CHILD PROTECTION AND DOMESTIC ABUSE
GUIDANCE FOR NHSGGC STAFF

April 2009

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Responsible Director:	Directors of Acute Service CHCP Directors Director of Mental Health Partnership (Glasg Head of Homelessness Partnership (Glasgo Joint General Manager, Addictions (Glasgow Joint General Manager, Learning Disability,
Approved by:	Child Protection Forum
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DRAFT 2

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1. Introduction

1.1 NHSGG&C is committed to realising the aims of equality legislation as it recognises it's significance in addressing health inequalities overall. This guidance recognises the distribution of opportunities for good health and quality of life differ between people of different social classes, women and men, white populations and black and ethnic minorities, non disabled and disabled people, different sexual orientation and different religion. The guidance has been scrutinised using the NHSGG&C EQIA tool.

1.2 Between 1 in 3 and 1 in 5 women will experience domestic abuse from a partner or ex-partner during their lives, with approximately 1 in 10 women estimated currently to be subjected to some form of abuse. It should be recognised that the abuse may be directed by women against men, occur in single sex relationships or be carried out by other family members. Given the attendant health consequences of such abuse the role of the NHS is pivotal in identifying and responding to this issue.

1.3 Although both domestic abuse and child protection have received considerable public attention in recent years, the overlap between them has not been adequately addressed. A number of studies have demonstrated the co-existence of child abuse in many situations of domestic abuse where children may be abused by the perpetrator or be accidentally injured in trying to protect their mother. Children exposed to domestic abuse, whether this is direct or indirect witnessing of abuse, may experience a range of negative developmental outcomes, emotional distress, and behavioural difficulties. Similarly there is increasing awareness of the increased risk of sexual abuse of children within homes where the mother is also being abused.

1.4 At a national level the correlation between domestic abuse and child protection has been highlighted in *The Audit and Review of Child Protection (2002)* and in the *'Children and Young People Experiencing Domestic Abuse: Guidance Note for Planners (2004)*'. To ensure that staff understand the links between child protection and domestic abuse, and are clear on their role, the NHSGG&C Child Protection Forum has produced this guidance.

2. Scope - who is this guidance for?

2.1 This Guidance has been produced to assist all healthcare professionals in NHSGG&C in relation to child protection and domestic abuse.

2.2 Staff in NHSGG&C work in a variety of settings, and contact with families may be ongoing, or sporadic. For those working in adult services, there may be no direct involvement with children within the family. Nonetheless, there are circumstances in which there may be some suspicion about the possibility of child abuse or neglect upon which they need to act.

2.3 The guidance will:

- Outline role and responsibilities of health professionals
- Detail process of risk assessment for women and children
- Outline documentation and recording
- Provide information on services to support women and children experiencing abuse
- Provide information for staff currently experiencing domestic abuse.

3. Roles and responsibilities

Director of Corporate Policy and Planning

- Overall responsibility for policy framework.
- Provide advice on policy processes including approvals process and equality impact assessment, through the Head of Policy and the Corporate Inequalities Team

Head of Policy

- Author and lead manager for the policy development framework
- Provide advice on policy processes
- Ensure implementation of the framework, including the development of policy management systems.
- Ongoing review of the framework and processes to ensure it remains fit for purpose

Heads of Administration

- Ensure a database of policies and procedures is maintained and that the documents are readily accessible to all relevant staff.
- Provide advice on the policy framework
- Ensure appropriate distribution and review of policies, strategies and procedures
- Ensure a system is for policies to be placed on the intranet

Lead Manager

- Meet the requirements for consultation, review of evidence, impact assessment and document format as set out in the Policy Development Framework
- Develop a communication and implementation plan for the policy, strategy or procedure, working through the general management structure for implementation.
- Disseminate the document as appropriate with support from the Heads of Administration if required.
- Ensure that the policy, strategy or procedure is reviewed at the stated date.

Responsible Directors

- Ensure that the requirements of the Policy Development Framework are followed
- Provide advice to the lead manager on the approvals process, taking account of the impact assessment

Approving Groups

- Ensure that the development process has included appropriate consultation and review of evidence prior to approval
- Ensure an appropriate implementation and communication process is in place
- Review the impact assessment
- Ensure that policies, strategies or procedures are not approved outwith the authority of the group

Directors and General Managers

- Ensure systems are in place to implement relevant policies in their areas

Line Managers

- Ensure policies, strategies and procedures are accessible for all their staff
- Ensure staff have read and understood the relevant policies, strategies and procedures
- Ensure systems exist to identify staff training needs on the implementation of new and updated policies, strategies and procedures

Employees

- All staff must ensure that their practice is in line with current policies, strategies and procedures relevant to their area of work.

