

Tackling Domestic Violence: the role of health professionals

2nd Edition

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Tackling Domestic Violence: the role of health professionals

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This report has been written for a range of health professionals. It is intended to raise awareness of the scale of the health problem represented by domestic violence and to alert health professionals to the contribution they can make to tackling this issue.

The report explains how health professionals can make an important contribution to tackling domestic violence:

- by asking women directly about whether they have experienced abuse;
- by enabling women to access specialised services; and
- by supporting them in changing their situation.

In order to achieve this, training is necessary, and the report describes the nature of this training. This report is *not*, however, a substitute for such training and thus should not be seen as a comprehensive 'how to' guide. The evidence base for this guide is detailed at the end of the document.

Domestic violence is a major health issue for women

About one in four women will experience domestic violence at some time in their lives. This applies to women in all walks of life, across all ages, ethnic groups and socio-economic classes. Research has documented numerous significant health impacts on both adults and children who have experienced abusive relationships; these include short and longer-term health effects, in terms of physical, mental and sexual health.

Domestic violence is not restricted to physical violence; it may include psychological, emotional, sexual and economic abuse, and these may occur together or separately within the same relationship. To reinforce the fact that domestic violence does not necessarily involve physical violence, some prefer the terms domestic abuse or partner abuse.

What needs to be done by the health service?

Three types of action are needed:

- improving availability of information on domestic violence and services for those who experience it;

- providing/acquiring appropriate training for health professionals; and
- instituting systems of enquiry about domestic violence.

These are explained in the sections below.

Recognising that responding to domestic violence is a *process* rather than an *act*, health professionals need to work with other agencies in supporting, and providing options for, survivors of domestic violence. The health service *alone* cannot meet all the needs of women experiencing domestic violence. But it is uniquely placed to help change public attitudes to domestic violence, and ensure that women experiencing domestic violence can access services to help them change their situation.

A survivor talks about how she wanted her GP to ask her directly about abuse: "Told him [her GP] I'd fell. ... He didn't quiz me about it. He didn't say anything more about it. I just said I fell and the look he gave was 'well, I don't think you have, but...' 'I remember sitting there and thinking 'quiz me, quiz me, ask me', and he never did. ... Because he didn't, I didn't tell."

Home Office Development and Practice Reports draw out from research the messages for practice development, implementation and operation. They are intended as guidance for practitioners in specific fields. The recommendations explain how and why changes could be made, based on the findings from research, which would lead to better practice.

Box 1: Possible signs/symptoms of domestic violence

This list is not exhaustive; women may demonstrate a variety of signs/symptoms or none at all. These should act as a trigger for direct enquiry.

Physical

- stress-related ailments – headaches, irritable bowel syndrome;
- STDs, vaginal infections or other frequent gynaecological problems;
- miscarriages / history of miscarriages;
- repeated terminations of pregnancy / still births;
- premature labour;
- low birth weight babies;
- fractures to the foetus;
- forced removal of sutures;
- bruises on the body, particularly on the breasts and abdomen;
- injuries to face, head or neck;
- multiple injuries in different stages of healing;
- burns – cigarette burns, rope burns;
- hair loss – consistent with hair pulling;
- bilateral injuries;
- unexplained injuries or those inconsistent with explanations; and
- unexplained “accidents” to children.

Behavioural

- frequent A & E visits;
- appears fearful, evasive, ashamed, embarrassed;
- partner answers questions directed to woman;
- use of alcohol and drugs (e.g., use of tranquillisers);
- eating disorders;
- frequent use of pain medication; and
- presents with vague symptoms and conditions.

Psychological/emotional

- depression / anxiety / panic attacks;
- self-harm; and
- attempted suicide.

Health professionals can make a difference

The difference that health professionals can make to the lives of women who experience domestic violence and the lives of their children is shown by the case of Nicki (a pseudonym), see Box 2.

Nicki’s case illustrates how a swift and co-ordinated response from a number of agencies made a real difference to the health and quality of life for her and her children. Unfortunately, at the moment, her experience is rare. Women all too frequently endure long periods of abuse. During their repeated contacts with the health

service, which are often directly caused by abuse, their disclosure is not responded to appropriately or they are never directly asked about the issue.

