 years or under) are most likely to experience physical abuse from an intimate partner.[69]

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

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

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

Lesbian, Gay, Bisexual and Trans individuals

Much of the imagery and public information on violence against women, domestic abuse and sexual violence presents it as a problem of heterosexual relationships; physical violence perpetrated by the bigger, 'stronger' heterosexual man against the

smaller, ‘weaker’ heterosexual woman. LGB and T individuals may be less likely to label themselves as experiencing abuse if they are unable to identify with the characteristics this “public story” presents.[70] Although 80% of respondents to the Scottish Survey of Transgender People’s Experiences of Domestic Abuse identified having experienced some form of abusive behaviour from a partner or ex-partner, only 60% of respondents recognised the behaviour as domestic abuse.[71]

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

Research into the experience of abuse for LGB and T people describes a “gap of trust” between those in same-sex relationships and Public Services. This is typically based on a fear these agencies may be homophobic or transphobic, will not be sympathetic or will not understand the experiences of the client.[72] For some clients, this will arise from previous experience of real or perceived trans or homophobia from service providers. Moreover, some services may appear heterosexist (i.e. they assume all clients are heterosexual) and, as such, inadvertently exclude LGB and T individuals.

In order to disclose the experience of abuse an LGB or T person will be required to ‘out’ themselves to services. This can also lead to concerns around confidentiality if the client is not ‘out’ in every part of their life (e.g. to colleagues or family). This may be information they are not yet prepared to share, or they may fear repercussions if the ‘wrong’ people hear about their sexuality or gender identity.[73]

Trans people commonly describe their gender identity being used as part of their experience of violence against women, domestic abuse and sexual violence. The type of abuse most frequently experienced by trans people is transphobic emotional abuse, with 73% of the respondents experiencing at least one type of transphobic emotionally abusive behaviour from a partner or ex-partner.[74]

Disabled people

Disabled people are more likely to be physically vulnerable than a non-disabled people and less able to remove themselves from an abusive situation.

Disabled women are twice as likely to experience domestic abuse as non-disabled women.[75] They are also likely to experience abuse over a longer period of time and to suffer more severe injuries as a result of the violence.

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

People with learning disabilities

Very little research is available in relation to this client group. However the small scale studies completed to date describe the experience of domestic abuse (specifically) for women involving multiple forms of abuse, much of which is severe. It

describes unique grooming or “softening up” behaviour used by perpetrators against this client group as part of the development of abuse.

Those with learning disabilities may have additional fears and barriers for disclosure associated with fear of being institutionalised or losing their children.[76]

Examples of current practice

Wales will be the first part of the UK to introduce a national process of targeted enquiry across the Public Service. However, smaller scale, similar projects have been running in the UK for some time.

Depending on budget and aim, these projects may provide examples of models for local adoption.

Identification and Referral to Improve Safety- IRIS

IRIS is a General Practice-based domestic violence training, support and referral programme for primary care staff. It is a targeted intervention for female patients aged 16 and above experiencing current or former domestic abuse from a partner, ex-partner or adult family member.

The model rests on one full-time advocate educator working with 25 GP practices. The advocate educator is a specialist worker who is linked to the practices and based in a local, specialist domestic abuse service.

At each practice a lead professional is identified to be the IRIS practice champion. This person is the main point of contact for the advocate educator and can be any member of the practice team and is not limited to one professional.

Practices also utilise an electronic prompt in the medical record called HARKS (Humiliate, Afraid, Rape, Kick and Safety) and is linked to health symptoms of domestic abuse. This pop up is installed centrally via the practice's existing electronic medical record system and provides a practical reminder to ask about abuse, a safety tool based on risk and a mechanism for recording disclosures of abuse.[77]

The Peabody model

Peabody, one of London's oldest and largest housing charities, is leading the way in improving how housing providers respond to domestic abuse. Over the last 5 years it has introduced domestic abuse training for frontline staff, and members of associated trades (for example gas inspectors, maintenance contractors) to raise their awareness of the issue and improve their response. It has also developed a more efficient case management system, strengthened links with local authorities and added two qualified independent domestic abuse advisers to its community safety team.

