Researching **E**ducation to **S**trengthen **P**rimary care **ON** **D**omestic violence & **S**afeguarding (**RESPONDS)**

THINK CHILD – THINK FAMILY – THINK SAFETY

Trainers Pack

This pack was developed in partnership between:

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Contents

Introduction

This trainer's pack has been designed for professionals rolling out RESPONDS training and awareness sessions which aim to 'bridge the knowledge and practice gap between domestic violence and child safeguarding'

The training session is 2 hours in duration. It is designed to be delivered face to face to an audience of primary care professionals with specific emphasis on GPs. The 2 hour session covers the following topics which are divided into sections throughout the training:

1. Welcome and Context Setting
2. Linking Child Safeguarding and Domestic Violence in practice
3. Holding difficult conversations (in which safety and multi-agency working are considered)
4. Confidentiality
5. Speaking directly with children and young people
6. Child Protection Thresholds
7. Supporting victims of domestic violence and abuse (DVA), and negotiating referrals
8. Role of primary care after disclosure of DVA
9. Record Keeping

Each topic has a specific session within the training course and has key messages attached which clarify what you want your audience to take away with them. Any adaption's you make, for example if you decide to shorten the session to fit with your audience, should ensure that the key messages are still delivered.

When running training or workshops it is important to consider the following and plan how you will create a safe environment for learning. This needs to be a consideration even when delivering 'in house' to your own colleagues.

Language

Victims of domestic abuse are referred to as 'victim', 'patient', 'survivor' and 'client' interchangeably depending on the context of the point being made. We also use 'child' or 'young person' throughout and by this we mean 0-18 year olds. The use of the term young person is not to in anyway negate that those under 18 are legally children and it is essential that trainers keep a focus on abuse within this age group being a child protection issue.

Learning Environment

Trainers will need to make sure everyone feels it is a safe learning environment and monitor this throughout the session. Often it is preferable to invite participants to ask questions or to make comments as they arise throughout the training. This makes for better engagement and discussion between the trainer and the learners and amongst learners.

It is common to form an agreement about how this and other ways of working will be managed. For shorter sessions, creating a group agreement in conjunction with participants will take up disproportionate amounts of your session time so instead you might create a simple list of points for learners to consider and present this to them. Commonly group agreements include;

- Sticking to time.

Both in terms of arrival and coming back after breaks/group work – this is a group experience and not being on time delays the start of the session and impacts on others. Considering the topics to be covered during the training, time is of the essence!

- Giving everyone space to participate.

People learn differently, some by asking questions and debating points whereas others are more reflective. It is important that everyone thinks about the needs of others. Encourage participants to ask questions but to also consider holding back when they know they have contributed a lot to the discussions so that quieter group members can also have an opportunity. Acknowledge that some debate may need to be limited due to time constraints

- Respecting difference.

In terms of professional background and level of experience; everyone has something to contribute however experienced they are in this field or their role. It is also important that participants remember that we are all diverse and that some diversity is not visible. Ask participants to think carefully about the language they use and how this could impact on others. You may have an agency policy on discrimination and equality that you want to remind learners of. Or you may want adapt the following for your use: "It is the responsibility of the entire group to ensure that: this training actively contributes to developing a diverse learning environment which leads to the delivery of appropriate services; The particular needs of each person are recognised and respected whether they are training participants or clients."

- Confidentiality.

Whilst we want participants to take their learning and share it widely for the benefit of patients, this does not include details of disclosures that other participants may have made about their personal or professional life. Participants must remember that sensitive information should be left in the room. Trainers have a duty of care; where you have concerns that someone may be at risk in their personal life or if you have concerns about their practice you will need to speak to them about this and potentially escalate concerns. Be transparent about this from the outset, but reassure participants that you would consult with them privately first. Link this to GP's own duty of confidentiality and care toward their patients

- Self-care.

There is no requirement or necessity for participants to make personal disclosures. We know that many people have personal experiences of DVA and child abuse and some participants may choose to share this. Encourage participants to think carefully before doing so as it may impact on how comfortable they feel within the group for the remainder of the session. This may be particularly so if they are training alongside people they know and work with. Although many

participants will be exposed to upsetting and challenging situations daily in their work, when on training participants are not in their usual professional environment and this can mean that material upsets them in a way they were not expecting. Normalise this and encourage participants to look after themselves; opting out of exercises or taking time out when they need to.

Jargon

Trainers may wish to list and display unusual terms and acronyms; professional 'jargon', on flipchart e.g. DVA, CS, SafeLives DASH RIC, IDVA, CAF etc and invite learners to highlight any jargon used throughout the session for inclusion on the list. You will find a glossary at the back of this pack. Highlight at this point that names of services can be confusing e.g. social services v children's services. Explain that social services formerly applied to adult and children services combined but these are now separated across all local authorities. Throughout the training the terms children's services or children's social care will be used to refer to the social services focused on the welfare of children and young people. It is also important to point out that during the RESPONDS interviews with health professionals, some GP's talked about children's services when they were referring to health services for children and young people

Participants prior knowledge

For each session, the trainer(s) may choose to start with introductions to establish prior knowledge and also encourage contribution. In particular, establish what if any specific domestic violence training participants have had.