Box 2: A co-ordinated service response – the case of Nicki

In her early 30s, with two children, Nicki experienced years of abuse from her partner, initially when they lived together and then after he moved out and they lived separately. Once she started taking the children to school and making friends she realised that “something was wrong”, and that she should not have to tolerate the abuse. She presented at her GP with injuries and was told about the specialist Women’s Aid outreach service at the practice. An appointment was arranged for the following day. The outreach worker discussed Nicki’s options with her and a few days later Nicki moved into a refuge with her children. She was given help to apply for housing, and relatively quickly was offered a suitable property by the council. She left the refuge after three months for her new home. Although, it is impossible to know what her life would have been like if she had received an unhelpful response at the point of initial disclosure to the GP, it is also evident that the validating, co-ordinated and informed response of the surgery had a profound and health-improving impact on Nicki and her children.

Improving availability of information on specialised services for domestic violence

Domestic violence is a hidden and stigmatised issue. Women and professionals report a lack of knowledge of abuse and of services available for those who experience it.

Information for the public and health professionals is required, in a variety of forms. Information can help to dispel the myths about domestic violence and be an important form of primary prevention.

The section at the end of this report gives details of sources of information about local services available for women who experience abuse.

Women and health service staff suggest that a wide variety of different means of presenting such information would be helpful (posters, leaflets, postcards, small cards with key contact numbers), in *all* health service settings, (including GP practices, clinics, hospitals etc.) in reception areas, waiting areas, consultation rooms, cafeterias and toilets.

For professionals, devices such as coasters, key-rings and

'post-it' blocks were useful additions to information packs/guidelines. Highly visible forms of this information in the consultation setting serve as helpful prompts to routine enquiry.

Good practice point

Health professionals found 'post-it' notes containing the phone number for the local domestic violence support agency particularly helpful in prompting them to remember to ask.

Providing/acquiring appropriate training for health professionals

All health professionals and staff working in health settings should ideally receive training on enquiring about domestic violence. Given the importance of domestic violence as a factor impacting on health, training about enquiry should be part of pre-registration curricula *and* post-registration on-the-job training for *all* health professionals. Basic awareness training is also useful for administrative staff with patient contact, e.g. GP receptionists, A&E receptionists.

Appropriate training can overcome health professionals' concerns about raising the subject and enable them to provide more appropriate care for their patients.

"If we can support a woman through HIV screening, we can ask domestic violence questions." [Midwife, Birmingham]

Training packs exist that can be drawn on. Local Women's Aid affiliated organisations and Domestic Violence Forums can often provide suitable trainers¹

There are advantages to using a training team that have both members with detailed knowledge of specialised domestic violence services and members with detailed knowledge of the health service setting(s) that trainees come from.

Training for health professionals in preparation for enquiry about domestic violence should have the following characteristics:

- at least one day in length (this can be spread over a number of sessions);
- includes coverage of the nature and extent of the health problem represented by domestic violence;

- includes coverage of how to ask direct questions about experience of violence without compromising women's safety, for example never asking when a possible perpetrator is present;
- includes coverage of how to respond appropriately to those disclosing abuse;
- provides information on the local availability of services for those experiencing violence;
- includes coverage of safety planning for those experiencing abuse;
- includes coverage of safe documentation of violence; and
- includes explicit recognition that a large proportion of those being trained are likely to have personal experience of domestic violence and ensures that time/resources are included to respond to trainees' own needs regarding any personal experience of abuse.

Below, a GP and a Health Visitor talk about their experience of training and putting enquiry about domestic violence into practice.

