domestic abuse commissioner

Manchester Metropolitan University

Summary Report

Domestic Homicide Oversight Mechanism for Health

(Physical and Mental Health)

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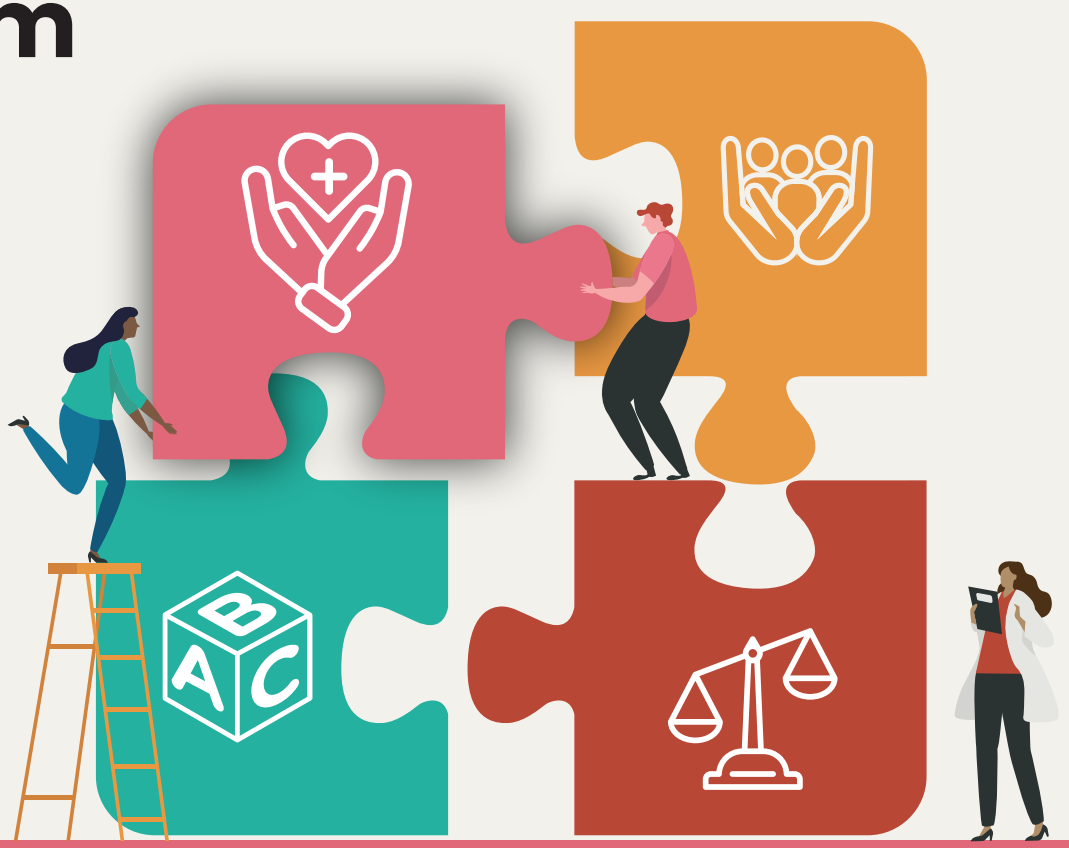


Domestic Homicide Oversight Mechanism for Health (Physical and Mental Health) Summary of Findings

Khatidja Chantler, Victoria Baker, Clare Gunby, Kim Heyes

Introduction

Domestic violence and abuse (DVA) can have a significant impact on a person's physical and mental health. Healthcare professionals (HCPs) have a responsibility to respond appropriately to disclosures of DVA, and to follow relevant escalation pathways to ensure a multi-professional approach where necessary. It is a frequent complaint of healthcare professionals that documentation is not shared correctly (or at all), that information recorded within these documents is not accurate (Dheensa and Feder, 2022) or always acted upon. Several national policies and guidelines have been developed to support HCPs to identify and respond to DVA (e.g. DoH, 2017; NICE, 2014). The purpose of this work is to better understand the types of recommendations made in Domestic Homicide Reviews (DHRs) for physical and mental health, relating both to intimate partner homicide and adult family homicide. The study will help to inform the Domestic Abuse Commissioner's[1] Domestic Homicide Oversight Mechanism for Health.

