Safeguarding Children and Young People:

The RCGP/NSPCC Safeguarding Children Toolkit for General Practice

5.1 Exposure of children to domestic violence

In the UK domestic violence is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

This can encompass, but is not limited to, the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

Domestic violence is a devastating breach of human rights as well as a major public health and clinical problem. The 2011–11 Crime Survey for England and Wales (CSEW) reports lifetime partner abuse prevalence of 31% for women and 18% for men; 7 and 5% respectively had experienced abuse in the previous 12 months. The CSEW also measures non-partner domestic violence (termed 'family abuse'), reporting a lifetime prevalence of 9 and 7% for women and men, respectively.

The starkest gender difference in prevalence is for sexual assault (lifetime experience: 20% women and 3% men), and women generally experience more severe, repeated abuse from male partners, with more significant injuries and long term health consequences then men. The prevalence in clinical populations, including general practice, is higher than in the general population: 40% of women patients ever experienced physical abuse in an east London study. This is often invisible to GPs; in the same study less than a 1/5th of survivors had any mention of abuse in their medical record.

Impact of domestic violence on children

Exposure to domestic violence during childhood and adolescence damages health across the lifespan. The impact of domestic violence on children does not require witnessing of violent acts. Exposure also includes hearing or seeing the consequence of the abuse and experiencing depleted parenting.

There is a moderate to strong association between children's exposure to interpersonal violence and internalising symptoms (e.g. anxiety, depression), externalising behaviours (e.g. aggression) and trauma symptoms. Children exposed to domestic violence are 2–4 times more likely than children from non-violent homes to exhibit clinically significant problems. Children's exposure to domestic violence also damages social development and academic attainment.

The harmful effects of living with domestic violence accumulate over time for children and this is a strong argument for intervention. There is considerable variation in children's

reactions and adaptation. This is partly explained by the presence or absence of other adversities in children's lives. For example, children exposed to domestic violence are at increased risk of being maltreated directly or neglected, with higher rates of maladjustment amongst children experiencing this 'double jeopardy'. The overlap with direct maltreatment ranges from 40 to 60% of children exposed to domestic violence, who may also experience a range of other adversities such as poverty, parental mental ill health, substance misuse and antisocial behaviour. The more adversities a child is exposed to the greater the risk of negative outcomes.

Presentations of children's domestic violence exposure

The most likely route of disclosure will be via the non-abusing parent's account of domestic violence but this is unlikely to be a spontaneous disclosure, although mothers may be prompted to seek help because of fears about their children's safety or well-being. Disclosure is more likely if the GP asks directly about domestic violence, preferably after training and with knowledge of local domestic violence services. Women may be reluctant to disclose because of fear about children being taken away. By the same token, spontaneous disclosure by a child, particularly in the presence of a parent is rare.

GPs benefit from training about how to approach this issue, focusing on support to the parent experiencing abuse which does not conflict with prioritising the child's safety.

When should a GP suspect that there is domestic violence in a family? Some of the presentations that should bring the question to mind are the same as those that should raise the suspicion of direct child maltreatment. However, anxiety is a key feature and children may be constantly alert.

Anxiety or fear related behaviour includes bed wetting or unexplained illness, running away from home, constant worry about possible danger or safety of family members, and aggression to other children and/or parents.

Resources: RCGP guidance on practice level response to domestic violence

AVA offers detailed guidance on exposure of children and young people to domestic violence:

Action Against Violence and Abuse

Identifying a child or young person's exposure to domestic violence and immediate response to disclosure

A central feature of good practice is creating opportunity and time to speak to the child or young person on their own in a way that is safe for them and the parent who is experiencing domestic violence, seeking that parent's permission to do so. Other features of good practice for primary care professionals include:

- being realistic and honest about the limits of confidentiality (but promise to keep the child/parent informed of what is happening);
- helping the child or young person to understand that they are not to blame for the domestic violence and that they are not alone;
- letting them know that domestic violence is never acceptable;

- being careful to acknowledge their experiences, help them understand that it is not their responsibility to protect the non-abusive parent, while validating their concern and any action they may have taken to protect that parent.

Children and young people can find it hard to talk for many reasons, such as shame, guilt, torn loyalties, threats as to what will happen if they tell anyone, not wanting to leave home or split up the family, or simply not having the language to express what is going on. If you are the first person a child has disclosed to, you are a very important person for that child. It is not the GP's role to gather evidence, but you will need to find out enough to determine whether a referral to social services is necessary. Your continuing support to the child is essential whatever you decide about referral.

Further response to disclosure

If a child is at risk of harm, the local safeguarding children board procedures should be followed immediately. The decision to refer to children's social services in the absence of direct maltreatment is a difficult judgment in relation to domestic violence exposure and it hinges on the concept of significant harm: 'any impairment of the child's health or development as a result of witnessing the ill-treatment of another person, such as domestic violence'.

This can include emotional and psychological harm, the form of harm most associated with exposure to domestic violence. Some localities have a policy to refer all children when you suspect domestic violence, although this is impossible to implement as services would quickly become overwhelmed. Not all children require referral. Discussion with your practice's safeguarding lead is essential and – if you are that person – discussion with your local Named Nurse, Named GP or Doctor for safeguarding will be helpful in reaching a decision about referral.

The common assessment framework has a section on domestic violence within the parenting capacity section that can inform the referral decision by identifying children's level of need.

Domestic violence advocacy services, which will be able to support the parent experiencing abuse, also have the expertise to assess children's needs and the need for referral. These services also undertake risk assessment for the parent and their children, a task beyond the capacity of most general practices.

Supporting the parent experiencing domestic violence is crucial to protecting children exposed to that violence. Stopping the violence towards a parent is the most effective way of protecting children and reducing adjustment difficulties associated with exposure. In some localities there are child-focussed services (e.g. run by NSPCC or Barnardos) to which you can make a direct referral in tandem with a referral to a domestic violence services.

Information sharing

Domestic violence is a challenge to safe information sharing. It is crucial to minimise the risk that perpetrators of domestic violence do not receive information about what their victim or children have said about the abuse. Risks to the safety of the non-abusive parent and their children through inappropriate sharing of confidential information must be recognized and prevented.

Information about domestic violence sent to the practice from a 3rd party (such as police, multiagency risk assessment conferences, see Section 5.5) should be noted in the medical records of children in the family, but not on the front screen in an easily recognizable form. That information should not be entered in the perpetrator's record unless there is assurance that they are already aware of the allegation.

If children's records are requested by the perpetrating parent, these need to be redacted so as not to endanger the children and the non-abusing parent. The same holds for disclosures by parent experiencing domestic violence: that information should be noted in the children's records in a disguised format and must not be entered into the perpetrator's medical record. GPs must guard against discussing disclosure of domestic violence with the perpetrator, as this may endanger the survivor. Police notifications of domestic abuse incidents may be coded using a special code for "Police domestic incident report received" V2 = 9NDJ, V3= Xaaqr.

The full document is available to download as a pdf from:
http://www.rcgp.org.uk/clinical-and-research/clinical-resources/children-and-young-people-toolkit.aspx