Gender

Non-abusing men are key allies in the work against domestic violence. Current data shows that the majority of high risk victims are female and domestic violence is widely acknowledged as a gendered issue. It is helpful to try and use gender neutral language to remind learners that domestic abuse can be perpetrated within same sex relationships and by women against male partners. However it must be acknowledged that women (particularly young women) are more at risk. If one or more participants are keen to debate this point, remind them that time is of the essence and suggest that they read some of the research about 'who does what to whom?' (Hester 2009)

Preparation for delivery

Please check the list of resources needed for each session (listed at the start of the session scripts). The majority of the resources will be at the back of your training pack. In addition you will need to;

- Personalise PowerPoint slides where applicable: PowerPoint slides are available to support the sessions in this pack. Notes to assist trainers in delivering them are contained within the script for each session. There are some slides that are blank for you to tailor to the session you are running e.g. the slide of local resources/services

- Training DVD: Most of the sessions use the training film as a learning medium. Check the facilities you will have available to you before the session to ensure you can show the DVD. Consider what you will do if there is a technical problem. For example, the film scenarios could be available as a written case study. You will need to check there is adequate audio and that the DVD can be played on any equipment you are using

- Identify any other domestic violence training in your area and any strategies that include such training. It is important they know you are rolling out the training so that training pathways can be established

- Speak to your local MARAC co-ordinator. Your local MARAC co-ordinator will collate MARAC referrals and can tell you the process for this in your area. You can use this information to personalise the MARAC information

- Speak to your local domestic abuse service: ask your local domestic abuse service for a summary of what they offer and copies of leaflets etc. These can be displayed at training to encourage learners to make referrals. In the case of an IRIS practice, communicate directly with the IRIS advocate educator.

Background reading and sources of further information

Suggested background reading:	**Overview**
National Institute for Health and Care Excellence Domestic Violence and Abuse – how services can respond effectively 2014 http://guidance.nice.org.uk/PHG/Wave20/60	Public health guidance, PH50 - Issued: February 2014. Domestic violence and abuse is a complex issue that needs sensitive handling by a range of health and social care professionals. The recommendations cover the broad spectrum of domestic violence and abuse, including violence perpetrated on men, on those in same-sex relationships and on young people. Working in a multi-agency partnership is the most effective way to approach the issue at both an operational and strategic level.
National Institute for Health and Care Excellence Domestic Violence and Abuse Pathway http://www.nice.org.uk/Search.do?searchText=domesticviolence	Fast, easy summary view of NICE guidance on '**Domestic violence** and abuse'
Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children. HM Government March 2013 http://www.workingtogetheronline.co.uk/documen	The guidance covers the legislative requirements and expectations on individual services to safeguard and promote the welfare of children and provides a clear framework for Local Safeguarding Children's Boards (LSCB's) to monitor the

ts/Working%20TogetherFINAL.pdf	effectiveness of local services.
Responding to domestic abuse – Guidance for general practices http://www.safelives.org.uk/sites/default/files/resources/SafeLives_GP_guidance_manual_STG1_editable_0.pdf	This document provides guidance to general practices to help them respond effectively to patients experiencing domestic abuse. It is produced collaboratively between RCGP, IRIS and SafeLives
Safeguarding Children and Young people: roles and competencies for health care staff Intercollegiate Document September 2010 http://fflm.ac.uk/upload/documents/1290784237.pdf	To protect children and young people from harm, all health staff must have the competencies to recognise child maltreatment and to take effective action as appropriate to their role. The document describes six levels of competencies and provides model role descriptions for named and designated health professionals. (Updated from 2006, further updates were due in 2013)
Section on domestic violence in updated RCGP/NSPCC toolkit	Not published yet, so not in public domain; included as Appendix B to this pack
CAADA Insights 2: In Plain Sight: effective help for children exposed to domestic abuse (February 2014) – policy report http://safelives.org.uk/sites/default/files/resources/Final%20policy%20report%20In%20plain%20sight%20-%20effective%20help%20for%20children%20exposed%20to%20domestic%20abuse.pdf	This policy report examines the grave impact domestic abuse has on the children forced to live with it, challenges policy makers and commissioners to act now and provides practical recommendations about what to do. (Evidence taken from Insights Database – information relating to those identified as high risk victims of domestic abuse)
Suggested Research	**Overview**
Pearson, C. Hester, M. Harwin, N. (2006) *Making an Impact – Children and Domestic Violence A Reader*. Jessica Kingsley Publishing	This fully updated Reader provides a comprehensive review of recent research and legislation relating to domestic violence and its consequences for children, and identifies the implications for practice
Stanley, N. (2011) *Children Experiencing Domestic Violence: A Research Review.* Research in Practice	This research review explores the research and evidence around children's experience of domestic violence and the role of multi-agency service responses and interventions
Hester, M. (2009) *Who Does What to Whom? Gender and Domestic Violence Perpetrators*, Bristol: University of Bristol in association with the	This research explores how male victims and perpetrators of domestic violence may differ from female victims and perpetrators with regard

Northern Rock Foundation	to the nature and number of domestic violence incidents recorded by the police. The report explores 'who does what to whom', taking into account both context and consequences
Suggested websites	**Overview**
The Royal College of General Practitioners (RCGP) http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx	Advice and guidance for general practice on responding to domestic violence and abuse. This site also contains an e-learning package which is free to access and contains some useful resources
IRIS – Identification and Referral to Improve Safety http://www.irisdomesticviolence.org.uk/iris/	IRIS is collaboration between primary care and third sector organisations specialising in DVA. It is a general practice-based domestic violence and abuse (DVA) training support and referral programme that has been evaluated in a randomised controlled trial.
IDAS http://www.idas.org.uk/training/index.asp	A free online e-learning tool on the dynamics of domestic abuse. This is ideal for professionals. Learners can test their knowledge and print off a certificate when completed.

Time table

Section	Activity	Duration
1	Welcome and Context Setting - introductions, background to training and experiential exercise	15 mins
2	Linking Child Safeguarding and Domestic Violence in practice - Training DVD, Group Discussion, power point	15 mins
3 and 4	Holding difficult conversations and confidentiality - Training DVD, Group Discussion, power point	20 mins
5 and 6	Speaking directly with children and young people and child protection thresholds - Training DVD, Group Discussion, power point	20 mins
7 and 8	Supporting victims of domestic violence, negotiating referrals and the role of primary care after disclosure of dva - Training DVD, Group Discussion, power point	30 mins
9	Record Keeping - Training DVD, trainers to set task, power point and handouts	10 mins
10	End of Course Reflections - comment from each learning participant	10 mins

1: Welcome and Context Setting: Timing 15 mins

Aim of section	To welcome participants, provide an overview of the training session and give a background to its development
Methods	Trainer presentation, individual learner input and experiential group exercise
Materials	PowerPoint slides 1-3 Space for group to stand in a circle

Key Messages

- **Training has been designed based on evidence from RESPONDS research findings in particular listening to what GPs want from training on links between domestic violence and child safeguarding**
- **There is no 'magic wand' but by considering positive practice and reflecting on our own practice, we can ensure that we are seeing multiple perspectives of risk in families and therefore focusing on safety of all individuals involved**

<u>Welcome, Introductions and context setting (15 mins)</u>

- Welcome participants to the session and introduce yourself. Remember to type in your name on power point!
- Inform participants that the training lasts for 2 hours and it is preferable to work straight through, however be mindful of learners' diverse needs – this may have to be negotiated with the group.