This work has been driven by analysis of existing provision, improving policy and practice and rolling the approach out to other housing associations and councils. So far, Peabody has trained 552 housing professionals and has seen a notable increase in identification and referrals. Since 2009 on average, a quarter of the Community Safety Team case load has been domestic abuse. Between 2006 and 2009 an average 7 cases of domestic abuse a year were identified within Peabody. Following implementation of the training and support programme an average of 81 cases per year are now identified.

Definitions

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

Act: A term used to describe the process followed by the relevant professional depending on the response of the client to being asked.

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

Ask: A term used to describe the recognition of potential indicators of violence against women, domestic abuse and sexual violence and subsequent enquiry with the client by this professional.

Association (as defined by the Act): A person is associated with another person for the purpose of the definition of "domestic abuse" if they fall within the definition set out in section 21(2) and (3) of the Act.

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

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

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

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

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

"Gender-based Violence"

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

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

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

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

Indicators: For the purposes of this guidance the term indicators is used to describe all of the signs, symptoms, cues or situations through which violence against women, domestic abuse and sexual violence can be identified. In this respect it does not refer to indicators as measurements of performance.

> **Cues:** The presence of some other information which suggest the experience of abuse.
>
> **Signs:** The potential outward and physical signs someone is experiencing domestic abuse.
>
> **Situations:** Such as when there are concerns about child maltreatment or in mental health settings where asking all clients/patients would be considered good practice.
>
> **Symptoms:** Symptoms of abuse or of associated impacts (such as anxiety or depression).

Local Authority: A county or county borough council.

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

The Public Service includes 'devolved public sector workers' in Wales – this includes the devolved civil service, local authorities, health, education authorities, Fire and Rescue and Welsh Government Sponsored Bodies.

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

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

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

Screening tools: A short focussed questionnaire which aids professional identification of the occurrence of violence against women, domestic abuse and sexual violence.

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

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

Screening tools

There are many screening tools for various forms of violence against women, domestic abuse and sexual violence available. These tools have been tested in various settings (primarily clinical settings) and evaluated in various ways.

This chapter lists a small selection of such tools. These have been selected as they are known to be in use within the Public Service or have been subjected to multiple evaluations.[78] Inclusion on this list should not be taken as endorsement or preference by the Welsh Government.

HITS[79] Tool for Intimate Partner Violence Screening:

This tool is a short instrument, designed in the US for "domestic violence screening". It purposeful brevity is such that it can be easily remembered and administered by family physicians. It is a four-item questionnaire which asks respondents how often their partner physically Hurt, Insulted, Threatened with harm, and Screamed at them. These four items make the acronym HITS.

The HITS tool has been evaluated through a two phase study which compared the verbal and physical aggression items of the Conflict Tactics Scale (CTS) with the HITS tool. The conclusion of this evaluation suggests the HITS tool is promising as a domestic violence screening mnemonic for family practice physicians. The HITS tool has been found to also be sensitive and useful in relation to abuse experienced by men.[80]

The tool includes 4 questions: How often does your partner?

1. Physically hurt you
2. Insult or talk down to you
3. Threaten you with harm
4. Scream or curse at you

Those responding to the questions are asked to respond with either "never", "rarely", "sometimes", "fairly often" or " frequently". Each of these responses is scored from 1-5. A score of greater than 10 is considered to be a disclosure of abuse.

The HARK screening tool[81]

The HARK screening tool is commonly used as an electronic prompt within medical records. It is a mnemonic for Humiliate, Afraid, Rape, Kick and Safety and is linked to health symptoms of domestic violence and abuse.

The aim of HARK is to provide a practical reminder to clinicians to ask about domestic violence and abuse, to flag the requirement to any of the behaviours on the patient record, to link to safety and the assessment of immediate risk. One point is given for every yes answer.