4. What is domestic abuse?

4.1 Guidance for healthcare workers from the Scottish Government in "Responding to Domestic Abuse, Guidelines for Healthcare Workers" (Scottish Executive 2003) defines this as follows

"*Domestic abuse (as gender based abuse) can be perpetrated by partners or ex-partners and can include physical abuse (assault and physical attack involving a range of behaviour) sexual abuse (acts which denigrate and humiliate women and are perpetrated against their will, including rape) and mental and emotional abuse (such as threats, verbal abuse, racial abuse, withholding money and other types of controlling behaviour such as isolation from family and friends".*

4.2 Domestic abuse occurs within all social classes, occupations, religions and cultures. It affects people of all ages and with any kind of disability. Factors such as stress, poverty, alcohol and drug abuse, and unemployment may contribute to abuse but are not the primary reason for its occurrence. Domestic abuse is overwhelmingly perpetrated by men against women; it is generally purposeful and deliberate behaviour, designed to exercise power and control within the relationship. It is important to recognise, however, that abuse occurs within same sex relationships, that some men are abused by women, or that the perpetrators may be other family members.

4.3 Recognising that domestic violence often escalates in frequency and severity over time is similarly crucial in shaping the understanding of, and response to, women experiencing such abuse. Domestic violence includes:

Physical abuse including punching, slapping, shoving, pulling hair, kicking, stabbing, throwing against walls and/or down stairs, head butting, choking, hitting with objects, sleep deprivation, threatening with a knife/gun.

Sexual abuse including rape (vaginal, oral & anal), sexual assault, penetration with implements (e.g. screwdrivers, brushes, bottles), unwanted sexual intimacy (sometimes to avoid a beating) coercive involvement in acts of pornography. Physical violence can often culminate in sexual violence.

Emotional abuse includes constant criticism, financial abuse, verbal abuse, degradation, humiliation - especially in front of children, isolation from friends & family, timing woman's movements e.g. visits to shops etc. This form of abuse is often systematic and occurs over a prolonged period of time.

Psychological abuse including distorting women's sense of perspective - disorientation, playing mind games.

5. Impact of domestic abuse

5.1 The health consequences of domestic abuse are considerable, and have significant implications for healthcare professionals. For many families, their main contact with a statutory service will be with the NHS. It therefore has a crucial role to play in understanding and responding to the range of problems with which women and children experiencing abuse may present.

a. Health consequences of domestic abuse for women

Domestic abuse impacts on the physical, emotional and mental health of women experiencing abuse. For some women abuse commences or escalates during pregnancy, risking both the health of the woman and her unborn child. Effects of abuse include:

PHYSICAL

- Contusions, abrasions, fractures, sprains
- Injuries to head, neck, chest, breasts and abdomen
- Internal injuries, unconsciousness,
- Repeated or chronic injuries
- Pregnancy complications – higher incidence of miscarriage, adverse birth outcomes
- Unwanted pregnancy
- Gynaecological difficulties

MENTAL/EMOTIONAL

- Depression
- Anxiety
- Panic attacks
- Somatic complaints
- Eating disorders
- Post-traumatic stress disorder
- Alcohol or drug use
- Self-harm; suicidal ideation
- Attempted or completed suicide

6. Impact of domestic abuse on children

6.1 There are no accurate figures relating to the numbers of children affected by domestic abuse but it has been estimated to be around 100,000 in Scotland (Scottish Executive 2001).Children exposed to domestic abuse are at higher risk of developing a series of behavioural, cognitive and emotional problems that may persist into

adulthood. In addition to the emotional impact of living in an atmosphere of violence, there is also evidence to suggest that men who abuse their partners may also abuse their children, or force them to participate in the abuse of their mothers (McGee 2000, and Mullender et al 2002). The overlap between domestic and child abuse is estimated at between 45-70% (Stark & Flitcraft, 1988, Bowker et al 1988). Enquiries into child deaths indicate that violence towards women may coincide with their children being at greatest risk of suffering significant harm or death [Farmer and Owen, 1995; O'Hara, 1994]. Research has also indicated a raised incidence of child sexual abuse in households where the woman is subject to violence [Forman, 1995; Hester and Pearson,1998].

6.2 Many children will witness or be aware of domestic violence being committed. One study found that over 90% of children were in the same room or next room when their mother was being abused. Children can be hurt themselves, either by trying to intervene to protect their mother or being physically abused by the perpetrator. Abusive men often use threats to harm or abduct their children as a means of reinforcing his dominance within the family and ensuring the woman's compliance.