- Set the context of the training by informing participants:

- - Training has been designed based on evidence from emerging findings from RESPONDS. RESPONDS is a 2 ½ year project, funded by the Department of Health policy research programme, aiming to bridge the knowledge and practice gap between domestic violence and child safeguarding: developing policy and training for general practice. A variety of research methods have been employed, including a systematic review of training evaluations, interviews with 69 frontline primary care professionals and scrutiny of DV content in CS training for GPs. The training has been designed in particular listening to what GPs want from training on the issues of domestic violence and child safeguarding
- The session therefore will be:

- focusing on unfolding a case study that will be viewed on screen throughout the training and
- discussing collectively issues associated with responding to DV and CS and sharing practice ideas. These are two key methods GPs indicated they would find useful

Inform participants it would be impossible to capture every scenario that a health professional may face and the hope is that this will be a guide to reflecting on other presentations of domestic abuse and child maltreatment

The session aims to encourage health professionals to be proactive in making links between the issue of domestic abuse and child maltreatment and address the complexities of doing so (as identified by GPs in the RESPONDS research)

- Depending on group size, ask learners to introduce themselves providing their name and their role. This should be a swift round although it will be useful to get an understanding of how much training participants have done. It may well be that all participants know each other but if they don't, for e.g. multi agency group - introductions will be important as working in partnership with other services is a key aspect of the training. The experiential exercise is optional to allow trainers to decide if they need to spend more time on introductions

- You may want to show a working together agreement or present one of your own. Inform learners that while discussion is an important component of the training – time is of the essence! It may be an idea to negotiate with the group how you will close down discussions and move on when necessary.

Experiential Exercise: Optional but great for illustrating key points

Trainer: ask group to stand in a circle. Ask for a volunteer from the group to stand in the middle or take this position yourself. If asking for a volunteer inform the group that the person won't have to do anything silly but will be required to stand still in one position for a few minutes. When the person is in the middle ask 2 or 3 group members who are in different positions in the circle to comment on what they can see only in terms of the person in the middle's eyes, ears and hands. NB. This needs to be carefully managed as sometimes participants wish to provide huge amounts of information about what they can see – we are only wanting to know fact i.e. two hands, back of two ears, but can't see any eyes. It is important for the trainer to keep this snappy and quick so that it doesn't become patronising.

Key messages to pull out very quickly with group:

- We all have different perspectives
- Some parts are invisible
- We may make assumptions about what is there or not there
- We will need to share information if we are to get a full picture of what is going on

Inform the group that the person in the middle represents a victim of domestic abuse

Ask the group to consider 'if a participant from one part of the circle wants information about the person in the middle from a participant in another part of the circle, how should they approach them? (consider formalities around information sharing e.g. directly? request in writing?, pick up the phone? It will also be important to have an understanding of the role of the person you are obtaining information from)

Ask the group to consider 'now they both have more information about the person in the middle, who is responsible for them?' (we want the group to recognise that both people have responsibilities regarding the person in the middle)

Ask the person in the middle – how does it feel with everyone looking at you? Or comment on this yourself if it is you (it is important to recognise that the situation may feel overwhelming for a victim and they may want everyone to stop looking at them, therefore sensitivity is needed in our responses to intervening in families experiencing domestic abuse)

It is important we focus on safety with victims of domestic abuse and keep them central in our work but who remains invisible? (children maybe, perpetrators definitely!)

- Introduce Aims of the session
- **Show PowerPoint slides 2 & 3**

2: Linking Safeguarding Children and Domestic Violence in Practice

Timing: 15 mins

Aim of section	To provide knowledge of link from CS to DV and DV to CS and to strengthen self-efficacy in when to go for further investigation
Methods	Training DVD scenario 1 and Talking Head 1, group discussion, trainer input
Materials	PowerPoint slides 4-10 Flip Chart to document learner responses

Key Messages

- **Think Child, Think Family, Think Safety**

<u>Training DVD – scene 1 Opening Scene (5 mins)</u>

<u>Key learning point:</u>

For learners to appreciate that children and young people's behaviour may be indicative of witnessing and experiencing domestic violence and abuse and primary care professionals have a significant role to play in responding to and safeguarding both children and adults in these situations

- Show training DVD – scene 1 Opening Scene

- Hold discussion with training group asking the following questions

- What are they thinking about Jake?
- What are they thinking about Susan?
- Would you consider domestic violence and abuse as an issue affecting this family? Why might it be important to do so?
- What are the indicators?

This is a generally snappy discussion to gather the initial thoughts of the group. As a trainer you are likely at this stage to be assessing the general knowledge levels and attitudes of the group. It is very likely that they will vary! Your aim is to motivate participants' 'curiosity' in patients' situations and to encourage them from the outset to think about wider issues in family life that may be interconnected e.g. aggression and violence, alcohol, depression, children's behavioural issues. Guide the discussion to make these points and highlight the importance of early identification

Power Point and discussion (10 mins)

Key learning point

To be aware of the evidence of the links between child maltreatment and domestic violence and abuse and begin to consider health professionals' responses to families where these issues could be occurring

- **Show power point slide 4 , 5 and 6** to confirm the above points and suggest that the opening scene viewed on the DVD is the sort of situation in which GPs should have the issue of child maltreatment and domestic violence in their minds

- Hold further group discussion and ask the following questions;

- How might they proceed with the appointment?
- What are the challenges in practice?