Study Methods

Fifty-eight DHRs published between 2017-2019 were identified for analysis. Our mixed methods approach comprised a qualitative template to identify examples of good practice, areas for development and learning, and to analyse recommendations made in relation to Health. After extraction, a thematic approach was used. A quantitative matrix was developed based on the qualitative themes and subthemes, identifying the most prevalent recommendation types, any specific recommendations related to protected characteristics, and the targets of those recommendations within Health Services. An additional descriptive analysis of quantitative data already collected on the DHRs within the HALT study provided an overview of characteristics.

1. This research was commissioned by the Domestic Abuse Commissioner. Funding reference DAC-DHOMOct22-Mar23.
2. One perpetrator was a trans woman.

Key findings

Victim and perpetrator demographics

Sex: Most victims were female (49/58, 84%) and most perpetrators male (54/58, 93%).[2]

Ethnicity: Victims (43/57, 75%) and perpetrators (40/58, 69%) were in the majority White British, with the remainder coming from minoritised backgrounds (including White Europeans). One victim had missing ethnicity data.

Homicide types

- 46 of the 58 (79%) were intimate partner homicides (IPH).
- 11 (19%) were adult family homicides (AFH).
- 1 was an amicicide (killing of a friend) – in this case a victim killed by the sons of a woman she cohabited with.

IPH relationship details

- Perpetrators were mostly current or ex- male partners (42/46, 91%).
- 30% of victim-perpetrator dyads (14/46) were separated.
- Most couples had been in their relationship for over three years (30/44, 68%).
- Only eight dyads had been together for a year or less.

AFH relationship details

- Most perpetrators were sons (5/11, 45%) or other male family members (5/11, 45%).
- Only one case involved a daughter (a trans-woman) killing her father.

Prior domestic abuse

- **Over three-quarters** of DHRs (44/58, **76%**) reported **prior domestic abuse** within the victim-perpetrator relationship.
- Proportions were **higher in IPH cases compared to AFH** (**87%** vs. **27%**).
- In **all 44 cases perpetrators had been abusive** to the victim.
- In **nine of the 44 cases** (**20%**) there had been abusive behaviour *from* the victim.

Homicide contexts

- The most common contextual or escalating factor leading up to the homicides appeared to be victims' attempts to end the relationship with the perpetrator (15/58, 26%).
- Other factors included: perpetrators experiencing acute episodes of mental health (7/58, 12%); perpetrators' carer stress (3/58, 5%).
- In nearly half of cases (25/58, 43%) no clear single escalating feature could be identified.

Risk and vulnerability factors

Victims

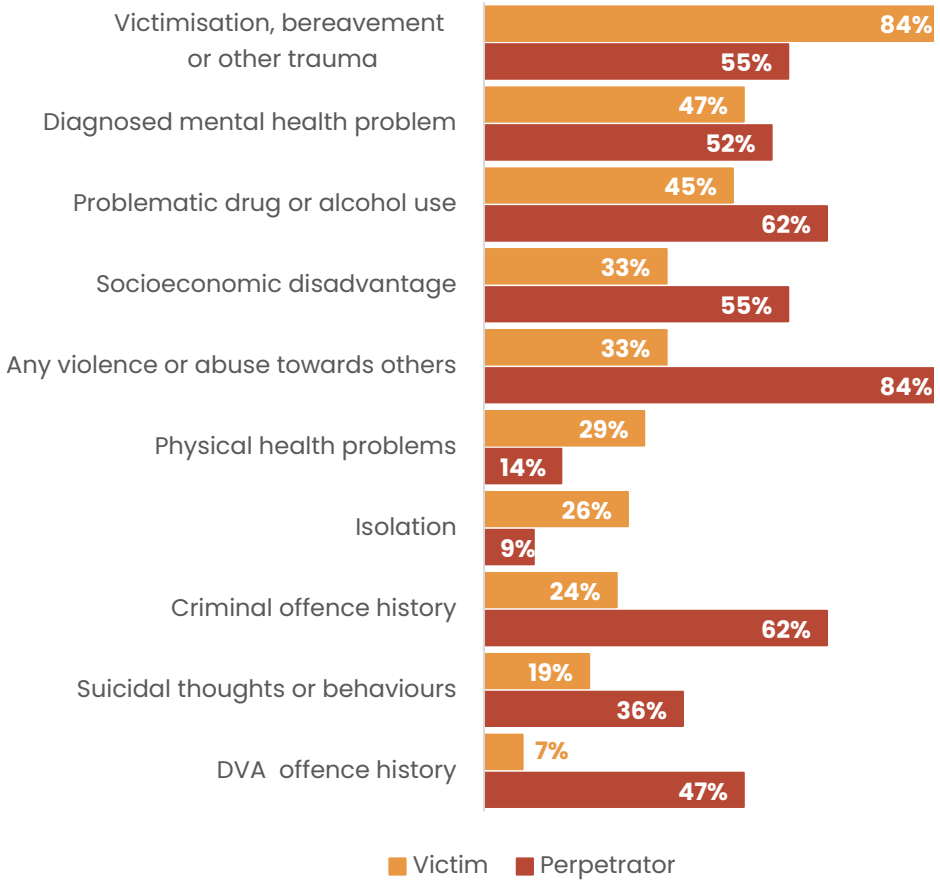
The most prevalent risk factor identified for victims was victimisation or trauma – reported in 84% (49/58) of DHRs – due mostly to DVA from the perpetrator. Abuse from the perpetrator was experienced more often by victims of IPH (40/46, 87%) than AFH (3/11, 27%). Nearly half of victims (27/58, 47%) had been diagnosed with a mental health condition, with 19% (11/58) having had suicidal thoughts or behaviours. Nearly half (26/58, 45%) had difficulties with substance use and socioeconomic disadvantage was also prevalent, having been reported in a third of DHRs (19/58, 33%). Violence or abuse towards others was also common (19/58, 33%) and criminality also featured (14/58, 24%).