"It's like taking care of someone's bad knee and not taking any notice of the fact that they weigh 25 stone and don't do any exercise. If you ignore it, you can't manage your patient effectively. I felt (domestic violence) was a huge undiagnosed problem. I felt uncomfortable about what to do, so it was a good opportunity to go and find out. I've got this lady who is a victim of abuse, but it is emotional and financial; it used to be physical, but not any more. She's got arthritis, depression, a multitude of various things. I think this has a big impact on her health. And because we both know, we can talk about it; we don't pretend that I can make her better. She has been offered help, and she's refused, she copes the best way she can. It makes it a lot more effective, and I don't beat myself up that I can't get her better. At least I know I have been able to offer the help. It's a missing piece in the picture. I think it is a bigger piece than she thinks it is; she thinks the physical abuse was the worst but I think the emotional and financial abuse is holding her back. But we can keep talking about it until she decides to deal with it in a more formal way. That is going to take time." [GP, Wakefield]

1. See section on resources for details of training packs and contacts.

"I think (the training) gave me insight into why people don't leave, because I think your initial reaction when somebody tells you is 'Leave' and if they don't leave then it is their fault. But things aren't that simple. It's taught me a little about how to support people if they decide to stay in that situation because you can't just wash your hands of them. You need to provide on-going support and advise them on how to stay safe while in that situation." [Health visitor, Wakefield]

Instituting systems of enquiry about domestic violence

Two useful definitions²

Routine enquiry refers to asking *all* women who are using the service direct questions about their experiences, if any, of domestic violence regardless of whether there are signs of abuse or whether violence is suspected.

Selective enquiry refers to asking women directly about their experiences, if any, of domestic violence where there are concerns or suspicions, including the presence of the signs/symptoms listed in Box 1.

What systems of enquiry are required for domestic violence?

1. *All* health professionals should practise selective enquiry.
2. Routine enquiry should be considered in a number of different settings, in particular in primary health care and when case-taking, e.g. in maternity services or mental health settings.

Research demonstrates that women who experience domestic violence are more likely to access health services. Research has also shown that domestic violence increases during pregnancy and many projects have therefore implemented training and questioning in maternity services. However, in view of the advantages of asking *all* women, efforts need to be made to ensure that in each locality there is a mechanism and setting whereby *all* women can be reached. The mechanisms will differ from place to place; the best setting for ensuring that all women are most likely to be reached is primary health care, and in particular general practice. Different settings for routine enquiry are described later in this report.

Routine and selective enquiry form the basis for providing women who are experiencing abuse with information about

2. The literature demonstrates a wealth of different uses of terms like 'screening' and 'routine enquiry'. The definitions given here are based on those found useful in the Crime Reduction Programme (CRP) Violence Against Women Initiative (VAWI) projects which were evaluated.

the local specialised services available to them. These specialist services include those provided by a variety of voluntary sector organisations, in particular by Women's Aid affiliated organisations, and in some instances by Victim Support, specialist Domestic Violence Units and Domestic Violence Officers within the police.

Routine enquiry should be implemented in a way that suits the local context; this is explained further under the section on different settings for routine enquiry.

Enquiry about domestic violence – some findings

- The vast majority of women (both those with experience of abuse and those who have not experienced abuse) find being asked about abuse acceptable.
- Routine enquiry uncovers significant numbers of previously hidden cases of domestic violence.
- Repeated enquiry at a number of consultations increases the likelihood of disclosure.
- Many women will not disclose abuse without being directly asked; they report *wanting* to be asked.
- Trained staff find routine enquiry acceptable and helpful to their practice.
- Routine enquiry does not take a long time in most cases (an average of four to five minutes per woman in one study in primary health care).

Asking *all* women has several advantages over selective enquiry.

- It contributes to changing social attitudes to domestic violence.
- It is less likely to make women experiencing violence feel stigmatised.
- It is less likely to compromise the safety of women experiencing violence.
- Health professionals report that their perceptions about which women were free from abuse were often incorrect.

"It was quite a shock to me that people don't talk to me about it unless they're asked. Some patients where I was rather sniggering to myself and knowing the answer would be 'no', I heard, 'Yes, I've dealt with it, I was abused....' It has made me routinely ask about it." [GP, Wakefield]

Good practice point

Notices in the cubicles of women's toilets in health settings can let women know of some way to alert staff that they want to discuss domestic violence without their partner or children being aware of it.

What systems of enquiry are required for domestic violence?