- Collect ideas and issues raised on the flip chart (it may be helpful to have 2 columns 1- ideas for proceeding appointment 2 – practice challenges) but do not delve too deeply into discussion as hopefully issues raised will be covered as we progress through the training DVD. Write them onto the flip chart as questions/issues

- Ideas for proceeding with appointment will hopefully include asking questions about domestic abuse, thinking about speaking with Jake, thinking about safety, recognising the need for further appointments

- Challenges may include 'difficult asking questions about domestic abuse', 'not having time to address it', 'people might not want help', 'they may not acknowledge that's what is happening' 'we might be jumping to conclusions', 'not having time to ask everyone', 'difficult to speak with children', 'might make things worse'

- Ask the group further about their practice in terms of asking questions about domestic abuse. Do they feel it's important? How and when can this be done? Ask for examples. Acknowledge complexities involved in this but encourage participants to think creatively

- Inform participants that it can be helpful to obtain different perspectives of people working in the field. Throughout the training, perspectives of practitioners from Health and Social Care have been incorporated to stimulate further thinking and provide helpful suggestions from research and practice – introduce and play training DVD **GP perspective 1**

- Following the excerpt ask participants what further practice information did they gain? Draw out the point that it is important not only to prepare to ask questions, but to think what information you may need from the initial consultation.

- Round up discussion **using power point slide 7, 8 , 9 and 10**. Highlight the key message here, that we are encouraging GP's and health professionals to 'think child, think family, think safety' – a proactive and holistic response to protecting children and victims of domestic abuse

- Some trainer prompts are below to help guide the discussions outlined above but be mindful of time – you want to extract the key points swiftly. It is important to be familiar with the training content so you know what will be covered later during the training. The information column can be used to address discussion points raised

Issue	Information	Discussion points
Asking questions about domestic violence and abuse	NICE guidelines recommend that health and social care organisations should create an environment in which DVA can be disclosed and frontline staff are trained to ask questions about it HARKS provides a model of asking http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2034562 Children are suffering multiple physical and mental health consequences as a result of exposure to domestic abuse (CAADA 2014)	Should we ask women and men? Together or separately? In what circumstances? What may create an environment that will encourage disclosure? (posters, leaflets, information in waiting areas) Should concerns raised about children prompt questions about domestic violence and abuse? Do you have a policy and is everyone familiar with it?

When to ask about domestic violence and abuse	RESPONDS research highlighted GPs more likely to consider child protection issues when they encounter DV than they are to look for DV in child protection cases RCGP training online explores indicators of domestic abuse	What might the benefit be of asking if we had a child protection concern? Trainers can bring into discussion point raised in Talking Head 1: There is no evidence to suggest that screening increases safety but thresholds for asking about domestic violence and abuse should be low
Privacy	NICE guidelines highlight the enquiry should be made in private, on a one to one basis in an environment where the person feels safe, in a kind, sensitive manner.	What if the partner is present? (many creative examples of obtaining privacy are adopted in a number of health settings e.g involving other members of trained staff to ask while they obtain specimens or suggesting follow up appointments) What if children are present? (it is not recommended that questions are asked when children over the age of 3 are present)
Limited Time	RESPONDS research highlighted that time was a barrier for GP's exploring issues such as domestic abuse	Trainers can bring into discussion point raised in Talking Head 1: Viewing relationship with patient as continuous and ongoing helps address a barrier such as time. You don't have to do everything at once!

Section 3 and 4: Holding difficult conversations and confidentiality

Timing 20 mins

Aim of section	To provide examples of holding difficult conversations and increase participant's' awareness of support services and interagency working To raise the issues of confidentiality and record keeping and provide guidance for practice
Methods	Training DVD scenario 2 and Talking Head 2, group discussion, trainer

	input
Materials	PowerPoint slides 11 - 13 Flip Chart to document learner responses

Key Message

- **GP's and frontline health professionals should ask questions where appropriate about domestic violence and abuse and the safety of all those concerned. They cannot however be responsible for managing potential risks alone. It is essential to work with other services when domestic abuse is disclosed and there are children in the family**

Training DVD scene 2 – Progression of appointment (10 mins)

Key learning point:

Practitioners should handle difficult conversations sensitively, have knowledge of services that can offer support to victims of domestic abuse and their children and consider safety of all family members

- Ask participants to hold in their minds, thoughts about how they may progress the appointment started in scene 1. Explain we will now see how the appointment progressed in this case. **Show training DVD, scene 2**

- Following the scenario, collect some initial thoughts from the group about the approach they have seen.

- Ask the group 'what risks have you identified from what you have seen?'

Group exercise and power point presentation – options available to GPs when supporting patients experiencing domestic violence and abuse (10 mins)

Key learning point:

Knowledge of local services and systems can improve the range of support GP's can offer patients

- Ask participants on their tables (or in small groups) to discuss if there is anything else the GP could have done/suggested? Would they do anything differently? Give the groups time to discuss but remind them that they will only have a few minutes. You are only asking them to make one or two suggestions

- Collect an example from each table/group (group size permitting – there may of course be one group if numbers are small)

- As examples are given, it will be interesting to see if any suggestions relate to the perpetrator. Stress that interventions here must always consider safety to all family members – however opportunities may present e.g. if the perpetrator is registered at the same practice, if alcohol is identified as an issue, if routine health checks can be suggested. But beware of severe risk to DVA survivor if her disclosure is inadvertently revealed to the perpetrator, including information put into his medical record.

- Notice if suggestions include all family members i.e. the 4 year old daughter. She may be easily missed and if this happens it is an important learning point! – how easily children can become invisible to practitioners – a point raised in many SCRs. If she is not mentioned, ask the group directly about her, what are the risks in assuming she is 'good as gold' as suggested by her mother? The role of the health visitor may be crucial here to ensure all children are safeguarded.