The four HARK questions have been found to accurately identify women who have experienced Intimate Partner Violence within in the past year. The most straightforward way of using HARK is as a simple test with a cut off score of 1 or less. A score of 1 has been found to identify 81% of women affected by Intimate Partner Violence. There is an 83% probability a woman with this score has experienced Intimate Partner Violence in the past year and she is 16 times more likely to have been affected by Intimate Partner Violence in the last year than some-one with a score of 0.[82]

The tool contains 4 questions:

HUMILIATION: Within the last year, have you been humiliated or emotionally abused in other ways by your partner or your ex-partner?

AFRAID: Within the last year, have you been afraid of your partner or ex-partner?

RAPE: Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?

KICK: Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner?

The Woman Abuse Screening Tool (WAST)[83]

The eight-item WAST was originally developed for General Practice and has also been tested in emergency care settings. The WAST has been found to have good internal reliability to differentiate the experience of abused and non-abused women.

No fixed scoring is assigned to this tool-relying on professional judgement. However, the tool is often used by asking the first two questions which ask general relationship questions as opposed to specific questions about violence. Where a respondent answers with "a lot of tension" and "great difficulty" to these questions, they should be followed with completion of the remaining questions. The WAST has been found to be a reliable and valid measure of abuse in family practice settings, with both patients and family physicians reporting comfort with it being part of the clinical encounter.[84]

1. In general, how would you describe your relationship?
    - A lot of tension
    - Some tension
    - No tension

2. Do you and your partner work out arguments with:
    - Great difficulty?
    - Some difficulty?
    - No difficulty?

3. Do arguments ever result in you feeling down or bad about yourse1f?
    - Often
    - Sometimes
    - Never

4. Do arguments ever result in hitting, kicking or pushing?
    - Often
    - Sometimes
    - Never

5. Do you ever feel frightened by what your partner says or does?
    - Often
    - Sometimes
    - Never

6. Has your partner ever abused you physically?
    - Often
    - Sometimes
    - Never

7. Has your partner ever abused you emotionally?
    - Often
    - Sometimes
    - Never

8. Has your partner ever abused you sexually?
    - Often
    - Sometimes
    - Never

Related documents and useful links

This guidance should be read in conjunction with additional Welsh Government published guidance on Multi Agency fora, the National Training Framework and Information Sharing.

Information sharing and data protection

Caldicott guidelines

http://www.wales.nhs.uk/sites3/page.cfm?orgid=950&pid=51917

Wales Accord on the Sharing of Personal Information Framework

http://www.waspi.org/

Policy and guidance

National Institute for Health and Care Excellence (NICE) guidelines on Domestic Violence and Abuse – How services can respond effectively

http://guidance.nice.org.uk/PHG/44

Responding to Intimate partner violence and sexual violence against women. World Health Organisation clinical and policy guidelines (2013)

http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/

Building effective responses: An independent review of violence against women, domestic abuse and sexual violence services services in Wales (2014)

http://wales.gov.uk/statistics-and-research/building-effective-responses-independent-review-violence-against-women/?lang=en

Practitioner resources

Live Fear Free

http://livefearfree.org.

The DASH Risk Identification Checklist

http://www.safelives.org.uk/sites/default/files/resources/Dash%20with%20guidance%20FINAL.pdfl

Safeguarding

Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (January 2013)

http://ssiacymru.org.uk/home.php?page_id=8297

All Wales Child Protection Procedures

All Wales Protocol: Safeguarding Children and Young People Affected by Domestic Abuse

All Wales Protocol: Female Genital Mutilation

http://www.awcpp.org.uk/home/wales-protocols/

HM Government Multi-Agency Practice Guidelines: Female Genital Mutilation (Foreign & Commonwealth Office 2011)

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124588.pdf

Appendices

Appendix 1: Evidence base for screening

Research into the variety of screening techniques is limited in its number, by the variation of practice and the lack of longer term work. As with many areas of work to tackle violence against women, domestic abuse and sexual violence, additional work in this area would be useful in refining future practice.