The table on Page 6 describes some of the ways in which routine enquiry has been implemented in different circumstances and settings. It is illustrative and *not* exhaustive. Each of these have been implemented and proved feasible. Routine enquiry needs to be implemented flexibly to take account of local factors, including the availability of private space, the staff based in the setting, and the nature of any specialised clinics run at the setting. Resource packs exist (Wakefield and Suffolk projects have both produced packs, see section on resources for contact details) that can be used in any setting to help decide how best to implement routine enquiry.

Advantages of routine enquiry

Routine enquiry has the potential to:

- give *all* women basic information about the unacceptability of domestic violence and that abuse is not just about physical violence;
- give *all* women information that will be relevant to their friends, relations, neighbours, even if it is not personally relevant to them;
- help reduce both the stigma associated with abuse and the hidden/taboo nature of domestic violence; and
- give a clear message to women experiencing domestic violence that they are not alone in their experience, that the abuse they experience is unacceptable, and that there are services available for them to seek help in changing their situation

Good practice point

The implementation, and the actual practice, of routine enquiry should be regularly reviewed in supervision, team meetings and/or review sessions. Enquiry requires:

- adequate training for health staff;
- careful planning for implementation, with guidelines, protocols and information about local specialised support services.

Adequate resourcing for local specialised domestic violence support services is also important.

In response to a question about the future for routine enquiry, one GP said:

"It will go much more into education, GP practice, [as a] routine thing for registrars to do, for practice nurses in the well-woman clinic, and in 30 years we will be astonished that we didn't do it before." [GP, Wakefield]

Good practice point

In rural and semi-rural areas in particular, women may find it difficult to travel to support services. Providing such services on a sessional basis in more accessible venues such as general practices can help. For example:

- in one general practice on the outskirts of a large city, a Women's Aid worker (accompanied by a crèche worker) is available half a day each week to see any woman requiring support; the service has been well used and enables women to access support without travelling to the city centre (this can easily operate alongside routine enquiry models A to C below).
- In a rural A&E department, volunteers from Victim Support can be contacted by telephone (at any time) and will travel into the department to see women (this can easily operate alongside routine enquiry model F below).

Table 1.1 Models of ways in which routine enquiry has been implemented

<i>Model</i>	<i>Description</i>	<i>Comments</i>
A* General practice – GPs	A GP systematically works his/her way through all the women on their list by asking one woman each surgery session.	<ul style="list-style-type: none"> ● For average list sizes, this would enable a GP to ask every woman once every two to three years.
B* General practice – well-woman clinic	A practice runs a well-woman clinic to which every woman registered with the practice is invited once every three years. Questions on domestic violence are included in the list of areas to be covered. Each woman is seen on her own, in a private room.	<ul style="list-style-type: none"> ● The nurses running the clinic arrange for one of their team to be carrying out paperwork at the same time as the clinic. Then, if a woman discloses abuse and some considerable time is required for her during the clinic session, another nurse is available to step in so that other clinic attendees are not disadvantaged.
C* General practice – practice nurse	A large general practice has a practice nurse on duty at all times surgeries are running. Women are invited for a short health promotion consultation before or after a GP appointment. This is used to take blood pressure, weight (if not taken recently), to discuss routine smear and breast screening and to enquire about domestic violence.	<ul style="list-style-type: none"> ● The practice estimates that it will be able to ask each woman every three years.
D General practice – health visitors	Women are asked about domestic violence in the course of routine home visits following childbirth.	<ul style="list-style-type: none"> ● Health visitors are careful to ensure that they ask only when they are alone with the woman, and have well-rehearsed strategies to manage any interruptions safely.
E Antenatal booking	Midwives have instituted the practice of always setting aside some private time with the woman on her own, in order to enable her to raise any issues she likes. This private time is also used to enquire about domestic violence.	<ul style="list-style-type: none"> ● Routine antenatal appointments offer several opportunities to enquire about domestic violence, staff can use their discretion as to whether the booking appointment is a suitable opportunity, or use a later appointment if there are many other issues to be dealt with at booking.
F A&E/Minor injuries units/ Walk-In centres	Every unaccompanied woman is asked about domestic violence. This is done in a private space with the woman on her own for confidentiality.	<ul style="list-style-type: none"> ● Staff report that a considerable proportion of women are accompanied and it may not be possible to see them alone. ● Access to private space may be difficult. ● Of all the models listed here, this one is likely to provide the lowest coverage of women.