Compared to IPH victims, AFH victims were more likely to have physical health problems (7/11, 64% vs. 10/46, 22%) and both those with disabilities were AFH victims.

Perpetrators

The most prevalent risk factor identified for perpetrators was violent/abusive behaviour (49/58, 84%). Perpetrators' experiences of victimisation and trauma were relatively high (32/58, 55%). Other perpetrator vulnerabilities were difficulties with: substance use (36/58, 62%); criminality (36/58, 62%) including DVA related offences (27/58, 47%); socioeconomic disadvantage (32/58, 55%); diagnosed mental ill health conditions (30/58, 52%) and over a third had reported suicidal thoughts or behaviours (21/58, 36%). Only three perpetrators (5%) were identified by DHR authors as having a disability.

Figure 1 Risk and vulnerability factors

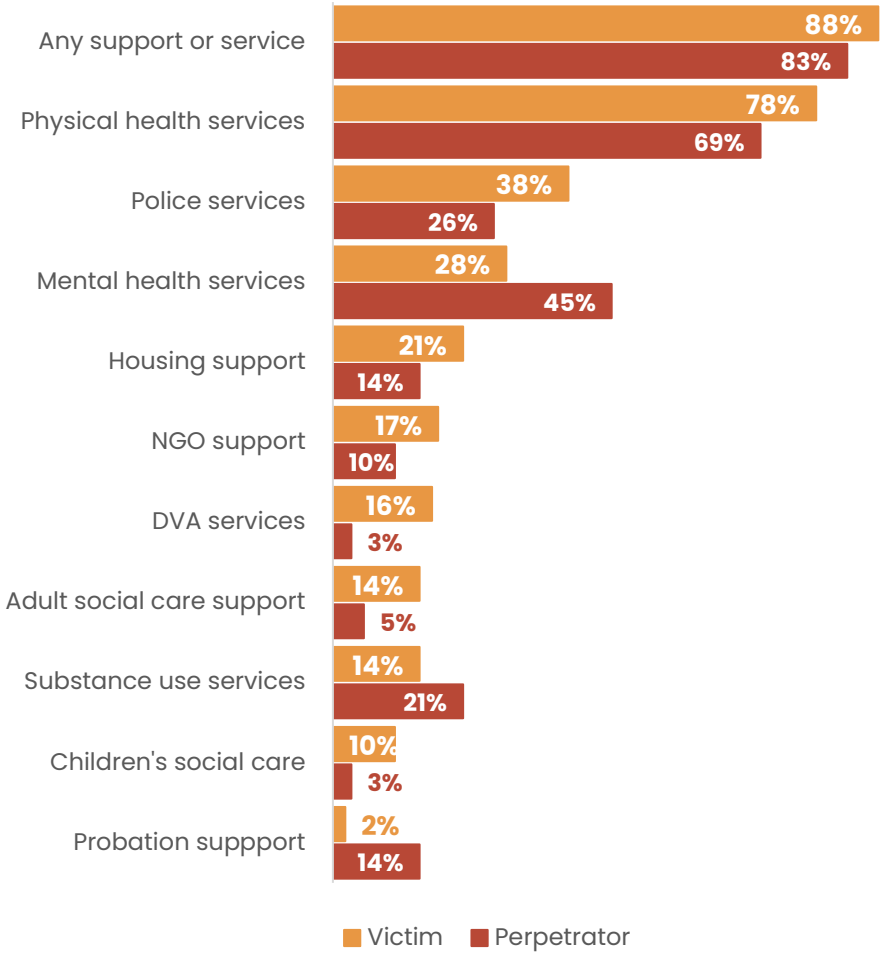


Compared to IPH perpetrators, AFH perpetrators were more likely to have been diagnosed with a psychotic disorder (3/11, 27% vs. 2/46, 4%); more likely to have had housing difficulties (6/11, 55% vs. 8/46, 17%) and more likely to have been isolated (3/11, 27% vs. 2/46, 4%).

Service involvement

The majority of victims (45/58, 78%) and perpetrators (40/58; 69%) had received physical health services over the period covered by the DHR. They had also accessed mental health services (victims:16/58, 28%; perpetrators 26/58; 45%). AFH perpetrators were more likely than IPH perpetrators to have received mental health support (8/11, 73% vs. 18/46, 39%). Perpetrators also received support from substance use services (12/58, 21%). Only a minority of victims received specialist DVA support.

Figure 2 Service involvement



Risk assessment and service awareness

In over half of cases (33/58, 57%) services were aware of domestic abuse in the relationship between the victim and perpetrator, and this equates to 75% of those victim-perpetrator relationships where prior DVA was reported in the DHR. However, service awareness was significantly lower in AFH cases (3/11, 27% vs. 30/46, 65%), with DVA risk assessment also less likely (2/11, 18% vs. 25/46, 54%) – although this is most likely explained by the lower levels of reported DVA within this sample of AFH cases.

A 'high' rating was given in just over a third of DVA risk assessed cases (10/27, 37%). Eleven cases (19%) were reported as having been referred to a Multi-Agency Risk Assessment Conference (MARAC) prior to the homicide and all 11 were cases of intimate partner homicide.

Thematic Analysis of Recommendations

