



Responding to the rise in domestic abuse:
who, where and why

WEBINAR
July 15, 2020 10:00-11:00 BST

The Violence Against Women and Girls
Research Network

<https://vawgnetwork.mdx.ac.uk/>

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fleeing domestic violence and abuse,
who have no recourse to public funds
during the pandemic:

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Violence, Health and Nursing.

DOMESTIC VIOLENCE NEEDS TO
BE A **CLINICAL**
PRIORITY ↓



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Nicky Lambert (Assoc. Prof)

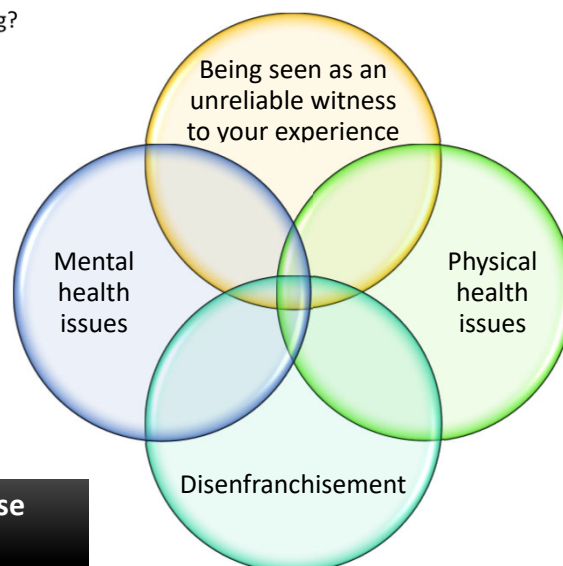
n.lambert@mdx.ac.uk

Health impact of violence

Justice or
wellbeing?

- A wide range of associated physical, neurological, psychological and psychogenic health problems are linked to VAWG.
- Health issues include: *chronic problems with digestion, stomach, kidney and bladder function and headaches, poorer pregnancy outcomes and lower birthweight babies.*

Recognition by nurses about the extent of these health consequences is central to their commitment to working with women to address the underlying cause of poor health.



Trauma and Health are directly linked

Highest risk for development of mental disorder amongst those who are re-victimised

Trauma, MH & DVA are interrelated (Khalifeh et al. 2015)

- *Sexual abuse in childhood 3-5x risk of common MH disorder*
- *Significantly increased rates of DV & SA amongst those who access MH services (lifetime and in the last year)*
- *More likely to report to health professionals*

Childhood abuse strong association with suicide



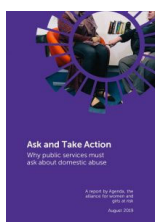
<https://www.youtube.com/watch?v=ehGUziolY2Q&feature=youtu.be>

RCN: *Domestic abuse is a significant safeguarding issue for all societies.*



- **Understanding of the issue:** Worrying increase in cases being reported during COVID-19 pandemic, Resources developed for health workers
- **Changing role:** Nurses & midwives have key roles to play in identifying and supporting victims of domestic abuse, whether they are patients/clients and/or colleagues. (CQC Sexual safety report / Safeguarding / Public Health)
- **Taking action:** In May 2020 the RCN signed a **collaborative letter** in support of the reintroduction of the Domestic Abuse Bill and the Government's ambition to transform the national response to this public health epidemic

Ask and Take Action is kindly supported by a range of charities, practitioners and other experts, including:



**Use your voice
and networks –
every time all
the time!**

Ask and Take Action

<https://weareagenda.org/askandtakeaction/>

“Health staff see the impact of abuse on people experiencing mental distress every day, and it forms one of the hardest parts of our working lives. It’s easy to feel overwhelmed in the face of a public health crisis like domestic violence, but there are things that we can all do to turn the tide. We can celebrate colleagues who are getting this right and replicate their successes in our own areas. We can use research and national guidance to raise standards and can write better local policies to ensure that we actively promote the safety of everyone we work with. Most importantly of all – we can make sure that we have the skills to ask people about what’s happening in their lives in a respectful and compassionate way and take action to safeguard them and their families.”

– Nicky Lambert, Assoc. Professor Middlesex University.

We have to do better here:

80% of women experiencing domestic abuse seek help from health services and these are often a woman’s first, or only, point of contact.