* A to C and F reach all women, D and E reach only those with young children

Women from Black and other minority ethnic communities

- Women's Aid affiliated organisations and Refuge have a range of specific projects for women from Black and minority ethnic communities (see section on resources).
- A separate report on providing advocacy support for women from minority ethnic communities exists in this series. [forthcoming]
- Where women can only communicate with health professionals through an interpreter, a professional and independent interpretation service should be used. Language Line (see section on resources) is a national interpretation service that provides interpreters who can be accessed via the telephone. This minimises the possibility that the interpreter is a relation, or is from their community, which in some cases could jeopardise their safety. The use of an independent interpretation service is likely to reassure the woman about confidentiality and impartiality. Female interpreters can be requested.
- For women whose first language is not English, information on how to access help in a variety of languages is available on the Women's Aid Federation website (see section on resources).

Summing up

This report has been written for health professionals. It aims to raise awareness of the scale of the health problem represented by domestic violence and to ensure that health professionals are alerted to the contribution they can make to tackling this issue.

The report shows how health professionals can make an important contribution to tackling domestic violence, by asking women whether they have experienced abuse, enabling woman to access specialised services, and supporting them in changing their situation. In order to achieve this, it is critical to provide training and the report describes the nature of this training. This report is *not*, however, a substitute for such training and thus should *not* be seen as a comprehensive 'how to' guide.

Women need:

- to be asked;
- to be believed;
- to be treated with respect;
- to be given time; and
- to be given information.

Use RADAR! A mnemonic for professionals³

Below are quotes from three women who were asked about domestic violence in a health setting and were referred onto professional support services. The quotes illustrate how the specialised support services have made a difference to their lives.

RADAR

- R Routine enquiry
- A Ask direct questions
- D Document findings safely
- A Assess woman's safety
- R Resources: give women information on resources available and Respect their choices

Local support service for women:
[insert telephone number(s)]

"I really hope Women's Aid get the credit they deserve from everybody. Because I give them credit for everything they've done. I couldn't have done anything without them. I think I probably still would have been there." [Interviewee, Salford]

"And sometimes you still get down, but I know when I'm down without a shadow of a doubt, I'm going to come back. I'm happier now. In one of my things I wrote at college - I say this to a lot of women I talk to - I had to write, you know you used to write about what you'd learned that week and what have you, and I thought 'I was somebody's wife, I was somebody's mother and then I was somebody's possession and now I'm me' [emphasised]. That you should put down because that I feel is relevant." [Interviewee, Wakefield]

"I left after 48 years of marriage of which I suffered 33 years of verbal abuse. WA [Women's Aid] gave me a new life at 71. [After] about a month of contact with WA I was in my own flat and at peace for the first time in many years. Three and a half years on they are still there when I need them, no praise is high enough for the women who run this service." [Questionnaire respondent, Salford]

3. This is a modified version of the mnemonic produced by the Philadelphia Family Violence Working Group, US.

Resources and further information

Sources of advice for advocates and professionals

Department of Health

<http://www.doh.gov.uk/pdfs/domestic.pdf> *Domestic violence: a resource manual for health care professionals*. London: DoH, 2000.

Home Office

Useful links to other organisations working in the field of violence against women and domestic violence

<http://www.crimereduction.gov.uk/dv04.htm>

Government policy on Domestic Violence

<http://www.crimereduction.gov.uk/dv01.htm>

Domestic Violence publications

<http://www.homeoffice.gov.uk/crime/domesticviolence/publications/index.html#4>

<http://www.homeoffice.gov.uk/rds/violencewomen.html>

National Domestic Violence Health Practice Forum (NDVHPF)

This organisation aims to influence and promote sustainable development in good practice within the NHS, as part of a national domestic violence strategy, through:

- sharing, collating and evaluating current initiatives;
- the development of policies, training, guidance, protocols and research; and
- liaising and lobbying at international, national and regional level.