Many of the themes identified through our analysis overlap. For example, training regarding domestic abuse will hopefully enhance professional curiosity, risk assessment, improve record keeping and generate a multi-agency response. These recommendations are also made in other forms of review across time, demonstrating the need to ensure that they become embedded in policy and practice.

Lack of multi-agency working and information management

The analysis of recommendations relating to physical and mental health services identified a lack of multi-agency working and poor information management in 39 of the 58 DHRs (67%). Most commonly, recommendations were targeted towards GPs, NHS Trusts and Clinical Commissioning Groups (CCGs) (now ICBs – Integrated Care Boards). Recommendations most often highlighted the need for: improved recording and maintenance of information (32 DHRs); improved gathering, reporting and sharing of information to/from partner agencies, as well as better intra-agency communication and co-ordination (22 DHRs); and improved referral into other agencies (including advertising DVA pathways) (16 DHRs).

Improving Assessments

Across DHRs it was evident that risk assessment did not always take place – even when overt threats were known. Risk information was not always well coordinated or shared across agencies. Indeed, multi-agency working, information sharing, training, and professional curiosity all impact on how well (or otherwise) risk is identified and understood in health contexts. The evidence illustrates that there were multiple known risks across DHRs that should have resulted in a more comprehensive risk assessment.

Developing Practice

Recommendations relating to the need to develop practice appeared in 33 of the 58 DHRs (57%). Most commonly, recommendations highlighted the importance of: increasing professional curiosity and assertiveness (embedding DVA enquiry and improving response to disclosure) (25 DHRs); and thinking holistically and systemically, ensuring family needs and risks are considered, as well as patterns of behaviours over time (e.g. frequent attenders, repeat non-

attenders, repeat assaults) (14 DHRs). Other recommendations within this theme related to: the need for improved continuity of care – including the provision of a single point of contact (SPOC) for families (3 DHRs); increasing the capacity of services to address specific issues such as alcohol dependency and suicidal ideation (2 DHRs); and lastly, ensuring the use of interpreting services and the provision of DVA materials in alternative languages (2 DHRs).