6.3 Children may feel responsible for the abuse e.g. if their behaviour is used as a trigger for violence. Abusive men are often very controlling and may impose rigid and unreasonably routines in the home, or prevent normal social contacts with friends, extended family, clubs etc. The man's control is often maintained by a regime of fear.

6.4 Coping with such abuse can adversely affect a woman's ability to meet her children's emotional needs. It can also put children at risk of neglect.

6.5 The negative impact of abuse can be manifested in a number of ways, e.g.

a. sleep disturbances,
b. temper tantrums, disruptive behaviour, and an inability to concentrate.
c. aggression, anxiety and feelings of powerlessness, guilt, shame, and fear (ref)

6.6 There is further evidence that many men use their relationship with their children to continue to harass women who have left them. Research conducted by Hester & Radford noted:

"...a variety of incidents and tactics, including physical and verbal abuse of the mother or others at 'hand over' time, abduction and

use of a child as a hostage in an effort to secure the mother's return to the marriage, grilling children for information about their mothers and manipulating legal procedures relating to child care in an effort to involve the courts and the law in continued harassment"

7. Role of health professional

7.1 Whilst a relatively small percentage of women experiencing abuse may use other services, virtually all women will at some point interact with health services, either on their own or children's behalf. Accordingly they have a pivotal role to play in identifying and responding to abuse. Presentation to a health professional may be the first opportunity women have to disclose and seek help.

7.2 The provision of an appropriate and sensitive response is crucial both for the welfare of women and their children. Engagement with women experiencing abuse will therefore encompass the following :

- ***Identification of domestic abuse***
- ***Assessment of risk***
- ***Identification & assessment of child protection issues***
- ***Intervention***
- ***Referral***
- ***Communication /sharing information***
- ***Documentation***

7.3 The key features of each step are discussed in turn.

8. Identification of abuse

8.1 It is important that women are asked about the existence of abuse in their lives. Research indicates that women do find it acceptable to be asked about abuse but often feel inhibited about raising this because of fears around stigmatisation, disbelief, being blamed and concerns about having their children removed (often a threat made by the perpetrator).

8.2 Women should be given the opportunity to speak to someone of the same sex. When a woman is deaf or her first language is not

English, arrange for a skilled interpreter or advocate to be present; it is unacceptable to use friends, family or children to interpret in this situation. Where a woman has learning disabilities staff should ensure that information is given in a format that she understands – learning disabilities team can offer support with this.

8.3 Possible indicators of abuse are:

- An injury that is inconsistent with the explanation
- Attempts to minimise/hide injuries with clothing or jewellery
- Anxiety, depression, agitation or panic attacks
- Evidence of sexual abuse
- Missed or postponed appointments
- Has a history of attempted suicide or self-harm
- Appears evasive socially withdrawn and is hesitant
- Repeated non specific symptoms
- A partner or relative accompanies her and answers questions for her
- Alcohol or substance misuse
- Frequent use of prescribed minor tranquillisers or analgesics

8.4 These lists are not exhaustive and there may be other causes. Some women experiencing abuse may show no signs or indications.

8.5 Research indicates that women want to be asked about abuse and consider this a legitimate area of enquiry for health professionals. Asking direct or indirect questions can validate women's experiences and provide an opportunity to discuss this and seek help.

8.6 The National Guidelines on Domestic Abuse for Healthcare Staff in NHS Scotland issued in 2003 provides the following examples of questions to ask when domestic abuse is suspected. The questions are intended as prompts - it will not be necessary to ask all of them and they should not be used as a checklist. In particular, the questions tend to focus on evidence of physical assault and injury,

but many women, who routinely access health care services and who are experiencing domestic violence, will not have physical evidence of injuries at the time.

- I noticed a number of bruises/cuts/scratches/burn marks: how did they happen?
- Do you ever feel frightened of your partner or other people at home?
- Does your partner ever treat you badly, such as shout at you, constantly call you names, push you around or threaten you?
- Have you ever been in a relationship where you have been hit, punched, hurt in any way? Is that happening now?
- Some women tell me that their partners are cruel, sometimes emotionally and sometimes physically hurting them - is this happening to you?
- We all argue at home. What happens when you and your partner argue or disagree?
- Has you partner ever-destroyed things you cared about? Threatened you? Forced sex on you/or made you have sex in a way that you are unhappy with? Withheld sex/rejected you sexually in a punishing way? Used your personal fears to 'torture' you?
- Does your partner get jealous and if so, how does he then act?
- You mentioned your partner misuses drugs/alcohol. How does he act when drinking excessively or on drugs?
- Your partner seems very concerned and anxious. That can mean he feels guilty. Was he responsible for your injuries?
- Has your partner ever prevented you from doing things, for example leaving the house seeing friends, getting a job or continuing your education?
- Has your partner ever threatened or abused your children?
- Have your children ever witnessed abuse towards you?