Contact: Dr Lorraine Bacchus

St Thomas' NHS Hospital Trust (Maternity Services Research Team), Women's Health Academic Unit, 10th Floor North Wing, St Thomas' Hospital, Lambeth Palace Road, London SE1 7EH

020 7188 6854 loraine.bacchus@kcl.ac.uk

Refuge <http://www.refuge.org.uk/>

Refuge is the UK's single largest independent provider of specialist accommodation and support to women and children escaping domestic violence, currently managing refuges around the country in both urban and rural areas. Also runs community-based floating support projects. Manages safe house specifically set up for African Caribbean and Asian women. Trained staff help women and children access the services they need, e.g., local social services, doctors, schools and solicitors.

Women's Aid Federation <http://www.womensaid.org.uk>

The website contains a wide variety of useful information including:

- a directory of multi-agency fora as well as contact numbers for refuges and a list of useful organisations <http://www.womensaid.org.uk/network/index.htm>
- a factsheet on health and domestic violence <http://www.womensaid.org.uk/dv/dvfactsh2.htm>

The website has information in languages other than English. <http://www.womensaid.org.uk/lingual/main.htm>

Training and resource packs

Wakefield (contact Rachel Payling, Domestic Violence Health Initiative, Eastern Wakefield Primary Care Trust, 01977-605500)

Hammersmith & Fulham Standing Together Health Project (email: admin@standingtogether.org.uk)

Suffolk Tools for Practitioners Project (contact Gaynor Farthing, 01473 275267 or gaynor.farthing@1hp.nhs.uk)

Camden: http://www.camden.gov.uk/camden/links/equalities/dm_health.htm

Leeds Interagency Project (0113 2349090 or admin@liap.demon.co.uk)

Redbridge and Waltham Forest Domestic Violence Health Project : www.dvhp.org

Sources of support and advice for women who have experienced DV

24 -hour National Domestic Violence Helpline (a 24-hour information service run in partnership by Women's Aid and Refuge, that provides support, help and information to women suffering domestic violence)

Freephone: 0808 2000 247 (minicom available)

BAWSO (Welsh organisation for Black women who are victims of domestic violence)

029 2043 7390

Broken Rainbow (Pan-London Lesbian, Gay, Bisexual And Transgender Domestic Violence Forum)

0781 2644914

<http://www.lgbt-dv.org/html/rainbow.htm>

Careline (Counselling services)

020 8514 1177

Community Legal Service Directory Line

0845 608 1122

<http://www.justask.org.uk/index.jsp>

Foreign & Commonwealth Office (advice on forced marriage)

020 7008 0135/0230

Language Line –

Translations: 0800 917 6564

Face-to-face interpreting: 0845 310 9900

National Child Protection Helpline (NSPCC)

0800 800 500

<http://www.nspcc.org.uk/nspcc/helpline>

Refuge (operates a network of safe houses and provides outreach services for women from minority ethnic groups)

020 7395 7700

<http://www.refuge.org.uk/>

Shelterline - National 24-hour Housing Helpline

0808 800 4444

<http://www.shelter.org.uk/housingadvice/shelterline/index.asp>

Southall Black Sisters (advice and support for women from Black and minority ethnic communities)

020 8571 9595

The Samaritans

0345 90 90 90

<http://www.samaritans.org/>

Survivors UK (organisation that supports and provides resources for men who have experienced any form of sexual violence)

0845 1221201

<http://www.survivorsuk.org.uk>

Victim Support

0845 30 30 900

<http://www.victimsupport.org.uk/>

Women's Aid

0117 944 4411

0808 2000 247 (Freephone- National Domestic Violence Helpline)

<http://www.womensaid.org.uk>

Welsh Women's Aid

029 20 39 0874

0808 80 10 800 (Wales Domestic Abuse Confidential Helpline)

<http://www.welshwomensaid.org/>

It is a good idea to remind women that they need to be cautious about accessing any of the above websites from a computer that their abuser has access to. The Women's Aid website contains information on action that women can take to minimise the chance of an abuser detecting that they have accessed the site.