Overall, the majority of studies relate to both routine and targeted enquiry and are before and after studies. Data on medium to longer term outcomes is often missing.

The majority of studies also focused on abuse of women by a male partner. Very few studies examined the impact of identification interventions or approaches for diverse sub-populations of women or screening for: perpetrators, children who witness violence, 'honour' based violence, and elders.

The majority of the evidence originates within health based practice, there is a lack of research examining the identification of the issues within social care settings, education, housing or within integrated approaches to identification across various health and social care settings.

Much of the evidence for processes of targeted and routine enquiry relate to domestic abuse, often termed Intimate Partner Violence (IPV). There are some descriptive accounts which relate to identification of sexual violence but there are no existing evaluations which specifically relate to the identification of sexual violence, forced marriage, Female Genital Mutilation (FGM), slavery or prostitution. It is reasonable, however to assume many of the evidenced-based interventions for identifying and referring domestic abuse, discussed could be applied to other forms of violence.[85]

Most of the studies did not measure rates beyond initial implementation.

Further research is required to examine and address the barriers providers face in identifying and responding to violence against women, domestic abuse and sexual violence. Furthermore, interventions are required which include a post-identification intervention and which measure health outcomes for participants.

Appendix 2: Potential barriers to "Ask and Act"

The benefits of implementation of a process of "Ask and Act" are outlined throughout this guidance.

Whilst recognition of the indicators of violence against women, domestic abuse and sexual violence should form part of good clinical and social care practice already, it is acknowledged the introduction of a formal process to support this could be met with challenges. This chapter outlines the barriers to effective implementation of targeted enquiry and proposals through which to mitigate for them.

Barriers to implementation can relate to professional attitude, organisational structure and the clients feelings and fears.

Professional attitudinal potential barriers to implementing Ask and Act		
Concern	**Response**	**Mitigation**
Targeted enquiry may offend the client or cause emotional distress and discomfort	In general minimal adverse effects of screening have been identified[86] Practice in this area suggests those who are asked about their experience of violence or abuse are generally supportive of the process.[87] This is particularly true of those who have experienced violence and abuse. Research also suggests women were much more likely than professional to support screening practices. Practice based feedback includes several examples of clients who experienced domestic abuse for decades but who didn't seek help due to lack of knowledge of fear but who would have if they had been asked.	Training on "Ask and Act" will best be co-delivered by a professional with strong audience knowledge (working in the same or similar field) and by a professional with strong knowledge of the experience and impact of violence against women, domestic abuse and sexual violence. The aim of such a delivery style will be to offer expert and practice based feedback to the training audience to increase their confident to practice targeted enquiry.
Targeted enquiry might further endanger the	It is first important to recognise, **if it is done privately and safely**, asking about the experience of violence of abuse	As above - the co-delivery by audience and subject experts will assist in increasing

client.	will not make it happen. Moreover all clients have a choice as to whether or not to disclose. The choice ultimately lies with them. However, a process of targeted enquiry may generate risks where it is not practiced properly or where it is not followed up appropriately with action.	professional confidence. Be aware of service generated risks and ensure staffs have the skills and tools through which to mitigate them. Ensure the organisation is signed up to a relevant Information Sharing Protocol which outlines a professionals duty of confidentiality and when and why this ma be breached. Ensure the organisation is working to clear referral protocols through which to offer options/take action to safeguard adults and children.
Organisational structure potential barriers to implementing Ask and Act		
Lack of capacity within client facing time to ask the client questions or respond adequately.	Targeted enquiry should be supported through the implementation of policy and organisational changes which facilitate the process.	Relevant authorities should work with staff teams and external partners to agree the process of ""Ask and Act"" which is most appropriate to their service function.
Lack of training/education/experience leads to: Staff feeling under-skilled and unconfident A lack of knowledge of available resources	Evidence shows comprehensive programs – those which support a process of targeted enquiry at different levels; through practitioner training, institutional support and infrastructure and investment reach higher levels of intimate partner violence identification than non-comprehensive ones.	Welsh Government funded training on the process of "Ask and Act" will be offered through the National Training Framework on violence against women, domestic abuse and sexual violence. Leaders in relevant authorities will also be offered support through this framework to demonstrate leadership on this issue and to develop infrastructures to support the practice.
Lack of access to effective interventions for VAWDASV	No agency can tackle violence against women, domestic abuse and sexual violence effectively alone. All work should be rooted within a multi agency response.	Ensure the organisation is working to clear referral protocols through which to offer options/take action to safeguard adults and children.