9. Risk assessment in domestic abuse

9.1 The nature and extent of domestic abuse varies in families. For some this may be sporadic or relatively 'low risk'. For some, however, this is more dangerous and threatening. Assessing the degree of risk to a woman and her child/ren is essential in establishing the safety of both and the potential for severe or lethal violence. For many women leaving is the most dangerous point in the relationship since this presents the most direct and clearest challenge to the man's authority and power within the relationship. Any fears articulated by women for their safety should therefore be taken seriously. Women seldom exaggerate the risk of harm; indeed are more likely to try to minimise the abuse.

9.2 Assessing for risk is not an exact business. It primarily involves balancing information with previous knowledge, practice and experience and then making a judgement about whether the women/children involved are at risk of serious harm. The following information should be sought when domestic abuse is disclosed to ascertain the nature of the abuse:

- *The type, frequency and severity of violence to which she is, or was, subjected. Is it becoming worse and/or happening more often? Has she sustained serious injuries?*

- *Has the perpetrator expressed/behaved in a jealous or controlling way? Does this cause significant concern? Is she isolated and without support?*

- *Is she in any present-day danger from the perpetrator? (e.g. is the perpetrator stalking her? does the perpetrator have access to guns or other weapons?)*

- *How does she feel her experience is affecting her now physically and psychologically? What is her assessment of the threat from her partner/ex-partner? How frightened is she of him and of taking action that may provoke further violence?*

- *Has she and/or the perpetrator had any suicidal ideation or suicide attempts?*

- *Does she and/or the perpetrator have problems with drugs and/or alcohol?*

9.3 Where any of the above factors are present in a relationship, there should be careful consideration of the need to involve other agencies.

9.4 Assessment should also include consideration about the staff member's own safety (NHSGGC Staff Safety Policies)

10. Identification and assessment of child protection

10.1 Whilst the existence of domestic abuse per se does not necessarily require the instigation of child protection procedures, it should ***significantly*** increase the index of suspicion by any health worker given the evidence of overlap between the abuse of women and the abuse of children and the emotional abuse that children suffer as a result.

10.2 Undertaking the risk assessment identified above should include risks to children. These are likely to be elevated where there are additional problems and stressors within the family, particularly in relation to addiction issues, chaotic lifestyles, homelessness and mental health issues. The vulnerability of children within these situations is heightened and requires careful assessment. Some groups of children have additional needs e.g. children affected by disability, children from minority ethnic groups or for whom English is not their first language.

10.3 Although much of the literature reveals higher risk of developing behavioural, cognitive, and emotional problems for such children, this is not inevitable and will be mediated by a number of factors, principally:

- Nature, frequency and severity of domestic abuse varies within families, as does the extent to which child abuse co-occurs within those settings.
- Degree of exposure to such abuse will vary as will the degree of risk i.e. from relatively mild exposure to being in a situation of grave danger, including risk of severe injury or murder.
- Number of other stressors within the family e.g. parental addiction, mental health problems, homelessness
- Varying protective factors in children's lives – children react differently; their coping skills differ; existence of wider family supports
- There is a wide variation in children's responses – some exhibit no greater problems than peers not exposed to abuse whilst for others multiple levels of difficulty may arise which can necessitate clinical intervention.

10.4 All of the above need to be considered as part of the response to children within domestic abuse situations. The Profile of Significant Factors and Care Pathway in Appendix 1 may be used where appropriate to identify the protective factors and significant indicators of adversity in a child's life and assist in making an assessment. Please note that it is not compulsory to use this. It is attached only as a tool to aid assessment, however it should be remembered that in some cases one significant adverse factor may be more than enough to initiate child protection procedures.

10.5 If women and children are identified as being in imminent danger then action must be taken swiftly. Where this is less apparent, assessment of risk should include the above factors. For children there should be an assessment of the extent to which they are exhibiting signs of distress, emotional disturbance or behavioural difficulties which may be associated with domestic abuse. The

possibility of direct harm to the child by abuse from the perpetrator should also be investigated. There should be vigilance around issues such as threats to harm children, emotional manipulation of them, destruction of toys, harm to pets etc which indicate a propensity for harm. Assessment of developmental progress should also be undertaken to explore possible negative impacts of abuse.