- Play the training DVD – **GP Perspective 2)** the services that are available to GP's and addressing the issue of confidentiality

- Following this excerpt **show power point slide 11**

Working in partnership after disclosure of domestic abuse

- Consider risks presenting to all family members
- Initiate a health visitor review where appropriate
- Inform patient where relevant that you will be working with other services e.g. school, school nurse
- Ask if this is ok
- Inform patients about specialist domestic abuse support services
- Seek consent to make a referral
- Ask if it safe for them to go home
- Provide domestic abuse basic safety information e.g.consider what you may do if you had to leave your home suddenly, in an emergency call 999

Working in partnership	Trainer's Notes
Consider risks presenting to all family members	Remind practitioners to gain as much information about who is in the home and who may potentially be at risk of serious harm
Initiate a health visitor review where appropriate	If children under 5 are present the health visitor can be a key professional in obtaining further information which may inform courses or action. They may be able to initiate a CAF or involve the relevant services who can. Health visitors can be lead professionals in safeguarding issues and interventions may be very effective if GP's and health visitors collaborate, sharing both information and decisions about safeguarding families
Inform patients where relevant that you will be working with other services e.g. school, school nurse	Being specific about who you will talk with and why is important. Victims of domestic abuse may be particularly worried about who gets to hear what is going on. Information gathering from other professionals does not necessarily need to involve information sharing without consent
Ask if this is ok	Seek consent where possible from patients regarding information sharing. If you believe that there is imminent risk of serious harm to children or adults you may have to share information without consent. SafeLiveshas an information sharing without consent form that may be useful to refer to which can be found on the SafeLives website
Inform patients about local specialist domestic abuse services	Remind practitioners to have information about these services available. If the practice is an IRIS practice, ask if everyone is aware of the direct referral pathway. Inform participants that domestic abuse services will most likely conduct a risk assessment with the victim when they receive referrals. If they are considered high risk they may be referred to MARAC. The next power point slides will cover this
Provide domestic abuse basic safety information	Ask participants to remember to check out how safe someone feels to return home. Name abusive behaviour where possible and reassure a victim that it is not ok and is not their fault. Remind them that they can phone 999 if they ever feel afraid of someone in their home and ask them to consider what they may do in an emergency e.g. if they had to leave the house suddenly

- **Show power point slide 12** to highlight the sorts of services patients and GP's can expect from a domestic abuse service

- Stress that most Domestic Abuse services will assess levels of risk and tailor the support offered to the needs of the patient/client depending on their assessed level of risk e.g. if high risk is identified a referral to MARAC will be made
- If GP's wish to know more about risk assessment or MARAC, direct them to local MARAC training and/or the SafeLives website http://www.safelives.org.uk/
- It is important to highlight to training participants that they should not assume referrals to children's social services would automatically be made by the domestic abuse service. If a GP has concerns about harm to the children they should follow child protection procedures which we will be moving on to consider in more detail.
- **Show power point slide 13** – trainers will need to tailor this slide to their local area to provide key service information for group participants

Section 5 and 6: Speaking directly to children and young people and Child Protection Thresholds

Timing 20 mins

Aim of section	To highlight ways health professionals can speaking directly to children and young people and consider thresholds for child protection intervention
Methods	Training DVD scenario 3
Materials	**Trainers should equip themselves and make available to participants any local safeguarding children's board threshold of intervention information**

	PowerPoint slides 14 - 15 Flip Chart to document learner responses

Key Message

- **Important information can be gained by speaking with young people on a one to one basis and therefore doing so can lead to health professionals making more accurate decisions relating to risk and intervention**

Acknowledge/remind the clinicians that they have great expertise in managing consultations with adults and children, but probably less experienced in speaking to child patients on their own. They are however familiar with talking with children and young people in sensitive situations such as when they are conducting a physical examination

Group discussion and training DVD – (10 mins)

Key learning point:

Being listened to and taken seriously can have a positive impact on the resilience of children who have experienced and witnessed domestic violence and abuse

- Explain to the group that RESPONDS research highlighted that GPs and health professionals found examples from others helpful when considering their own practice. In relation to talking to children directly, GPs interviewed varied in whether they did this or not and a number of those who said they didn't do so, thought on reflection that they should. Some of those who had done so in the past said that they now believed that it was important to do as children may not have anyone else they can talk to about DVA. The following excerpt from the training DVD demonstrates ways in which conversations with children and young people can be handled by GPs. Ask the group to note as they watch it aspects that they think are particularly effective when talking to a child.
- **Show scene 3 on training DVD**

- Take some feedback following the scenario and the notes that group members made while they were watching

- Ask the group the following questions

-Would they do anything differently so far? [Prompt: how would they modulate the intensity of the consultation?]

-What risks are identified and what does this mean in terms of actions? (this can be done in groups if time)

- Trainers will need to guide the discussion toward the issue of whether GPs and health professionals would involve children's services and gain an idea from participants of who would and wouldn't be

- **Remind participants to consider the needs of the 4 year old in the family – again highlight how easily children can become invisible!**

Group discussion and power point – (10 mins)

Key learning point:

By looking at children's needs on a continuum, GPs and other health professionals can match the child/young person's needs with the appropriate assessment and provision.

- The following model should be linked to GP's Child Safeguarding Training and is being used here to extend the model to DVA exposure. **Show power point slide 14**. The Continuum of Need model (windscreen) provides a multi-agency, whole systems approach to assessment, prevention and intervention for children, young people and their families and directly supports the full implementation of the CAF.

- Explain this model has been developed by the Torbay Safeguarding Children's Board and variations of it are used by many local authorities across England and Wales to provide guidance around 'thresholds of intervention'.

- Hand out local documents where possible

- Explain this model is dynamic and provides a needs led, outcome driven matrix of need and vulnerability which, when used effectively, can match the child/young person's needs with the appropriate assessment and provision.
- The Continuum of Need model describes the spectrum of support and the relationship between the different levels of need. It illustrates how a child's level of need can move forward and backwards across the continuum, highlighting the importance of integrated service delivery.

- It also reinforces the need for an effective seamless process to ensure continuity of care when a child or young person moves between different levels of support.