Training and development for staff

Recommendations relating to staff training and development appeared in 42 of the 58 DHRs (72%). Specifically, recommendations called for: an increase in or development of domestic abuse training, including expanding the definition to encompass coercive control, approaches to discussing DVA with clients and utilising tools and processes such as the DASH and MARAC (40 DHRs); an increase in or development of adult safeguarding training (12 DHRs) and child protection training (3 DHRs); training in record keeping/information sharing (5 DHRs) and on immigration issues (1 DHR). Monitoring the effectiveness of changes made to training was recommended in three DHRs and a further three suggested utilising supervision as a forum for raising any concerns practitioners experienced.

Policy and Process: develop, amend or follow

Recommendations to implement, revise, update or expand organisational policies, practice and process appeared in 46 of the 58 DHRs (79%). Most frequently, recommendations were targeted at developing or reviewing domestic abuse policy (24 DHRs). Several DHRs (21) underscored the importance of using and sharing the learning from the DHRs process. Other recommendations included developing and implementing a new/specialist service e.g., IRIS, DVA champions (14 DHRs); evaluating or auditing health processes, pathways or DVA interventions/ responses (11 DHRs); reviewing or complying with adult safeguarding (11 DHRs) and risk assessment (10 DHRs) policy and process; developing/reviewing protocol and policy for information sharing (7 DHRs) and meeting NICE or RCGP guidance on DVA (4 DHRs).

Good Practices

Examples of good practice were flagged in 27 of the 58 DHRs, just under half (47%). Good practices included timely and

safe communication (6 DHRs); sharing information (5 DHRs); referral to specialist DVA service (4 DHRs); making safeguarding referrals (4 DHRs); continual attempts to engage patients (4 DHRs); effective identification of risks and their management (4 DHRs) and follow-up with services/patients to identify if they had engaged with services (3 DHRs). Good practices noted in singular DHRs included involving family in care decisions; good inter-agency coordination of care and
good knowledge of different aspects of DVA. Good practices were most often flagged in relation to GPs, A&E departments, mental health services, and nursing.

National Recommendations

National recommendations appeared in 21 of the 58 DHRs (36%), most commonly relating to multi-agency working and information management (12 DHRs) and developing/reviewing policy and processes (11 DHRs). Recommendations were nearly always targeted towards NHS England, but also to the Home Office, the Royal College of Physicians, the Royal College of Nursing, the Secretary of State, and the Department of Health[1]. Guidance on the ethical and legal limits of confidentiality when domestic abuse is disclosed to GPs and other health professionals was also called for.

Similar to recommendations made at the local health service level, national recommendations relating to multi-agency working and information management most often related to the recording of information on electronic systems, and included: developing system flags for GP frequent attenders and for GP patients whose children are involved with children's social care; and recording the names of individuals who accompany patients to GP appointments and relevant early history such as being fostered as a child.

[1] Now referred to as the Department of Health & Social Care

Figure 3 Theme frequency by agency

	Target Agency (= 2 DHR = 1 DHR)						
Theme	**GPs**	**Hospitals / A&E (incl. ambulance)**	**Nursing**	**Maternity**	**Allied Health Services (e.g. substance use)**	**Mental Health Services**	**Health Trusts and CCGs**
							
							
							
							
							

Key Messages

- The DHRs show that routine inquiry in a range of health settings is absent, with recommendations for improvement being targeted most often at Health Trusts, CCGs and GPs. In several cases, even where patients presented with serious physical injuries and disclosed domestic abuse, no further action or enquiry took place.

- Limited domestic abuse risk assessments are carried out in health settings which is surprising given that most people access generic, universal health provision. This suggests a lack of engagement with DVA and risk assessment processes. Improving DVA risk assessments in health settings is crucial to ensuring safety for DVA victims.