10.6 It is important to note that risk assessment is not a one-off event. Circumstances change within families, and women/children may become more at risk over time. Where there is ongoing contact it is essential that the health worker reviews the assessment and is alert to the possibility of such change, which will require further intervention.

10.7 Where there is little indication of risk as identified above, but the worker feels uneasy or concerned about a family then this should be discussed with the supervisor/line manager or with one of the child protection advisers in the child protection unit and a decision taken re onward referral. It is important that where there is suspicion about safety that action is taken to safeguard the welfare of a child.

11. Intervention

11.1 Balancing the needs of children in a situation where domestic abuse exists can be difficult and can create anxiety for health staff. Whilst there may be no immediate need for referral to statutory agencies, there should be intervention to try to support the women and children within the family. As noted in the *Audit and Review of Child Protection (2002*)**:**

"*Agencies and professionals need to exercise greater levels of judgement, in consultation with others, about the best approach to securing a child's welfare, and recognise that protecting the mother may be the best way to protect the child/ren".*

11.2 Providing practical and emotional support is a major factor in influencing how women and children survive and cope with abuse. Women should be supported to access community resources.

11.3 The safety of the woman and her family is a high priority therefore staff should discuss various options with the woman:

- Does she want to report the incident to the police?
- Does she feel safe to go home?

- Does she have friends or family with whom she can stay?

- Does she want immediate access to a refuge?

11.4 If she **does** want immediate access to a refuge then contact a local Women's Aid organisation and enquire if there is a space available.

11.5 If she **doesn't** need immediate access to a refuge, discuss other safety options with her, for example:

- Identify possible escape routes for her & her children e.g. to a friend or family member
- Ensure she has phone numbers for organisations that can help including the police
- Have a bag packed with items such as clothes, money, important documents etc & leave it with a friend or relative
- Ask a trusted neighbour to watch for signs of violence and phone the police if they are concerned.

11.5 The Flowchart for Domestic Abuse attached at Appendix 2 can be a useful guide for staff in identifying key issues with women.

12. Referral to Social Work

12.1 Where there are child protection concerns action must be taken promptly. Referral to Social Work services must be taken without delay. To assist this process it is important that as much information as possible is provided on the basis for concerns. This should include:

- Nature of concerns – knowledge of the family, assessment of harm/risk. This should be as detailed as possible drawing on the profile of significant factors and care pathway.
- Information on involvement of other agencies
- Whether referral has been discussed with the woman
- Any immediate danger that may be caused by involvement .

This should be followed up in writing using the inter-agency referral form.

12.2 In some situations where there may be less tangible evidence but the potential for abuse appears real, it is important to share possible concerns. A discussion of concerns can be held with Social Work services and documented if there are no grounds for

immediate action. This is crucial where it may be a constellation of factors, which have become apparent over a period of time, that give rise to suspicion.

13. Sharing of information

13.1 Confidentiality of personal health information is the cornerstone of the patient/health professional relationship. In circumstances where a child is at risk this overrides the need to keep the information confidential. According to National Guidelines on Domestic Abuse "The need to ensure proper protection for children requires that agencies share information promptly and effectively when necessary".

14. Documentation

14.1 Within case notes and medical records the following should be documented:

- Findings of assessment, to include physical/emotional symptoms and injuries
- Details of domestic abuse disclosed/alleged, using the woman's own words – contemporaneous notes should be taken where possible and records completed as soon as possible after disclosure.
- Outcome of risk assessment, detailing concerns about woman and child/ren
- Action taken, including:
    - Information / support provided
    - Referral to other agencies
    - Any decisions made within each agency or in discussion with other agencies
    - A note of information shared with other agencies , with whom and when
    - Clarification on whether the woman has given or withheld consent for sharing of information
    - Decisions made regarding Child Protection

Where patient held records are in use, any reference to domestic abuse should be kept separate and cross referenced to the original record. The benefits of recording domestic abuse with regard to later legal action should be explained to the woman.

15. Resources

15.1 Appendix 3 details the Women's Aid services available to women living in the N.H.S.G.G.C. area, including the 24hour helpline number.

16. Support for staff

16.1 Given the prevalence of abuse, there are many staff who have experienced, or are experiencing, domestic violence. The following support services are available for staff in such circumstances:

- Employee Policy on Domestic Abuse
- Occupational Health
- Employee Counselling Service (0141 332 9833 or 0800 435 768)
- Spiritual and Pastoral Care Service.