- The view of a 'whole systems' approach highlights the importance of there always being a practitioner in place to co-ordinate service activity and to act as single point of contact whenever a child or young person requires integrated support. Ask the group who they think this practitioner should be and what is the role of health in this process?

- The model is also referred to as the 'Child's Journey' (e.g. in Torbay, Gloucestershire) and identifies four levels of vulnerability and need to assist practitioners to identify the most appropriate service response for children, young people and their families.

- **Show power point slide 15** and ask GP's what indicators they may see at each level in children and young people exposed to DVA and crucially what their role is in supporting them and what they can do at each level ;

Levels of Vulnerability and Need

Level 1 Universal	Children with no additional needs. Children who make good overall progress in all areas of development and receive appropriate universal services.
Level 2 Additional Needs	Children with additional needs. Children whose health and development may be adversely affected and who would benefit from extra help in order to make the best of their life chances.
Level 3 Complex Additional Needs	Children with complex needs. Children whose health and/or development is being impaired or there is a high risk of impairment.
Level 4 In Need of Protection	Children who are experiencing significant harm or where there is a likelihood of significant harm.

Section 7 and 8: Supporting victims of domestic violence, negotiating referrals and the Role of Primary Care after disclosure of DVA

Timing 30 mins

Aim of section	To demonstrate ways that GP's can negotiate referrals to ensure the safety of children and to know what they should expect from children's services as well as actively supporting victims of domestic violence and abuse. This section highlights the process as an ongoing relationship with the family.
Methods	Training DVD scenario 4 and Talking Heads 3 and 4
Materials	**Trainers should be familiar with local safeguarding procedures and**

	include local referral information PowerPoint slide 16 Flip Chart to record responses

Key Message

- **GPs and health professionals have an ongoing role to play in supporting both threshold and sub-threshold patients and an appreciation of the role of children's services can assist with understanding how best to do this**

<u>Group discussion and training DVD – (10 mins)</u>

<u>Key learning point:</u>

Negotiating referrals is an area which should be handled sensitively with patients who should be informed of all actions taken and encouraged to see the support that other services can provide

- Ask the group from what they have seen so far in the scenario, what do they think the GP will do next?
- Take a couple of comments from the group
- Explain that you will now show the outcome to this particular scenario and recognise that not all situations may progress like this
- **Show training DVD scene 4**
- Following the scenario ask the group for their thoughts on how the GP handled this situation
- In particular ask the group for key learning points around how the referrals were negotiated with Susan and Jake
- **Show slide 16 and ensure participants are clear of local procedures**
- Ask for thoughts around what would happen if Susan disengaged or Jake did not want to speak alone – how would the negotiations have to change?
- Be ready for question about some area policies (e.g. London) to refer all children exposed to DVA. If this were implemented, children's services would be quickly overwhelmed and, paradoxically, increase risk for the children with greatest needs. So, as we do in relation to potential direct maltreatment, we need to make a judgement, helped by the DVA agency if the parent has agreed to referral or the local named safeguarding lead

- (At this stage, trainers may need to highlight the statutory duty of care we all have when identifying high risk of harm. SafeLives has produced information sharing without consent form which can be accessed on the SafeLives website. This may be useful to refer to as it contains a decision making process for professionals to follow when they are faced with difficult decisions such as sharing information without consent)

The Role of Children's Services

The Training DVD 'Children's Services Perspective' (15 mins) is available for this section. Use of this section of the training film is OPTIONAL. To reduce overall film use, which is extensive throughout this training package, trainers may prefer to explain directly to GP's what they can expect from Children's services following a referral. The film can be made available to GP's following the training should they wish to directly view the perspective of children's services

Key learning point:

Information for GPs and frontline health professionals about the role of children's services, what they can expect following a referral and what referral information is most helpful to provide

- Explain to the training participants that GPs interviewed as part of the RESPONDS research clearly stated that they wanted more information about the role of children's services so they could be clear about their expectations when working with this service
- The following excerpt has therefore been recorded to help GPs and health professionals increase their understanding of children's services and consider the information they provide when making a referral
- Show training film Children's Services perspectives

The Role of Primary Care after disclosure of DVA– Group Discussion and Training GP perspective 1 & 2 (5 mins)

Key learning point:

Whether patients have met the threshold for children's services referral or not, the GP has an ongoing role to play with families experiencing domestic abuse

- Ask the group now that a referral has been made, has the GP fulfilled their role? (Hopefully the answer will be no!)

- Highlight to the group the importance of ensuring support is in place for the adult patient as we shouldn't assume that a survivor of domestic abuse will get appropriate support as a result of a children's services referral
- Ask what more the GP can do for Susan and/or Jake?
- Should they be taking any action with regard Dave (the perpetrator of domestic abuse)?
- Collect responses from group on flip chart (you may want to divide the flip chart in 3 columns e.g. Jake, Susan, Dave)
- Inform the group that the final section of DVD to play them is again the perspective's directly from GP's
- **Play training DVD GP perspective 1 & 2**

Group discussion and action learning (homework!) task – Recording Information (10 mins)

Key learning point:

RESPONDS research has highlighted that practice differs in terms of recording information about domestic abuse and this is an area which is being debated nationally

- Show training DVD **Talking Head Recording DV and CS issues**

Introduce a task that the RESPONDS project is keen to set. Encourage participants to see the task in the context of contribution to practice development. **Use slide 17** as a backdrop to discussing the task. The task is as follows and this information can be found in the appendix so that it can be given as a handout along with **Use of codes in relation to child safeguarding/DVA interface and Aspects of practice policy in relation to domestic violence and child safeguarding**;

Trainers to set group members the following task

Evidence from the Responds interviews shows that there are multiple methods of recording both CS and DV – different codes, within the text, flags, and hidden messages. Interviews suggest there were differences between general practices and *within* general practice – so you all probably do it differently. Serious case reviews suggest the most important thing is to have a consistent recording system that everyone in the practice understands and uses consistently, including locums, trainees, and new members of staff. NICE also recommend this approach and suggest using codes.

Currently there is no national guidance about which codes to use and your organisation needs to be confident and familiar with the recording system and ensure that there is a consistent approach to the way DVA and CS are recorded

There are some difficult areas – what codes? Which family members notes and under which circumstances? Do the people that redact notes know the policy? Because everyone does it differently you need to develop a policy

We suggest you hold a practice meeting to draw up a practice policy for how you record DV and CS, which codes you will use, and how you record in different family members' records. You will also need to develop a strategy for making sure everyone in the practice uses the codes and knows about the codes – we suggest an audit cycle. Advice is available at http://www.clininf.eu/maltreatment/ and we (the trainers) can help

Also available information at

http://www.rcgp.org.uk/clinical-and-research/clinical-resources/clinical-audit/safeguarding-children-multi-site-audit.aspx

If you already have a policy please review this after the training, make sure you are happy with it and make sure everyone in the practice knows about it and agrees with it.

The RESPONDS team would like to request your input into practice development in this area and would very much appreciate a copy of your completed practice policy (including any existing policies) on recording DVA and CS. Please send us a copy so that we can start to collect different policies and spread good practice.

We would be most grateful if this could be emailed to your trainer or to Eszter.Szilassy@bristol.ac.uk within 2 weeks following RESPONDS training.

Section 9: End of course messages, reflections and evaluation

Timing 10 mins

Aim of section	To close the training and ensure GP's are taking away key messages and actions
Methods	Trainer to obtain reflection from each group member
Materials	Discussion

- **Show slide 18 and 19 to highlight end of course messages**
- Thank participants for their time and ask for a closing reflection from each participant
- Ensure participants have completed evaluation form

Glossary of terms

Actuarial assessment	This involves the use of risk factors to compute the probability of harm occurring. In domestic abuse the risk factors identified and used in actuarial risk assessment of victims relate to the likelihood of homicide occurring.
Clinical assessment and professional judgement	The clinical assessment of dangerousness is based on an individual practitioner's judgement of a situation, based on knowledge and professional experience.
Common Assessment Framework	The CAF is a shared assessment and planning framework for use across all children's services and all local areas in England. It aims to help the early identification of children's additional needs and promote co-ordinated service provision to meet them
CS	Child Safeguarding
DASH	Domestic Abuse Stalking 'Honour'-Based Violence
DVA	Domestic Violence and Abuse
IDVA	Independent Domestic Violence Advisors. Work with high risk victims of domestic abuse. Attend MARACs to represent the voice of the victim.
MARAC	A Multi-Agency Risk Assessment Conference is a multi-agency meeting to address the safety of high risk victims of domestic abuse.
Multi-agency	This refers to a context in which a variety of agencies contribute towards achieving a common goal, for example client safety. A multi-agency approach is the most effective route to risk management, and IDVAs should always work in a multi-agency context.
Risk assessment	In the context of domestic abuse, this relates to the probability of further harm or homicide based on an understanding of visible risk factors and professional judgement. This information is used to inform safety planning and risk management measures.
Risk indicators	Factors that have been found, through research, to correlate to the likelihood of serious harm or homicide occurring in intimate partner relationships. These indicators have been used to create domestic abuse risk assessment tools.
SARC	Sexual Assault Referral Centre. A SARC is a one-stop location where female and male victims of rape and serious sexual assault can receive medical care and counselling, and have the opportunity to assist the police investigation, including undergoing a forensic examination.
Safety plan	Refers to a personalised plan completed with a client to address safety concerns, based on the risk assessment. This forms a key part of risk management.

Appendix A

Trainers to set group members the following task

Evidence from the Responds interviews shows that there are multiple methods of recording both CS and DV – different codes, within the text, flags, and hidden messages. Interviews suggest there were differences between general practices and *within* general practice – so you all probably do it differently. Serious case reviews suggest the most important thing is to have a consistent recording system that everyone in the practice understands and uses consistently, including locums, trainees, and new members of staff. NICE also recommend this approach and suggest using codes.

Currently there is no national guidance about which codes to use and your organisation needs to be confident and familiar with the recording system and ensure that there is a consistent approach to the way DVA and CS are recorded

There are some difficult areas – what codes? Which family members notes and under which circumstances? Do the people that redact notes know the policy? Because everyone does it differently you need to develop a policy

We suggest you hold a practice meeting to draw up a practice policy for how you record DV and CS, which codes you will use, and how you record in different family members' records. You will also need to develop a strategy for making sure everyone in the practice uses the codes and knows about the codes – we suggest an audit cycle. Advice is available at http://www.clininf.eu/maltreatment/ and we (the trainers) can help

If you already have a policy please review this after the training, make sure you are happy with it and make sure everyone in the practice knows about it and agrees with it.

The RESPONDS team would like to request your input into practice development in this area and would very much appreciate a copy of your completed practice policy on recording DVA and CS. Please send us a copy so that we can start to collect different policies and spread good practice.

We would be most grateful if this could be emailed to your trainer or to Eszter.Szilassy@bristol.ac.uk within 2 weeks following RESPONDS training.

Use of codes in relation to child safeguarding/DVA interface

REFERENCE TO MALTREATMENT		
U3.11 Non accidental injury	Every relevant child record	
13IB000 Child in foster care	Every relevant child record	These children often need high levels of continuing care
13W3 (*13W3.)* Child abuse in the family	Every relevant child record, including close family/household contacts of index case	Note the nature of the abuse and the relationship of the child to the index case
13VF *(13VF.)* At risk of violence in the home	Every relevant adult or child record	Note the nature of the abuse
14X3 *(XaJhe)* History of domestic violence	Every adult who has perpetrated DV **AND** disclosed it themselves	***Do not record unsubstantiated allegations – code should only be used when perpetrator themselves discloses or information from 3rd party (e.g. police report). Not safe to record in perpetrator's record if information comes from victim. If recorded in children's records, be aware of risk that perpetrator may discover disclosure through these records***
HISTORY / CAUSES FOR CONCERN		
13IS child in need	Every relevant child record	
13IF.00 child at risk	Every relevant child record	Note the nature of the risk
13If (XaMzr) Child is cause for concern	Every relevant child record	
Z613.00 other parent-child problems	Every relevant child record	