- Communication between different clinical specialisms dealing with patients experiencing DVA needs to be strengthened and intra-agency communication and coordination was mentioned in 22 DHRs. To achieve this, clear and comprehensible records need to be kept with sufficient detail for practitioners to understand the history of patient contacts – particularly as it is unlikely that patients will routinely be able to see the same HCP.

- Co-ordinated care is also hampered by IT systems not 'speaking' to each other or having the capacity - or using the capacity - to 'flag' DVA perpetrators, victims, and frequent or non-attenders.

- A lack of multi-agency working and poor information management was recorded in 39 of the 58 DHRs (67%). DHRs also illustrates that HCPs often do not understand multi-agency processes such as MARAC and MAPPA or their impacts. Clear and concise national guidance on when HCPs can share information with other agencies, particularly where a patient does not give consent is called for.

- DHRs show that HCPs often utilise constructions of victims/victimhood which hinder sensitive professional responses. These constructions normally involve negative labels (e.g. 'difficult or 'hard to engage') but sometimes also positive ones, especially in relation to older couples (e.g. 'close' or 'devoted').

The key challenge to practice is to develop skills to engage with those who are constructed as 'difficult' and to consider the possibility of DVA in 'devoted' relationships.

- Working holistically and appreciating the inter-relationships between health and social needs is important. It is understandable that HCPs prioritise medical/clinical need but there is good evidence for recognising the overlap between the two (Bradbury-Jones et al., 2011; Feder et al., 2006). Holistic working also means avoiding dealing with patients on a 'presenting incident' basis and to examine previous notes for more detailed information to inform a risk assessment or safeguarding plan.

- Particularly important is the need to be aware of symptoms that may at face value be unrelated to DVA. For example, unexplained pelvic pain, headaches, hearing loss or symptoms of depression, fear, self-harm/suicidal tendencies, substance misuse (DoH, 2017). Similarly, more than average attendance at GPs (where health issues do not warrant frequent appointments) or regular non-attenders may mask domestic abuse and further investigation of this is needed.

- A failure to recognise carers' needs, to complete carers' assessments or recognise the importance of carer insights was evident in DHRs. GPs are likely to have most contact with patients and their carers and carer needs require careful management, review and liaison with Adult Social Care where necessary.

- Recommendations relating to staff training and development appeared in 42 of the 58 DHRs (72%) – most often to Health Trusts and CCGs, GPs and A&E departments. These recommendations called for: an increase in or development of domestic abuse training, including increasing understanding of non-physical forms of abuse, approaches to discussing DVA with clients and utilising tools and processes such as the DASH and MARAC (40 DHRs); an increase in or development of adult safeguarding (12 DHRs) and child protection training (3 DHRs); training in record keeping/information sharing (5 DHRs) and on immigration issues (1 DHR). Any training should be

cognisant of intersectionality and how DVA is mediated by social identities.

- Several DHRs recommended a hospital-based IDVA or consideration of this. A specialist DVA provides DVA expertise as well as championing DVA within hospitals. Investing in hospital-based IDVAs constitutes a small financial investment for a potentially large gain.

- For primary care, the IRIS programme needs to be maintained and extended to GP practices where there is currently no programme. IRIS nationally has been found to be effective in recognising domestic abuse, together with referral to appropriate services (Feder et al., 2011; Sohal et al., 2020).

- Of the 58 DHRs included in the Health analysis, almost a third (n=19) involved either victims or perpetrators from a Minoritised background. Ethnicity, immigration issues, cultural contexts and language need to be identified early on in a patient's contact with health services so that an appropriate response is offered. HCPs' own responses including an uncritical acceptance of supposed cultural norms and potential unconscious bias towards Minoritised patients should also be explored and included in any DVA training.

- Most victims of domestic homicide in this study were female (49/58, 84%). Services largely designed for men (e.g. most substance misuse services and some mental health settings) should consider modification to a more gender-sensitive modality.

- 47% of victims and 52% of perpetrators had a diagnosed mental health condition and 45% of victims and 62% of perpetrators had substance use issues. The data suggests that these are two key service areas to prioritise for DVA interventions – both for victims and perpetrators.

- Recommendations to implement, revise or update organisational policies, practice and process appeared in almost 80% of DHRs, most frequently targeted at Health Trusts and CCGs followed by GPs, national bodies and A&E departments. Ensuring the implementation of DVA policies is key to more proactive engagement with DVA.

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