Nearly ¼ of survivors at high risk of serious harm or injury went to an Emergency Department due to their injuries in the year before getting effective IDVA support

Pregnancy can be a significant risk factor with 40–60% of women accessing domestic abuse services while pregnant.

Women who experience domestic abuse are x3 more likely to be diagnosed with a mental health problem.

<https://www.standingtogether.org.uk/health>

Complications! : ‘Skint, shaken yet still caring: But who is caring for our nurses?’ Cavell Nurses’ Trust. (2016)

NURSING PROFESSIONALS

ARE THREE TIMES MORE LIKELY

TO HAVE EXPERIENCED DOMESTIC ABUSE IN THE LAST YEAR THAN THE AVERAGE PERSON IN THE UK.



1/10 NURSES FACED NON-PHYSICAL ABUSE IN THE LAST YEAR. FOUR TIMES HIGHER THAN THE RATE FOR THE GENERAL PUBLIC.



1/7 nurses, midwives and HCAs has experienced domestic abuse in the last year.

UNDER THREAT. 4.4% of the nurses we spoke to had been threatened in the last year. This means that someone said they would hurt or kill them, or that they would use a weapon against them or someone close to them, like their child.

NHS staff as survivors and perpetrators of domestic abuse

The prevalence of domestic abuse within the UK means no workplace or set of employees is immune.

An estimated 51,355 NHS staff (44,825 female and 6,530 male) will have experienced domestic abuse in the last 12 Months



Over 51,000

An estimated 51,355 NHS staff (44,825 female and 6,530 male) will have experienced domestic abuse in the last 12 months⁴⁵.



82%

of midwives had experienced domestic abuse in their working lifetime and, of them, only 33% asked for workplace support.



29%

midwives surveyed reported that they received no support or had a poor experience of support for the abuse in the workplace.

Readiness of newly licensed associated degree registered nurses to screen for domestic violence Wyatt et al. (2018) and

Nurse education and understanding related to domestic violence and abuse against women: An integrative review of the literature Alshammari et al. (2018)

- **Nurses play a crucial role** in recognizing IPV/DVA & providing them practical, emotional and psychological support.
- **Inconsistent training and expectations** around identifying and responding to IPV/DVA screening. Training isn't consistent across nursing curriculums or work orientations.
- Newly licensed nurses quickly become **products of work environment**.
- Recognises that there is interpersonal or intimacy to screening for domestic violence that may require specialized training. Nurses can lack confidence in responding to IPV/DVA due to limited training and educational experience, **fear of offending, lack of effective interventions and communication skills**.

Sexual Safety Collaborative

The Sexual Safety Collaborative is part of a wider Mental Health Safety Improvement Programme (MHSIP) - NHS Improvement (NHSI), in partnership with the Care Quality Commission (CQC):

- CQC report on **Sexual Safety on Mental Health Wards**
- Produce a set of **standards** around sexual safety during the mental health and learning disability inpatient pathways
- Run a national **quality improvement** (QI) collaborative to support inpatient mental health teams in every mental health trust in England to use QI to improve sexual safety on their wards.
- Produce a library of **resources**, building on best practice to support the work of mental health trusts to improve sexual safety.

A link to an upcoming panel discussion: <https://www.eventbrite.co.uk/e/mhtv-episode-13-sexual-safety-in-inpatient-settings-tickets-109176929134?aff=erelexpmlt>

General Practice: The IRIS Model (*IRIS - Identification and Referral to Improve Safety*) a collaboration between general practice and specialist domestic abuse services.