The evidence base for this report

The Crime Reduction Programme (CRP) Violence Against Women Initiative (VAWI) was an evidence-led programme that aimed to find out which approaches and practices were effective in supporting survivors of domestic and sexual violence, and in reducing incidents of abuse. In July 2000 34 multi-agency victim-focused projects were funded, and they developed and implemented a range of interventions in various settings and among different population groups. Five of these projects were based within health contexts such as primary care and A&E. All five projects had the common aim of encouraging and supporting disclosure of domestic violence and facilitating the survivor's entry into specialist domestic violence support services. Independent evaluations of the projects were commissioned and this report is based upon findings from the evaluations, as well as the available published research literature.

The full report of the evaluation of four of the projects is:

Taket, A.R., Beringer, A., Irvine, A. and Garfield, S. (2004) *Tackling Domestic Violence: exploring the health service contribution*. Online Report 52/04, London: Home Office. This is available as an online publication at www.homeoffice.gov.uk/rds/pdfs04/rdsolr5204.pdf. The fifth project developed tools to help practitioners identify survivors of domestic violence, and findings from this evaluation along with the findings from all of the evaluated domestic violence projects, which were funded under the Crime Reduction Programme: Violence Against Women Initiative, are planned to be published at the end of 2004.

The report also draws on the good practice accumulated in a number of other projects in the health service and encapsulates the professional guidance issued by a wide range of professional bodies including: British Medical Association, British Association for Accident and Emergency Medicine, Community Practitioners' and Health Visitors' Association, Royal College of General Practitioners, Royal College of Nursing, Royal College of Midwives and Royal College of Obstetricians and Gynaecologists.

Previously published CRP: Violence Against Women reports

Rape and Sexual Assault

Lovett, J., Regan L., and Kelly L. (2004) *Sexual assault referral centres: developing good practice and maximising potentials*. Home Office Research Study 285, London: Home Office.

Regan, L, Lovett, J. and Kelly, L. (2004). *Forensic Nursing: An option for improving responses to reported rape and sexual assault*, Home Office Development & Practice Report, No. 31, London: Home Office.

Regan, L, Lovett, J. and Kelly, L. (2004). *Forensic Nursing: An option for improving responses to reported rape and sexual assault*, Home Office Online Report 28/04, London: Home Office.

Skinner, T. and Taylor, H. (forthcoming) *Providing counselling, support and information to survivors of rape: an evaluation of the Surviving Trauma After Rape (STAR) Young Persons' Project*, Home Office Online Report, London: Home Office.

Domestic Violence

Douglas, N., Lilley, S.J., Kooper, L. and Diamond, A. (2004). *Safety and Justice: sharing personal information in the context of domestic violence - an overview*, Home Office Development and Practice Report: No. 30, London: Home Office.

Mullender, A. (forthcoming) *Tackling Domestic Violence: providing support for children who have witnessed domestic violence*, Home Office Development and Practice Report: No. 33, London: Home Office.

Taket, A.R., Beringer, A., Irvine, A. and Garfield, S. (2004) *Tackling Domestic Violence: exploring the health service contribution*. Online Report 52/04, London: Home Office

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Errata

Page 2

Box 2, changed to **early 30s**

Page 5

References on page 5 to 'models A to C above' and 'model F above' changed to 'models A to C **below**' and 'model F **below**', since the table of models has been moved to follow this material rather than come before it.

Page 6

* at end of page A to C **and F** reach all women,

Page 8

Deleted contact Dawn Harvey and her details. Inserted the new details. The contact for National Domestic Violence Health Practice Forum is now Dr Lorraine Bacchus, St. Thomas' NHS Hospital Trust (Maternity Services Research Team), Women's Health Academic Unit, 10th Floor North Wing, St. Thomas' Hospital, Lambeth Palace Road London SE1 7EH
020 7188 6854, loraine.bacchus@kcl.ac.uk

Acknowledgements, page 11

Changed beginning of the first sentence of final paragraph to read:

The author would like to thank her colleagues at London South Bank University, Antonia Beringer, Angela Irvine and Shoshana Garfield (the research team who worked with her on the evaluation study),

Added new sentence in between second and third sentences of final paragraph

The author would also like to thank members of the National Domestic Violence Health Practice Forum for their helpful comments on the draft of this report.