17. Consultation Process

17.1 The reviewed guidance was distributed to a wide range of staff via the NHSGGC Child Protection Forum, NHSGGC Child Protection Operational Groups (Acute) and (Partnerships) and Lead Officers (CPC's)

Members of the Child Protection Forum are:

Rosslyn Crocket, Acute Director – W&C Directorate
Marie Valente, Head of Child Protection Development, CPU
Jean Herbison, Clinical Director for Child Protection, CPU
David Leese, Director, Renfrewshire CHP
Julie Murray, Director East Renfrewshire CHP
Kerry Milligan, GP with Special Interest in Child protection, CPU
Neil Hunter, Joint General Manager, Glasgow Addictions Services
Catriona Renfrew, Director of Corporate Planning, NHSGGC
James Hobson, Director, East Dunbartonshire CHP
Gwen Proctor, Consultant Nurse in Child Protection, HNS24
Anne Hawkins, Director for Mental Health
Catherine Jamieson, Glasgow Homelessness Partnership
David Walker, Director, Inverclyde
Michael McClements, Joint General Manager, Glasgow Learning Disability

Specific comments were received from:

Lorna Pender, Gender Based Violence Advisor, NHSGGC
Clare McAvoy, Strathclyde Police, Public Protection Unit,

LDT East Dunbartonshire (Marjorie Kenny, Ellen Laird, Ricky Mooney)
Liz Fourna, Senior Officer Planning, Policy & Equalities, Social Work Services
James Y Paton, Reader in Developmental Medicine, University of Glasgow
Diane Allcock, NHSGGC

18. Review

These guidelines will be reviewed every 3 years as a minimum, or sooner if there is a specific legislative or service requirement or change in guidance, law or practice. The review will take account of :

- The evaluation or audit of the current guidelines
- Changes to organizational and national policy and context
- The ongoing requirement for the guidelines.

19. Communication and Implementation Plan

19.1 This document will be made available on the intranet and widely circulated to Directors and Senior Managers via the NHSGGC Child Protection Operational Groups (Acute) (Partnerships). It will also be available in hard copy from the Child Protection Unit. Briefing sessions will be delivered to key managers by CPU staff. Key managers will then cascade the briefings. This document can be made available in alternative formats, large print, audio CDS, alternative languages and Braille if requested.

20. Monitoring

The monitoring of the implementation of the policy is the responsibility of the Acute and CHCP Directors, supported by CPU. A report on the audit of compliance /effectiveness of the policy is to be submitted to CPU in December 2011. This will be discussed at the NHSGGC Child Protection Forum.

21. Impact Assessment

21.1 The cost implications involve resources as follows:

- CPU staff and Manager's time to brief staff on content
- Staff time to read document if full.

21.2 There are no additional workforce and staff requirements.

21.3 The main service delivery implications are that there may be increased sharing of information with social work services.

21.4 There are no clinical or financial risks associated with this guidance.

21.5 There will be no impact on the environment associated with this policy.

21.6 An Equalities impact (EQIA) screening tool has been completed and is attached at Appendix 4.

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19. As in 17

Appendix 1

PROFILE OF SIGNIFICANT FACTORS

NAME (s) …… CHI ……
Post Code …….. GP Code ……

PROTECTIVE FACTORS **Tick if present**

Resilience factors evident in child	
Evidence of secure attachment to at least one parent / carer	
Extended family support	
Community supports for child or parents	
Willingness of parent to engage with professions	
Parents supported by partner	
Other please state	