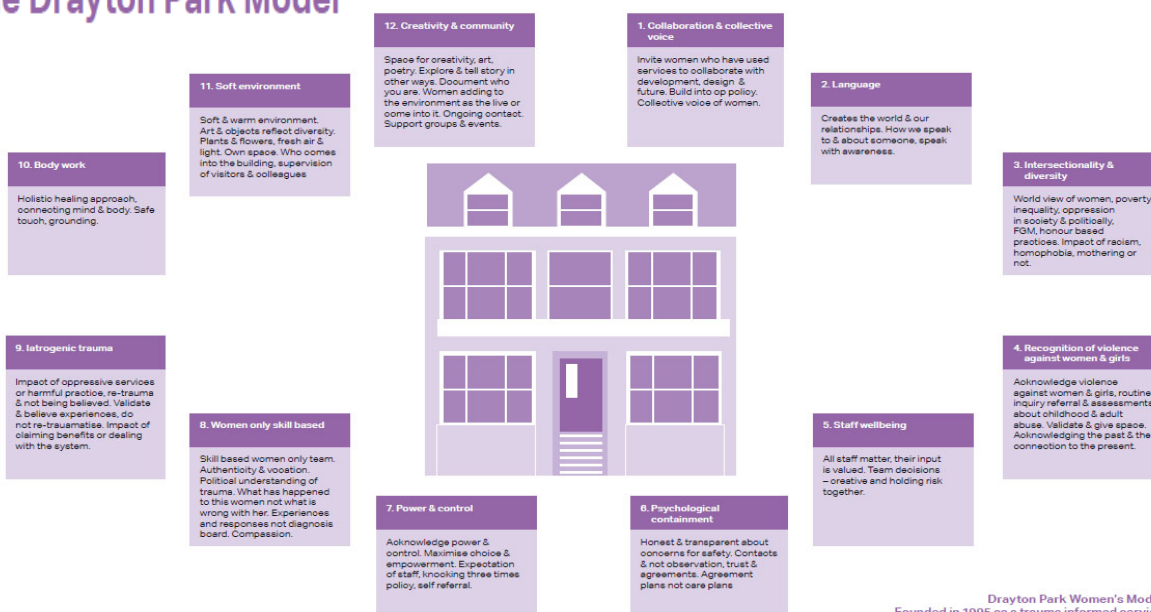
Core areas of the programme include:

- Embedding a specialist domestic abuse workers within surgeries
- Ongoing training and education for the clinical and non-clinical staff to support better identification and response to domestic abuse
- Support for those affected by domestic abuse
- Clinical enquiry and simple care pathways for clinicians
- An enhanced referral pathway for all female patients aged 16 and above

Dr Gene Feder, Bristol University - Increasing awareness of DA in general practice

<https://www.youtube.com/watch?v=ocOHMN66q90&feature=youtu.be>

The Drayton Park Model



Drayton Park Women's Model
Founded in 1995 as a trauma informed service
in Camden & Islington NHS Foundation Trust
Shirley McNicholas

<https://www.youtube.com/watch?v=EMyf3gJUM1Q>

Domestic Abuse Guide

NHS
Camden and Islington
NHS Foundation Trust

There is #NoExcuseForAbuse

 Do you feel doubted or criticised?	 Are you made to feel like you are losing your sanity?	 Do you feel anxious and stressed in their company?	 Do you feel intimidated, threatened or guilty?	 Is your mobile phone and internet use monitored?	 Are you forced to engage in sexual acts that make you feel sad, degraded or uncomfortable?
 Do they slap, pinch, bite, kick, choke or throw things at you?	 Are you being accused of flirting or having an affair?	 Are your movements monitored at home and work?	 Are you afraid for your safety, your life and the lives of others?	 Are you not free to do the things you want, wear what you want, see people you want?	 Are you being forced into a relationship or marriage?
 Do you feel controlled, isolated, scared, hurt, hopeless or trapped?	 Do they threaten to take their own life or lives of others if you don't comply?	 Do you have to justify how you spend your money? Is it taken away and given allowances?	 Have you ended a relationship or moved away, but are being harassed via social media or other people?	These are all signs of domestic abuse and coercive control. It is not OK for someone to make you feel like this.	

The Covid-19 pandemic means that helping people at risk of domestic abuse is more challenging. There is increased social isolation and as we all stay home we need to remember that home is not a safe place for everyone. Look out for your friends, family, neighbours and colleagues. If you think someone is at risk, please report this so they can get the help they need.

Domestic abuse can happen to everyone, regardless of gender or sexuality. We are asking you to look out for your colleagues and spot the signs that they may need help.

Do they have unexplained injuries?	Do they have decreased productivity?	Are they frequently late or absent?	Are there changes in behaviour?
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We understand it may be difficult to approach someone if you think they are at risk, but it may be the important first step in helping them. It will be difficult for colleagues to tell someone about the domestic abuse they are experiencing and your support is important.