	It is not the role of relevant professionals to become experts on the issues of violence against women, domestic abuse and sexual violence, or to become specialist workers. These roles will exist locally and effective practice will involve robust and sustainable partnerships between the Public Services and the specialist sector.	These referral protocols may involve co-location, although for many this will be unrealistic. Consideration should also be given to drop in clinics, direct, efficient referrals to local services and utilisation of the Live Fear Free Helpline.
Difficulty in providing a safe space	Targeted enquiry should be supported through the implementation of policy and organisational changes which facilitate the process. A safe space is a setting in which complete privacy can be assured. This will never be the case in a public waiting room or in a space which is only shielded by a curtain.	Organisation leaders should consider the accommodation resources available which offer private and safe spaces for client consultation. This may involve the use of interview rooms or creative use of other space. For some professional groups this may involve ensuring conversations which take place in client's homes or in public places cannot be overheard.
Clients feelings and fears as potential barriers to implementing Ask and Act		
Fear of reprisals, of response, of not being believed or response of organisation/professional.	An empathic, strong response to a client's disclosure which conveys belief and validates their experience will offer immediate reassurance to a client.	
Concern over a loss of privacy	It is imperative each client is aware of the confidentiality policy of the organisation with which they are engaging and is therefore able to make informed decisions about what information they choose to share with the professional they are working with and have reasonable expectations of how this information will be treated.	Ensure organisational policies on data protection, information sharing and confidentiality are up to date, legal and reviewed regularly. Ensure all staff understand the duty of confidentiality and can explain it clearly to their clients.

Concern disclosing may make situation worse	**The safety of the client and their children must be held central to any process of "Ask and Act".** No action should ever be taken which will knowingly put the client at risk and professionals should raise any concerns with their supervisor or manager if this is the case. Clients will often have been managing their own safety for some time prior to disclosing the abuse.[88] Professionals should hold in mind the client will know the person abusing them better than anyone and their own judgment of their situation must be taken very seriously. **A client is more likely to under estimate their risk than over state it.** Whilst seeking permission to share information on a client's situation should not be sought when they or their children are at risk, it is good practice to work with consent and to be led by client choice, wishes and feelings wherever possible.	Ensure opportunity is provided to identify risk shortly following disclosure (either through internal or external pathways). Ensure all staff understand the duty of confidentiality and can explain it clearly to their clients.
Lack of awareness of services	Relevant professions should not be part of a process of "Ask and Act" unless they have been sufficiently trained in the availability of local services. To "act" will invariably require an explanation of or referral to local and national specialist services.	Training on "Ask and Act" must include information on the availability of specialist services, thresholds and referral processes.

Appendix 3: Cost benefit of "Ask and Act"

The costs of domestic abuse in Wales are estimated to be £303.5 million annually - £202.6m for service costs and £100.9m in lost economic input.[89]

It is likely "Ask and Act" will initially see an increase in referrals to specialist services including the Independent Domestic Violence Advisor (IDVA) service. This model, integrated within Multi Agency Risk Assessment Conferences provides evidenced cost saving of at least £2.90 for every £1 of public, direct costs.[90]

If a process of "Ask and Act" is fully implemented it should be expected more people who experience violence against women, domestic abuse and sexual violence will be identified and provided with support. This may increase short-term costs, in terms of existing workforce capacity and support services. However, it may also lead to longer term savings for a range of organisations.