Aspects of practice policy in relation to domestic violence and child safeguarding

OUTCOME	**TASK(S)**
Practice Policy and Procedures	
1. The practice has a clearly defined and understood policy in place regarding safeguarding children, young people and at-risk adults that also addresses domestic violence and elder abuse issues. This policy is known to all members of the Primary Care Team, who can access these documents whenever required.	Develop a safeguarding practice policy which is regularly reviewed and updated.
2. Safeguarding and domestic violence are regularly addressed in practice meetings.	Include safeguarding and domestic violence as

	regular agenda items in practice meetings.
3. Any hospital communications to GPs raising potential concerns about children subject to a Child Protection Plan should be regarded as 'urgent' rather than 'routine' and followed up accordingly	Ensure that hospital communications to the practice about children subject to a Child Protection Plan are regarded as 'urgent' and followed up accordingly.
4. Reports received by GP practices from other health providers [A&E services] should take into account the content of the report and consider any actions required to safeguard children and/or vulnerable adults within the household.	Risk assessment process in place to consider the need to share information with other agencies where indicated.
	Record made of actions taken by the practice
5. Each general practice has a facility for flagging 'child at-risk' / 'vulnerable family' which can be seen and acted upon by all health professionals involved in the care of at risk/or potentially at risk children and their parents/carers. Action is taken immediately a domestic violence issue arises and processes for ensuring this is followed up in the longer-term are in place.	Ensure that a facility for flagging a 'child at risk' in electronic patient records is in place and ensure that this is consistently used.
	Put in place a process for following up domestic violence issues in both the short, and longer-term. Ensure that this procedure is understood and used by all GPs and practice staff.
6. Disclosure of domestic violence by the victim should be entered in their record, if possible disguised (e.g. "HARKS +") so that if they are accompanied at the next consultation by the perpetrator this is not visible. The problem should not be entered into the perpetrator's record, as this is a breach of confidence that potentially endangers the victim.	Ensure that this procedure is understood and used by all GPs and practice staff.
7. Information about domestic violence from a 3rd party (e.g. Police) should be entered into the victim's, perpetrator's and their children's records	Ensure that this procedure is understood and used by all GPs and practice staff.
6. When a printed copy of records from the electronic records system is transferred to another practice, or made available for serious case reviews, steps are taken to ensure that the copy includes all relevant entries and scanned summaries from the records.	Take steps to ensure that any printed copy of records transferred to another practice or provided for a serious case review include all relevant correspondence and Case Conference summaries
7. When a child is made subject to a Child Protection Plan, a record, including the category of the Child Protection Plan, is made in their medical notes and also when they are removed from a Child Protection Plan	Put in place a procedure to ensure Child Protection Plans are recorded in the child's notes, and also when Plan is removed.

Appendix B - "Pre-publication draft: not for further dissemination"

Exposure of children to domestic violence

What is 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 2010–11 British crime survey reports lifetime partner abuse prevalence of 27% for women and 14% for men; 7 and 5% respectively had experienced abuse in the previous 12 months. The British Crime Survey also measures *non-partner* domestic violence (termed 'family abuse'), reporting a lifetime prevalence of 10 and 7% for women and men, respectively. The starkest gender difference in prevalence is for sexual assault (lifetime experience: 17% women and 2% men), and women generally experience more severe, repeated abuse from male partners, with more significant injuries and long term health consequences then men.

Impact of domestic violence on children

The damaging health and psychosocial effects of domestic violence cascade though the generations. Exposure to domestic violence during childhood and adolescence damages health across the lifespan. 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. 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 behavior. The more adversities a child is exposed to the greater the risk of negative outcomes. The impact of domestic violence on children does not require witnessing of violent acts.

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, although this is unlikely to be a spontaneous disclosure and is more likely if the GP asks directly about domestic violence, preferably after training.[1] By the same token, spontaneous disclosure by a child, particularly in the presence of a parent is rare. When should a GP suspect that there is domestic violence in a family? Some of the presentations that should bring the question to mind, many the same as those that should raise the suspicion of direct child maltreatment: anxiety of fear related behavior or unexplained illness, running away from home, constant worry about possible danger or safety of family members, evidence of injuries.

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

A central feature of good practice is speaking 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[2] of good practice for primary care professionals include: be realistic and honest about the limits of confidentiality (but promise to keep the child informed of what is happening); help the child or young person to understand that they are not to blame for the domestic violence and that they are not alone; let them know that domestic violence is never acceptable; be careful to acknowledge their experiences and 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

[1] http://www.rcgp.org.uk/clinical-and-research/clinical-esources/~/media/Files/CIRC/Domestic%20Violence/RCGP-Responding%20to%20abuse%20in%20domestic%20violence-January-2013.ashx

[2] http://www.avaproject.org.uk/our-resources/good-practice-guidance--toolkits/improving-safety,-reducing-harm-children,-young-people-and-domestic-violence-%282009%29.aspx

going on. If you are the first person a child has disclosed to, you are a very important person for that child. Police and social services are trained to interview children. If a child discloses to you, it may be tempting to ask a lot of questions, but this is *not your role*. You will need to find out enough to determine whether a referral is necessary, but try to use open-ended questions. Should the case go to court, the court will need to ensure that words or suggestions have not been put in the child's mouth.

Further response

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 is a fine judgment in relation to domestic violence exposure in the absence of direct maltreatment hinging around 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'. Some localities have a policy – impossible to implement – that *all* children in families where you suspect domestic violence should be referred. Discussion with your practice's safeguarding lead is essential and – if you are that person – discussion with your local named nurse 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.

Information sharing

Domestic violence is a key issue for safe information sharing. It is crucial to ensure that perpetrators of domestic violence do not receive information about what their victim and/or children have said about the abuse except in exceptional circumstances. Risks to the safety of the non-abusing 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 (egs. police, multi-agency risk assessment conferences) 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 the non-abusing parent: 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