Do

- Ask if something is wrong
- Express concern
- Listen non-judgmentally and validate
- Offer help
- Prioritise safety over work efficiency
- Support their decision
- Encourage them to call helplines or police
- Give confidence and reassurances
- Allocate private time and space to listen
- Refer to the Trust's domestic abuse policy for help in talking with a colleague who has shared their experiences



Don't

- Wait for them to come to you
- Judge or blame
- Pressure the individual
- Give advice
- Place conditions on your support
- Show any doubt
- Seek proof of abuse
- Be afraid to ask a colleague for support and guidance

How the Trust can help

Adjusting their responsibilities and workload.	Making emergency and safe contact arrangements.	Arrange Flexible working hours and consider job sharing options.	Improving the safety of the employee while they are at work.
Agreeing a period of absence (dependent on the individual's situation) through collaboration with the employee, their manager (supported by HR) and their union representative is applicable.		Reviewing communications and IT safety.	Consider any other support that the person feels would help.

To raise any concerns in the workplace speak to a member of the HR team or your line manager for advice and support. You can also speak to Trust Wellbeing lead, Bev Flint (wellbeing@candi.nhs.uk) or Women's Lead, Shirley McNicholas (shirley.mcnicholas@candi.nhs.uk).

Further Support Information

Solace
0203 795 5070

Camden Safety Net
0207 974 2526

Rape Crisis
0808 802 9999

Online Support and Advice
www.chat.womensaid.org.uk

National Domestic Violence Helpline
0808 2000 247

LGBTQ - Domestic Abuse Helpline
0800 999 5428
galop.org.uk

Men's Advice Line
0808 801 0327
info@mensadviceline.org.uk
mensadviceline.org.uk

In an emergency dial 999. Silent calls can be made by dialling 999, then 55, if you can not talk.

Joining the dots...

How your mental health can be used to abuse you further – Women's Aid

- If you have a mental health diagnosis, your partner may have used this to abuse you even more. For example, by:
- Saying you couldn't cope without him. Saying you're "mad" Not allowing you to go anywhere alone because he is your "carer"
- Speaking for you: "You know you get confused/you're not very confident/you don't understand the issues".
- Telling you you're a bad mother and cannot look after the children properly.
- Forcing you to have an abortion because "you couldn't cope". Threatening to take the children away.
- Threatening to "tell Social Services" – the implication being they will take the children away.
- Telling the children "Mummy can't look after you".
- Deliberately misleading or confusing you. Withholding your medication. Withholding or coercing you into using alcohol or drugs.
- Undermining you when you disclose the abuse or ask for help: "You can't believe her – she's mad".
- These tactics will almost certainly add to your emotional distress and exacerbate any existing mental health issues.

<https://www.womensaid.org.uk/the-survivors-handbook/>

Resources

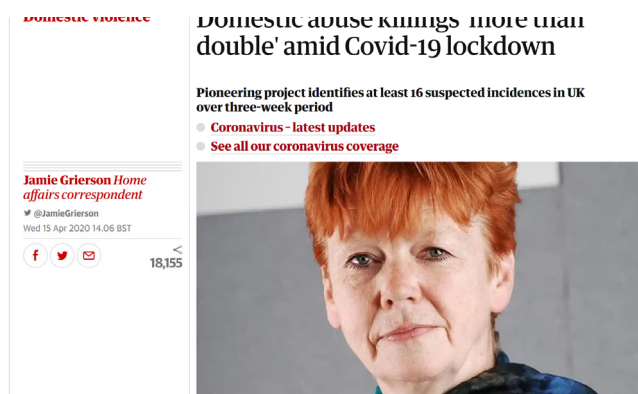
- Pathfinder:
<https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5ef35f557271034cdc0b261f/1593007968965/Pathfinder+Toolkit+Final.pdf>
- E-learning package developed by SafeLives for the Health Pathfinder project: <https://manuals.safelivesresearch.org.uk/Pathfinder/#/>
- The [NICE Domestic abuse quality standard \(QS116\)](#)



HALT – Homicide, Abuse, Learning Together

Learning from the Past
Rachel Robbins

Current Context



- Increased domestic homicides
- Increased calls to helpline
- The household isolation instruction as a result of coronavirus does not apply if you need to leave your home to escape domestic abuse
- Austerity continues to undercut rhetoric
- Short term funding over long term planning

Definition of a Domestic Homicide

- Since April 2011, Community Safety Partnerships (CSPs) are required to undertake a multi-agency review after a domestic homicide and to produce a Domestic Homicide Review (DHR).
- A Domestic Homicide Review (DHR) is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.