It is difficult to accurately describe these savings as local practice varies significantly and such savings will be tied to the characteristics of local service provision and process. Walby's research on the costs of domestic violence suggest increased utilisation of Public Services in tackling these issues does increase the cost of services. However she also links the development of and increased utilisation of Public Services with a decrease in domestic violence, as a result of which, the costs for business and the wider society of domestic violence have declined.[91]

Therefore, expectations of the cost effectiveness of the "Ask and Act" model include additional savings associated with reduced costs to the criminal justice system, the economy and in relation to the additional quality-adjusted-life-years for those affected by violence against women, domestic abuse and sexual violence. Small scale pilots of similar processes to "Ask and Act" indicate the cost, in both human and economic terms, is so significant that to take any action to intervene will be cost effective.[92]

Appendix 4: The 10 principles of "Ask and Act"

1) **Violence against women, domestic abuse and sexual violence require a Public Service response. Professional confidence to identify these issues, to ask about them and to respond effectively is fundamental for good clinical and social care practice.**

2) **Those who disclose violence against women, domestic abuse and sexual violence should mirror the diversity of the population of the locality.**

3) **The Public Service has an important role to play in addressing these issues, by supporting clients and strengthening the services they receive. A more consistent approach to identifying those who experience violence against women, domestic abuse and sexual violence, assessing risk and referring appropriately is required across Wales.**

4) **Clients will not always tell professionals about their experience without being prompted. It is the professional's role to consider whether it would be appropriate to ask direct and sensitive questions within a safe, confidential environment.**

5) **Clients require clarity of how their confidentiality will be treated.**

6) **Whilst never an interrogation, "Ask and Act" is not a single intervention. Every question is an opportunity to offer support. A process of targeted enquiry should include follow-up with victims beyond identification and repeat questions**

7) **Having a conversation with a client is preferable to use of a screening tool. A general question about someone's experience of abuse may lead to a disclosure of several forms of abuse.**

8) **Partnerships between Public Service providers and local specialist providers should be solidified in order to provide more comprehensive delivery of policy and practice.**

9) **Implementation of a process of "Ask and Act" must be accompanied and supported by training and leadership.**

10) **Missed opportunities to identify violence against women, domestic abuse and sexual violence are missed opportunities to prevent further abuse, identify risk to children and save lives.**

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[8] Feder, et al. (2011) Evaluation of the IRIS project

[9] Some differences noted between samples being compared (e.g. urban versus suburban participants

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Consultation Response Form

Your name:

Organisation (if applicable):

email / telephone number:

Your address:

1. Do you agree with the proposal for relevant authorities to demonstrate how they will implement “Ask and Act” (the guidance issued under section 15 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015)?

2. Section 3 of the guidance relates to the pre-planning, planning and implementation of a local or regional approach to “Ask and Act”. It is aimed at leaders, co-ordinators and managers. Is this section fit for purpose? What additional information is required?

3. Section 4 of the guidance relates to good practice for “Ask and Act”. It is aimed at practitioners. Is this section fit for purpose? What additional information is required?

4. It is important that “Ask and Act” integrates complements and aligns to existing statutory safeguarding processes. What more should this guidance include to clarify practice around these issues?
What related guidance/processes/protocols should be referenced?

5. “Ask and Act” requires long term support and this is acknowledged within the Welsh Government’s training plan for initial implementation. It is proposed that this guidance come into force in early 2016 with pre-planning and planning taking place between September 2016 and March 2017 with ongoing national rollout over three years thereafter. Does this timeframe seem appropriate, are there any aspects which cause concern?

6. Training for “Ask and Act” will be delivered through a “Train the Trainer” model which uses local expertise and experience to communicate the training messages. What existing local or regional training structures could such a model utilise? What are the challenges associated with this model and how can these be overcome?

7. What opportunities exist to ensure “Ask and Act” provides opportunities to use the Welsh language? Do you have concerns that “Ask and Act” could have an adverse effect on opportunities to use the Welsh language?

Please provide specific recommendations which can be incorporated into the “Ask and Act” guidance on the use of safe Welsh language and terminology.

8. We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

Please enter here: