**INCADVA Briefing on the Domestic Abuse Bill**

**03/06/2020**

**The importance of early intervention when responding to Domestic Abuse:**

**An integrated health care response**

1. Members of the INCADVA (Inter-Collegiate and Agency Domestic Violence Abuse) Forum welcome the re-introduction of the Domestic Abuse (DA) Bill, and the inclusion of measures such as the recognition of economic abuse within the statutory definition of domestic abuse and prohibition of cross-examination in family courts. However, we are clear that the Bill and supporting non-legislative package must go much further to meet survivors’ needs.
2. We are particularly concerned about the omission in both the Bill and accompanying guidance documents of the need for a coordinated response to domestic abuse across the health system. The Bill does not address the vital role of the healthcare system in responding to domestic abuse. **We therefore recommend:**

* **The Department for Health and Social Care ensures that all health services (including Trusts and CCGs) provide a strategic commitment to responding to domestic abuse.**
* **Sustainable and significant government investment is required to ensure that all key elements of best practice interventions in health are implemented consistently across all CCG areas.**
* **Sustainable funding is required for high-quality, specialist training of all healthcare professionals, including online resources that can be easily accessed during the current crisis. Sustainable funding also needs to be provided to ensure referral routes are in place for patients.**
* **An increase in funded quality-assured programmes for health professionals to refer perpetrators into underpinned by research and evidence.**
* **Survivors have priority and timely access to specialist mental health support services, which are adequately and consistently funded, and available across the country to all survivors, regardless of their immigration status.**
* **A long-term public health campaign to challenge public attitudes to domestic abuse.**
* **Representation from mental health services on the Domestic Abuse Commissioner’s advisory panel, in addition to the wider health service representation.**
* **The Bill recognises that domestic abuse is gendered in order to challenge existing myths about domestic abuse and its effects.**

1. The pandemic has shone a light on the need to protect victims from abuse and ensure they have access to life-saving support. We know that the number of women who have died from domestic abuse more than doubled in the first three weeks since the implementation of the lockdown[[1]](#footnote-2). Lockdown and self-isolation measures have exacerbated the isolation and risks experienced by survivors and increased barriers to support. Prior to the lockdown, data obtained by the BBC from 43 police forces across the UK showed that murders as a result of domestic violence were at a 5-year high (BBC, 2019[[2]](#footnote-3)).
2. The Bill must be seen in the global context of eliminating violence against women and girls. Violence against women in intimate relationships is recognised as a global public health problem and as a violation of women’s human rights. The World Health Organisation (2017)[[3]](#footnote-4) said that it would be a serious oversight for governments and states to ignore or overlook the gendered nature of violence in intimate partner relationships and that doing so, in policy, in law and in practice, could have wide reaching consequences for victims. Global statistics from the World Health Organisation (2017) showed that 30% of women have experienced some form of physical and/or sexual violence by an intimate partner in their lifetime and that 38% of female murder victims have been killed by a male intimate partner. In Jianli County, Hubei province of China, a police department reported a tripling of domestic violence cases in February 2020 compared with February 2019, estimating that 90% were related to the covid-19 epidemic.
3. COVID 19 is also having a significant impact on survivors’ mental health. Women’s Aid’s survey of survivors found that two thirds[[4]](#footnote-5) of survivors currently experiencing abuse who need mental health support were unable to access it since the pandemic started, and just over half of survivors[[5]](#footnote-6) who experienced abuse in the past that need mental support were unable to access it[[6]](#footnote-7). These barriers will be even greater for women facing multiple disadvantage.
4. These unprecedented times have highlighted that it is paramount that all opportunities are taken to intervene earlier, ensure all survivors of domestic abuse are provided with support and prevent harm. Specialist domestic abuse organisations are stating that there is likely to be a ‘surge’ in the number of survivors needing support as lockdown measures are lifted – dedicated, sustainable funding will be required to ensure the specialist domestic abuse sector and health partners are able to meet increased need in the long-term.
5. Having introduced Domestic Homicide Reviews (DHRs) as a statutory duty under the Domestic Violence, Crime and Victims Act 2004, with the aim to improve responses to domestic abuse and prevent homicides, we ask the government not to ignore the critical lessons emerging from these important reviews. DHRs and NHS Confidential Enquiries repeatedly highlight[[7]](#footnote-8) the need for systemic change across the health system and to better equip healthcare staff with the understanding to identify and appropriately respond to domestic abuse.[[8]](#footnote-9)
6. In addition, these reviews and enquiries highlight the disproportionate impact of domestic abuse on women facing additional forms of discrimination including minoritised, disabled and older women and women facing multiple disadvantage. DHRs emphasise the critical need for embedding an intersectional approach that is mindful of the needs and experiences of these groups[[9]](#footnote-10).

**The Evidence: Why an integrated healthcare response is needed**

1. A decade ago an independent taskforce led by Sir George Alberti concluded it was a ‘disgrace’ that the NHS had done so little on tackling violence against women and urged the government and health bodies to deliver comprehensive reform[[10]](#footnote-11). We remain highly concerned about progress made since. Although NICE has established a quality standard for the response to domestic abuse in healthcare settings, implementation remains inconsistent and funding is scarce.[[11]](#footnote-12)
2. Every year nearly half a million survivors of domestic abuse seek assistance from medical professionals. Given that just one in five survivors call the Police, it is vital that survivors can access a non-criminal or justice-based route to effective support.[[12]](#footnote-13) Seeing a health professional can often be the only time that a survivor is able to disclose abuse without the perpetrator present.
3. Analysis of DHRs and academic research[[13]](#footnote-14) has also shown that often health professionals are the only statutory service to come into contact with both the victim and perpetrator. They hold critical information around the safety of the family and can make a significant difference in intervening earlier and ultimately preventing a homicide from happening. Evidence shows however that most often than not these opportunities are missed and health professionals are not appropriately equipped to respond to domestic abuse.[[14]](#footnote-15)
4. Pathfinder[[15]](#footnote-16) is the first national health project to take a systemic approach to transforming the health sector’s response to domestic abuse. It combines all elements of evidence-based good practice from acute, mental health and general practice settings into a comprehensive model response to domestic abuse. From the work of Pathfinder, we know that a systemic approach to responding to DA in health is needed in order to make sustainable and meaningful change.
5. An integrated healthcare response to domestic abuse goes beyond training and stand-alone interventions. It requires a change in the culture of health services, partnership working with specialist domestic abuse services and a strategic, funded commitment to implement the necessary structural changes to embed this work. A coordinated and systemic approach lies at the heart of this work and is critical in ensuring sustainability and a safer and more effective response to domestic abuse.
6. **What is needed from Government to establish an integrated healthcare response:**
7. **DHSC to ensure** **that all health services (including Trusts and CCGs) provide a strategic commitment to responding to domestic abuse.** This must be done by requiring Board-level commitment to domestic abuse survivors by setting up:
   * Specific DA **governance structures**
   * Comprehensive **domestic abuse strategy** **and internal policies**
   * Effective and comprehensive **data and information sharing systems**

These strategic structures and processes are critical and will set the foundations to ensure this work is sustainable and embedded in all areas of the health system.

1. **Sustainable and significant government investment is required to ensure that all key elements of best practice interventions in health are implemented consistently across all CCG areas.** This will address current geographical discrepancies in services and responses. It will ensure that no matter the geographical location or area of the healthcare system where a survivor presents, they will receive an effective and safe response. There are a number of evidence-based and good practice interventions covering primary care, acute and mental health. They are integral components of a whole health response.

We recommend the following measures are implemented:

* + The **IRIS** (Identification and Referral to Improve Safety) **Programme**. IRIS is an evidence-based intervention to improve the general practice response to domestic abuse through training, support to practice teams and having a DA specialist embedded in practices. It is nationallyrecognised as best practice and has informed NICE guidance.
  + The **co-location of specialist Health IDVAs (Independent Domestic Violence Advisors)** within health settings.SafeLives report ‘A Cry for Health’ provides extensive evidence around the benefits of this intervention in acute hospitals and other studies[[16]](#footnote-17) find similar results when specialists are located in mental health settings[[17]](#footnote-18).
  + **The establishment of a Domestic Abuse Coordinator and the implementation of a Domestic Abuse Champions Network**. These have been core elements of the good practice that has emerged as part of the national project Pathfinder.
  + **Sustainable funding is required for high-quality, specialist training of all healthcare professionals, including online resources that can be easily accessed during the current crisis.** Sustainable funding also needs to be provided to ensure **referral routes are in place for patients.** As outlined by Agenda in the Ask and Take Action Briefing Paper[[18]](#footnote-19), there is a need for public authorities to ensure frontline staff in our public services are making trained enquiries into domestic abuse. Tiered and mandatory training around domestic abuse should be set up in all Health services. Training should include specialist content on how to identify, respond to and refer both survivors and perpetrators of domestic abuse in acute, mental health and primary care settings, as well as embed specialist workers within health settings. The training delivered should be led by specialists, trauma-informed and should take an intersectional approach.
  + **An increase in funded quality-assured programmes for health professionals to refer perpetrators into underpinned by research and evidence.** There are a range of interventions available for health professionals to refer perpetrators to that cover the spectrum of risk and harm, and different levels of motivation and ability to change. These must be independently quality assured and underpinned by research and evidence.[[19]](#footnote-20) Interventions such as the evidence-based programme Drive[[20]](#footnote-21) which works with high-harm perpetrators has demonstrated a significant reduction in abuse.
  + **Survivors have priority and timely access to specialist mental health support services**, which are adequately and consistently funded, and available across the country to all survivors, regardless of their immigration status[[21]](#footnote-22).
  + **A long-term public health campaign to challenge public attitudes to domestic abuse.**
  + Representation from **mental health services on the Domestic Abuse Commissioner’s advisory panel**, in addition to the wider health service representation.
  + **The Bill recognises that domestic abuse is gendered in order to challenge existing myths about domestic abuse and its effects.**

1. To conclude, we ask the government to ensure that an integrated healthcare response is implemented as part of its efforts to tackle domestic abuse. Domestic abuse cannot be effectively addressed unless the vital role of healthcare professionals is appropriately considered.
2. As well as saving lives and improving outcomes for adults and children, an integrated healthcare response to domestic abuse will also reduce costs within the NHS. The Home Office has estimated that every year domestic abuse costs the healthcare system over £2.3 billion[[22]](#footnote-23). To implement a hospital based Idva in each hospital would cost £15.7 million and to commission IRIS in general practices nationally would cost £25 million. Both hospital-based Idvas[[23]](#footnote-24) and the IRIS programme[[24]](#footnote-25) are highly cost-effective and cost-saving for the NHS.
3. Now more than ever, in light of the recent pandemic, the role of healthcare professionals in responding to domestic abuse has come into focus. The Covid 19 pandemic has also demonstrated that the health system is capable of unprecedented progress when provided with clear targets and direction.
4. A systemic approach is needed in order to effect meaningful change in the health service’s response to domestic abuse. This requires strategic commitment and leadership at a national and local level in addition to the funding of practical interventions and services.

**Endorsed by:**

**Standing Together Against Domestic Violence**

**IRISi**

**SafeLives**

**Women’s Aid Federation of England**

**End Violence Against Women**

**Respect**

**Royal College of Emergency Medicine**

**Woman’s Trust**

**Royal College of Obstetricians & Gynaecologists**

**Faculty of Forensic and Legal Medicine**

**MyCWA**

**Professor Jo Aldridge, Social Policy and Criminology, Loughborough University**

**Professor Gene Feder, Centre for Academic Primary Care, Bristol University**

**Against Violence and Abuse (AVA)**

**Professor Louise Howard, Institute of Psychiatry, Psychology and Neuroscience**

**King's College London**

1. In the UK, a project tracking violence against women noted that deaths from domestic abuse between 23 March and 12 April had more than doubled (to 16 deaths) compared with the average rate in the previous 10 years’ (Roesch et al, May, 2020, British Medical Journal). [↑](#footnote-ref-2)
2. BBC (2019) Domestic violence killings reach 5-year high: <https://www.bbc.co.uk/news/uk-49459674> [↑](#footnote-ref-3)
3. World Health Organisation (2017) *Violence against women: Key facts*: <http://www.who.int/news-room/fact-sheets/detail/violence-against-women> [↑](#footnote-ref-4)
4. 21 out of 31 survivors [↑](#footnote-ref-5)
5. 74 out of 141 survivors [↑](#footnote-ref-6)
6. Women’s Aid (2020) The Impact of COVID 19 on Survivors. Available [online](https://1q7dqy2unor827bqjls0c4rn-wpengine.netdna-ssl.com/wp-content/uploads/2020/05/The-impact-of-Covid-19-on-survivors-findings-from-Women%E2%80%99s-Aid%E2%80%99s-initial-Survivor-Survey.pdf) [↑](#footnote-ref-7)
7. [Mental illness and domestic homicide: a population-based descriptive study.](https://pubmed.ncbi.nlm.nih.gov/23820784/?from_term=oram+and+howard&from_page=3&from_pos=6)

   **Oram S**, Flynn SM, Shaw J, Appleby L,**Howard LM.**Psychiatr Serv. 2013 Oct;64(10):1006-11. doi: 10.1176/appi.ps.201200484. [↑](#footnote-ref-8)
8. Standing Together (2016) Domestic Homicide Review Analysis <http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf> [↑](#footnote-ref-9)
9. Ibid [↑](#footnote-ref-10)
10. [The Report](https://www.health.org.uk/sites/health/files/RespondingtoViolenceAgainstWomenAndChildrenTheRoleofTheNHS_guide.pdf) of the Taskforce on the Health Aspects of Violence Against Women and Children, March 2010 [↑](#footnote-ref-11)
11. <https://www.nice.org.uk/guidance/qs116/chapter/Introduction> [↑](#footnote-ref-12)
12. SafeLives (2016) A Cry for Health <https://safelives.org.uk/sites/default/files/resources/SAFJ4993_Themis_report_WEBcorrect.pdf> [↑](#footnote-ref-13)
13. [Violence against women and mental health.](https://pubmed.ncbi.nlm.nih.gov/27856393/?from_term=khalifeh+howard&from_pos=1)

    Oram S, Khalifeh H, Howard LM.Lancet Psychiatry. 2017 Feb;4(2):159-170. doi: 10.1016/S2215-0366(16)30261-9. Epub 2016 Nov 15. [↑](#footnote-ref-14)
14. Standing Together (2016) Domestic Homicide Review Analysis <http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf> [↑](#footnote-ref-15)
15. <http://www.standingtogether.org.uk/national-work-and-consultancy/local-partnership/pathfinder> [↑](#footnote-ref-16)
16. [Linking abuse and recovery through advocacy: an observational study.](https://pubmed.ncbi.nlm.nih.gov/23628450/?from_term=trevillion+and+howard&from_page=3&from_pos=4)

    Trevillion K, Byford S, Cary M, Rose D, Oram S, Feder G, Agnew-Davies R, Howard LM.Version 2. Epidemiol Psychiatr Sci. 2014 Mar;23(1):99-113. doi: 10.1017/S2045796013000206 [↑](#footnote-ref-17)
17. <https://safelives.org.uk/sites/default/files/resources/BEH-MHT%20LINKS%20pilot%20evaluation.pdf> [↑](#footnote-ref-18)
18. <https://weareagenda.org/wp-content/uploads/2020/04/Ask-and-Take-Action-Briefing-for-Second-Reading-2020-1.pdf> [↑](#footnote-ref-19)
19. <https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-4-Referral-to-specialist-services-for-people-perpetrating-domestic-violence-or-abuse> [↑](#footnote-ref-20)
20. <http://driveproject.org.uk/> [↑](#footnote-ref-21)
21. Law in the Making (2019) Experts by Experience Briefing: priorities for the Domestic Abuse Bill. Available [online](https://1q7dqy2unor827bqjls0c4rn-wpengine.netdna-ssl.com/wp-content/uploads/2020/02/Law-In-The-Making-Briefing-2019.pdf) [↑](#footnote-ref-22)
22. Oliver, R., Alexander, B., Roe, S. & Wlasny, M. (2019) The economic and social costs of domestic

    abuse Research Report 107. London: The Home Office [↑](#footnote-ref-23)
23. SafeLives (2016) A Cry for Health https://safelives.org.uk/sites/default/files/resources/SAFJ4993\_Themis\_report\_WEBcorrect.pdf page 20 [↑](#footnote-ref-24)
24. Barbosa EC, Verhoef TI, Morris S, et al Cost-effectiveness of a domestic violence and abuse training and support programme in primary care in the real world: updated modelling based on an MRC phase IV observational pragmatic implementation study BMJ Open 2018;8:e021256. [↑](#footnote-ref-25)