Pilot Study

- We retrieved 142 DHRs from CSP web sites (322 in England & Wales) in July 2016
- To investigate the characteristics of victims and perpetrators of domestic homicides
- To analyse the relationship characteristics of victims and perpetrators
- To investigate whether formal agencies knew of the victims or perpetrators
- To investigate whether friends/family were aware of domestic abuse prior to the homicide
- To investigate contextual features of a sub-set of DHRs

Characteristics of Relationships

- Homicides occurred across the life course
- Perpetrators were most often the husbands or ex-husbands of victims (38%), followed by partners/boyfriends (36%) and sons (19%)
- Intimate relationships accounted for over three-quarters (77%) of all the cases, with family relationships (mostly sons committing parricide) accounting for the remaining quarter (23%)
- Relationship length varied considerably: 3 weeks – 60 years, with a mean average of 12 years, but nearly half (44%) of all cases involved relationships of 5 years or less
- Nearly two-thirds (64%) of cases involved relationships where domestic violence and/or abuse was a known characteristic (either known by agencies, family, friends, neighbours or colleagues)

Further information on the Pilot Study

British Journal of Social Work (2018) 0, 1–18
doi: 10.1093/bjsw/bcy024

Children and Domestic Homicide

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Abstract

In England and Wales, Domestic Homicide Reviews (DHRs) are completed following domestic homicides. They provide multi-agency accounts of families living with domestic violence and abuse (DVA) and their interactions with services. This study addressed children's involvement in domestic homicide. We analysed all DHRs where there were children under eighteen years old published in 2013–16. This yielded a rich sample

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ORIGINAL ARTICLE

Health and Social Care WILEY

Learning from domestic homicide reviews in England and Wales

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Abstract

This paper aims to contribute to the prevention of future domestic homicide by analysing 141 domestic homicide reviews (DHRs) in England and Wales. All publicly available DHRs (n = 141) were retrieved from Community Safety Partnership websites in England and Wales in June 2016. Utilising a mixed methods approach, we designed templates to extract quantitative and qualitative data from DHRs. Descriptive statistics were generated by SPSS. 54 DHRs were analysed qualitatively, using N-Vivo for data management. The findings revealed that perpetrators were aged 16–82 years; with a mean average age of 41 years. Victims' ages ranged from 17 to 91 years old; with a mean average age: 45 years. Perpetrators' mental health was mentioned in 65% of DHRs; 49% of perpetrators had a mental health diagnosis. Healthcare services, in particular, mental health services, were most likely to be involved with per-



RESEARCH TEAM

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Dr Rachel Robbins (UCLan)

Dr Kelly Bracewell (UCLan)

Dr Cassandra Jones (UCLan)

Dr Alina Haines (MMU)

Elaine Craig (MMU)

Project dates: 1st May 2019 – 1st May 2022



STUDY OBJECTIVES

- To conduct a systematic review of domestic homicide reviews internationally to build knowledge about their focus, organisation and lessons identified in order to inform future developments of DHRs.
- To analyse all publicly available DHRs to identify possible risk and contextual factors preceding the homicides and the recommendations made in DHRs to prevent future domestic homicides.
- To explore the journeys of victim/survivors, families and agencies in relation to high risk domestic violence and domestic homicide to ensure policy and practice is cognisant of and learns from their experiences.





STUDY OBJECTIVES

- To investigate good practice, lost opportunities for interventions and to identify areas for strengthening responses for the prevention of domestic homicides.
- To work with key agencies to enhance policy and practice by improving methods for implementing the recommendations of domestic homicide reviews at the local level.



STUDY METHODS

- **Work Package 3:** uses experience-based co-design (EBCD), an innovative, action orientated method to interrogate the utility, learning and future development of services from domestic homicide reviews (DHRs) and key stakeholders. It will enable us to strengthen the learning components of DHRs through a 'co-design' process. It entails:
- Filmed interviews with family members who have lost a relative to domestic homicide
- Filmed interviews with current victims of domestic abuse
- Interviews with professionals involved in supporting families experiencing domestic abuse and those involved in the DHR process





STUDY METHODS

- Identifying 'touchpoints' in interviews
- Bringing together survivors and family members with CSPs in Lancashire and Wales
- Working together to reflect on what might work best in local areas to prevent future domestic homicide



STUDY OUTPUTS

- Website
- Repository of DHRs: easily accessible and potentially searchable
- Typology of domestic homicides
- Peer reviewed journal articles
- Film (family members and survivors)
- Thematic briefing papers






Individuals, families and neighbourhoods: predictors of domestic abuse

Dr Ruth Weir

University of Essex

 @DrRuthWeir

Research Questions

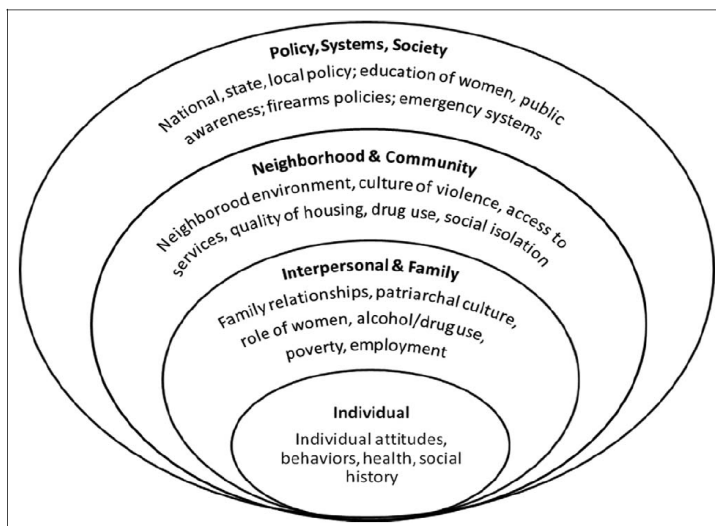
Key policy questions:

- Where should Essex County Council focus their resources and services to have the most impact in reducing domestic abuse?
- Can Essex County Council rely on Essex Police recorded crime data to predict the service requirements of those who do not report their abuse to the police?

Key academic question:

- Are individual or neighbourhood variables a better predictor of domestic abuse?

Research Framework



Beyer et al. (2013)

Neighbourhood level theory

- What can we learn about factors that might impact the levels of domestic abuse in an area?
- Combining geographical theory (Tobler, 1970), "Everything is related to everything else, but near things are more related than distant things" with revised Social Disorganisation Theory (Sampson and Groves, 1989)

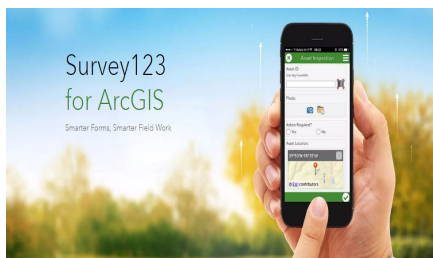
Results

- Number of models produced testing a range of predictors
- In the final model with the best fit the explanatory variables explain 82% of variability in the dataset (r-square). In social science this is very good!
- Variables in the final model
 - ASB rate
 - Proportion BAME
 - Population density
 - Income score (IMD)
- Weir, R. (2019), Using geographically weighted regression to explore neighbourhood level predictors of domestic abuse in the UK. *Transactions in GIS*.

Exploring the model outputs

- But model doesn't account for neighbourhood effects – the causes of the observed patterns.
- Sampson suggest local community acts as an essential ingredient to social good - Collective efficacy.
- Need to distinguish between neighbourhoods that have higher or lower levels of domestic abuse despite their circumstances and those that have higher or lower level of abuse because of their circumstances.

Survey123 for ArcGIS



- Interviewee – local stakeholder
- Half a day in each location
- Visiting assets that might be used by residents in the study LSOA

 The image is a screenshot of the Survey123 form interface. It includes fields for "Name of asset", "Type of Asset" (with checkboxes for Organisation, Group/Informal, Individual, and Other), "Number of members", "Opening times", "Asset details", "Asset photo" (with a link to upload a file), "Asset photo 2" (with a link to upload a file), "Asset website", and a "GeoPoint" section with a "Set Location" button.

Key findings - Inequality

- More services in areas that are homogenously deprived such as Greenstead in Colchester and Melbourne in Chelmsford
- What do victims do in affluent areas with limit services e.g. Thaxted?



Collective efficacy and social capital

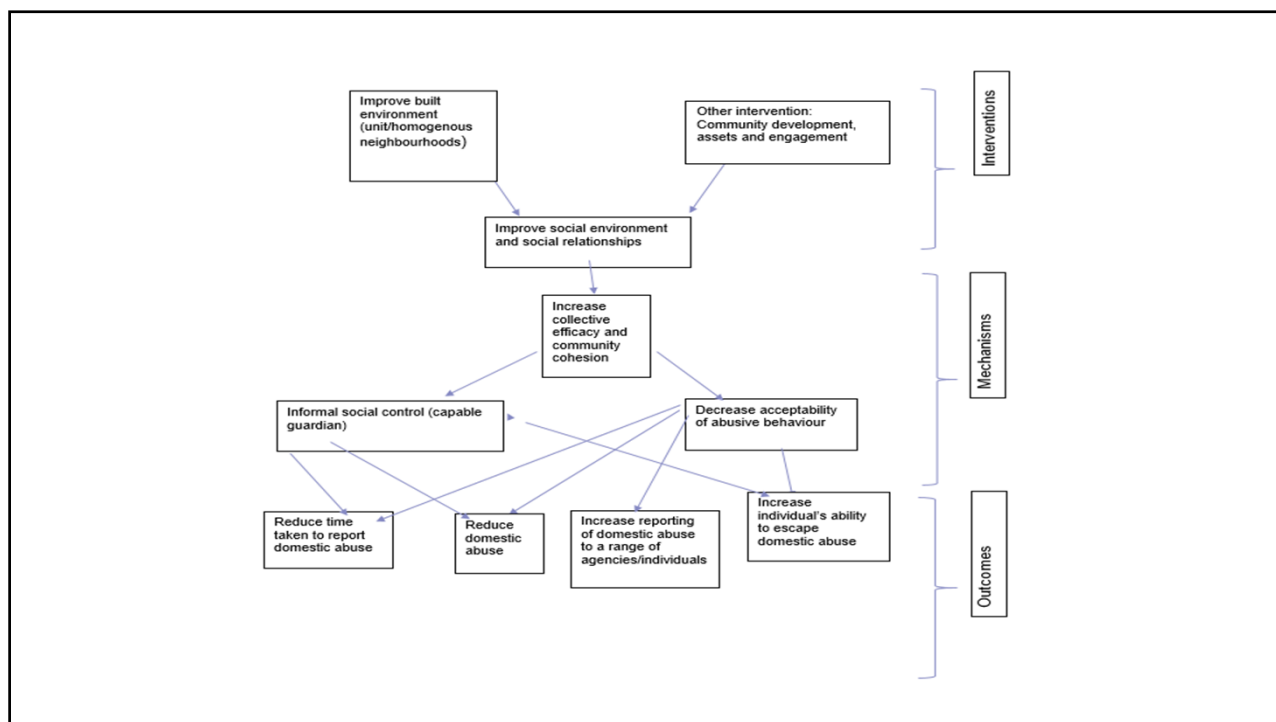
- Lack of collective efficacy particularly evident in Laindon and Clacton – but different levels of reporting.
- Influence of collective efficacy varies across population and different stages of life course. Such as older population in Thaxted.
- Influence of high residential mobility e.g. Clacton and local residents experiences.
- Areas where social capital particularly high also high human and economic capital. How can you create collective efficacy/social capital where it is most needed?



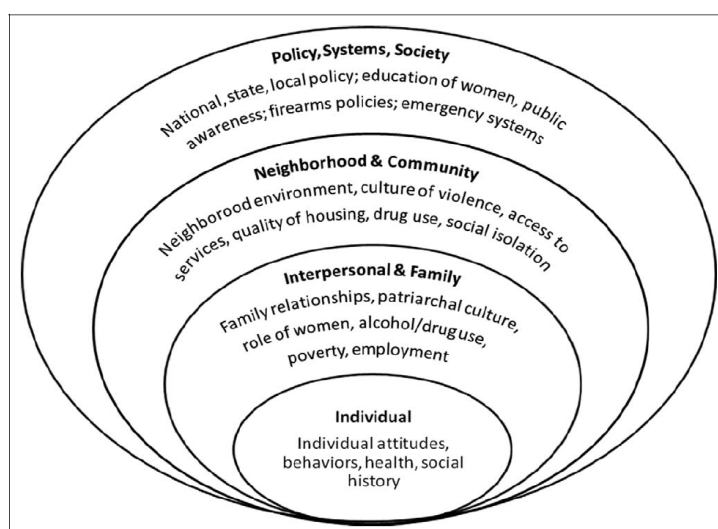
Churches, community centres and foodbanks

- Important role – particularly in deprived areas
- Active referral to other agencies other than the police
- Trust
- Confidential services for victims (e.g. counsellors and services for prostitutes).
- Wouldn't have discovered without community asset mapping

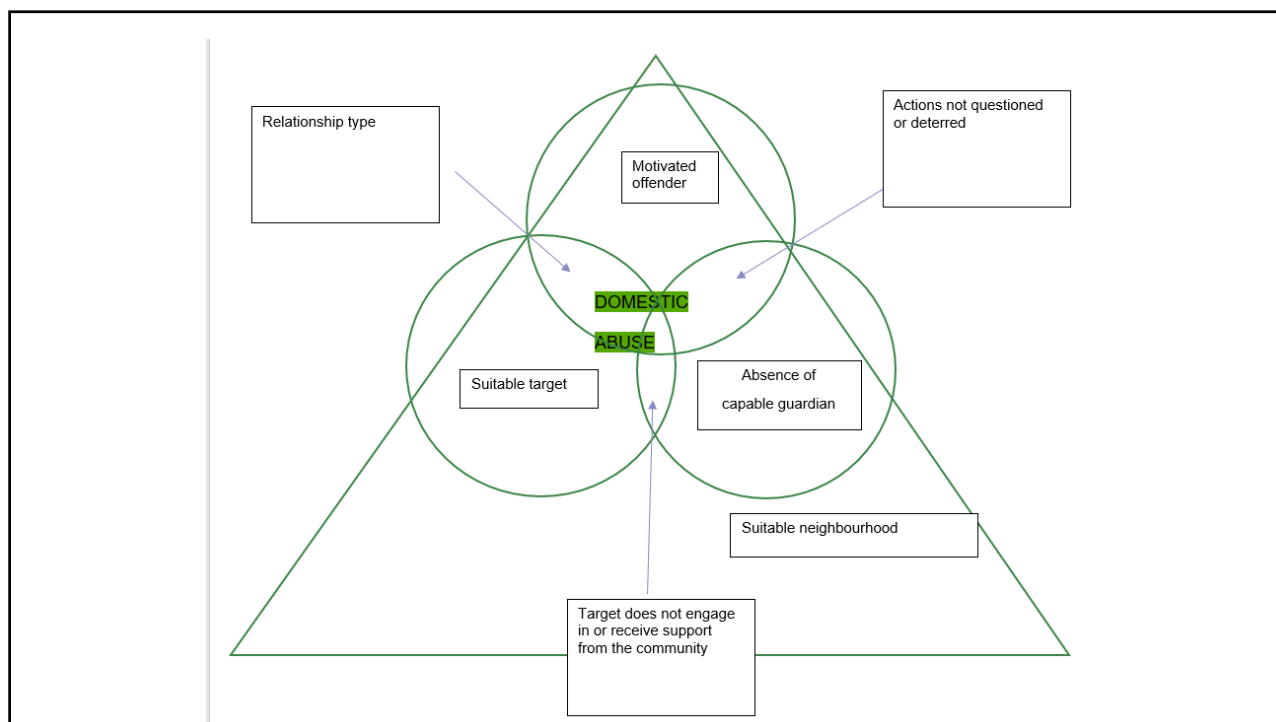




Research Framework



Beyer et al. (2013)



Conclusions and policy implications

- Mixed methods using GIS gives new insight
- Consider using as a hybrid approach – looking at needs and strengths
- Can we quantify collective efficacy?
- Multi-agency approach needed – cannot rely on police data alone
- CAM findings suggest that model gives a better estimation of abuse than using just police data.
- Implications for understanding impact COVID 19 on domestic abuse



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<https://bit.ly/38gb4Sc>

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