ADVERSITIES

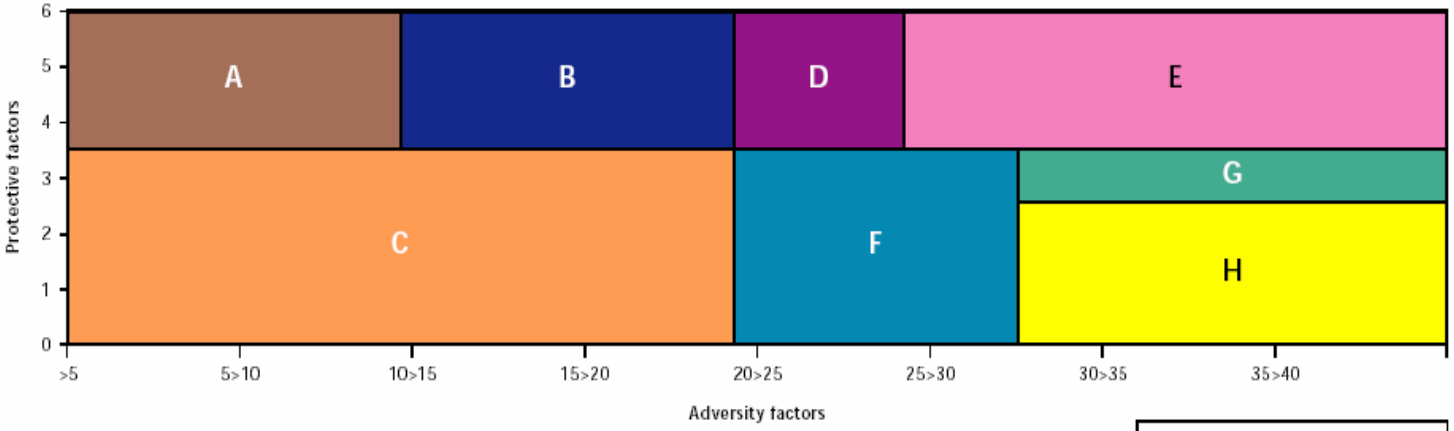
	PARENTS/MAIN CARER	
A	**Significant mental illness; past or current**	
B	**Significant physical illness; past or present**	
C	**Learning difficulties**	
D	**Negative Attitude towards pregnancy or birth**	
E	**20 Years or less at time of birth**	
F	**Evidence of substance abuse**	
G	**Evidence of domestic abuse**	
H	**Evidence of criminal activity**	

	CHILD	
S	**Early prolonged separation from mother**	
T	**Severe disability – or minor illness /disability causing concern**	
U	**Recurring illness or hospitalisation during first 12 months**	
V	**Failure to achieve milestones for development and growth**	

FAMILY BACKGROUND	
I Significant mental or physical illness; past or current	
J Evidence / suspicion of abnormal relationships in family – including abused parents.	
K Socio-economic problems, including unemployment	
L Housing problems or frequent changes of address	
M Relationship problems	
N Social isolation	
O Previous suspicion or evidence of child abuse in family	
P Male in household not father of child	
Q Sibling with chronic illness or disability	
R Evidence of ill treatment of animals	

PARENTING	
W Parents resistant to professional intervention	
X Excessive or inappropriate use of health services	
Y Baby /child perceived as difficult by parent	
Z Abnormal or unrealistic expectations of baby/child	
AA Rough or inappropriate handling of child in household	
BB Parent intolerant or over-anxious	
CC Parenting or caring skills questions by professionals	
DD Evidence of lack of emotional attachment between either parent and child	
EE Frequent non-attendance at child health appointments	

CARE PATHWAY



A	Good PF + lower adversity	*routine surveillance*
B	Good PF + increasing adversity	*review regularly*
C	Poor PF + increasing adversity	*attempt to increase PF*
D	Good PF + moderate adversity	*increase support possible refer to supporting agencies*
E	Good PF + significant adversity	*increase support/refer to supporting agencies*
F	Poor PF + moderate/significant adversity	*offer regular support and refer ot SWD*
G	Poor PF + significant adversity	*discuss with SWD/visit regularly*
H	Very low PF + very high adversity	*discuss with SWD urgently/may already be on CPR*

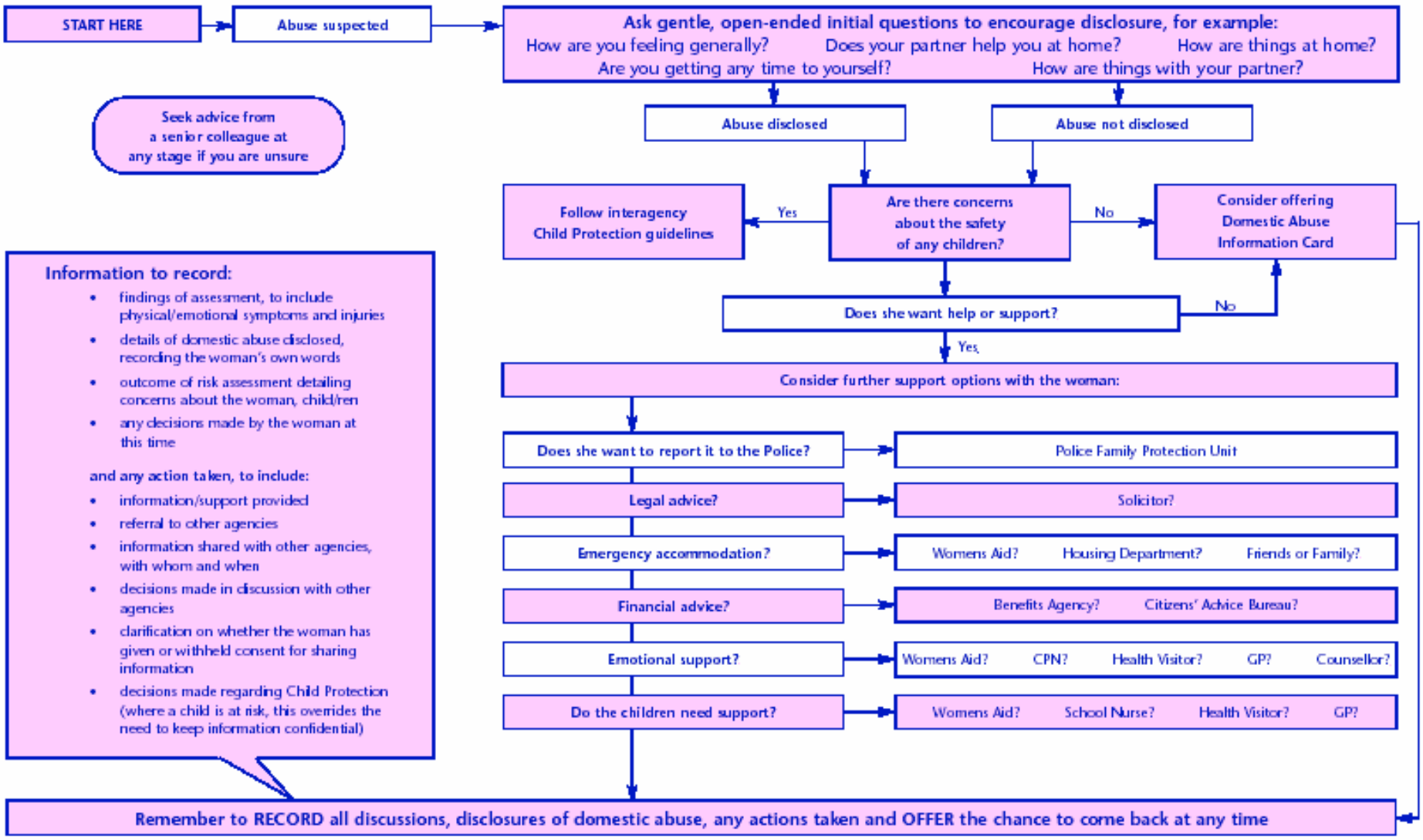
Maureen Houston, NHS Borders

	Result	
Date	Protective factors	Adversity factors

At any stage in the above process, referral should be made to Child Protection Services if there is a child protection concern. Entry to child protection procedures will in itself activate full multiagency standardised assessment.

IDENTIFYING AND RESPONDING TO DISCLOSURES OF DOMESTIC ABUSE - A GUIDE FOR HEALTH CARE WORKERS

Please refer to *Responding to Domestic Abuse: Guidelines for Health Care Workers in NHS Scotland (2003)* for more detail



Appendix 3

LOCAL CONTACT NUMBERS

Scottish Women's Aid	**0131 226 6606**
Domestic Abuse Helpline	**0800 027 1234**
Clydebank Women's Aid	**0141 952 8118**
Drumchapel Women's Aid	**0141 944 0201**
Dumbarton Women's Aid	**01389 751036**
East Dunbartonshire Women's Aid	**0141 776 0864**
East Renfrewshire Women's Aid	**0141 644 4342**
Glasgow Women's Aid	**0141 553 2022**
Greater Easterhouse Women's Aid	**0141 773 3533**
Hermatt Gryffe	**0141 353 0859**
Inverclyde Women's Aid	**01475 888505**
Renfrewshire Women's Aid	**0141 561 7030**
Domestic Abuse Website For Young People	**www.thehideout.org.uk**
Childline	**0800 11 11**

APPENDIX 4

EQIA Initial Screening Tool

STEP 1
Do <u>any</u> of the following apply?
It is already known or expected that the policy now, or in future, impacts differently on different groups of people - **NO** The policy has been identified as a corporate priority for EQIA (in which case the lead manager will have been informed) - **NO** The policy aims to address inequalities or specific requirements of equalities legislation **- NO** The policy has a major impact on the organization in terms of scale or significance, for example is likely to be high profile in the media or politically sensitive - **NO**
YES to one or more – EQIA REQUIRED, Proceed to STEP 3
NO – proceed to STEP 2

Who will be affected by the Policy	**In what way?**	**Impact**	**EQIA required?**
Small number of Children and Families	Improved sharing of information with relevant professionals regarding domestic abuse situations	Improved protection of children	no
Staff	Staff will have clearer guidance on domestic abuse and child protection	Greater confidence	no
EQIA required? **NO**			