INCADVA Briefing on the Domestic Abuse Bill

House of Lords Second Reading Debate

A whole-health response model to Domestic Abuse

1. INCADVA (Inter-Collegiate and Agency Domestic Violence Abuse) is a policy forum which brings together the expertise and knowledge of national health and social care bodies, medical royal colleges and the domestic abuse sector. As members of the INCADVA Forum we welcome the re-introduction of the Domestic Abuse (DA) Bill. We are clear, however, that the Bill and supporting non-legislative package must go much further in order to meet all of a survivors' needs. **We are clear on the importance of the following issues and strongly encourage Peers to raise these in the debate.**

2. We are concerned about the omission from 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 healthcare in responding to domestic abuse and other forms of violence against women and girls (VAWG). Recent years have seen important innovative work by the specialist VAWG sector in collaboration with the NHS and public health. We urge policy makers to promote this good practice also known as the *whole-health model* so that all survivors have access to the support they need and further harm can be prevented.

   Our key recommended actions are:

   I. The Department for Health and Social Care ensures that all health services (including integrated care systems, primary care networks, NHS Trusts, CCGs and public health services such as health visiting and school nursing) provide a strategic commitment to responding to domestic abuse.

   II. Sustainable and significant government investment is required to ensure that all CCG areas adopt the whole health model endorsed by the Pathfinder project including evidence-based interventions such as IRIS in GP practices, Health IDVAs in acute and mental health settings and a specialist coordinator to ensure this work is embedded at a strategic level as well as operationally.

   III. Sustainable funding is required for high-quality, specialist training of all healthcare professionals, including online synchronous training and 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.

IV. An increase in funded quality-assured evidence-based programmes for perpetrators to which health professionals can refer to.

V. Survivors have priority and timely access to adequately and consistently funded specialist mental health support services, available across the England and Wales to all survivors, regardless of their immigration status.

VI. A long-term public health campaign to help transform public attitudes to domestic abuse.

VII. Representation from mental health services on the Domestic Abuse Commissioner's advisory panel, in addition to the wider health service representation.

VIII. The Bill recognises that domestic abuse is gendered in order to challenge existing myths about domestic abuse and its effects. This needs to be enshrined in legislation in order to address the root cause of domestic abuse.

3. It is essential that domestic abuse is understood through a gendered lens in order to be addressed effectively. The DA Bill must be seen in the global context of eliminating violence against women and girls (VAWG). Since the cross-government VAWG strategy came to an end in March 2020 a new strategy must fill this critical gap to reinforce and emphasise that VAWG is a public health and human rights issue.

4. 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.[1] We remain highly concerned about progress made since. Despite NICE guidelines on domestic abuse and a linked quality standard[2] for the response to domestic abuse in health and social care settings, implementation remains inconsistent and funding is scarce.

5. 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 non-justice-based route to effective support.[3] Seeing a health professional can often be the only time that a survivor is able to disclose abuse without the perpetrator present.

6. Analysis of DHRs and academic research[4] 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 more often than not these opportunities are missed, and health professionals are not appropriately equipped to respond to domestic abuse.[5]

7. Domestic abuse is not only experienced by adults. There is a large body of evidence to show that the impact of a perpetrator's coercive control on the non-abusive parent has an equally devastating effect on children within the family.[6] As one of the only statutory services to interact with all members of a family, health professionals are well placed to spot the effects of domestic abuse on children as well as adults and intervene early. Best practice responses in health should recognise the need for a holistic, inclusive approach responding to needs of the non-abusive parent and child. Evidence shows that providing support to keep the survivor safe is often the best way to safeguard children in the context of domestic abuse.[7]

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[1] The Report of the Taskforce on the Health Aspects of Violence Against Women and Children, March 2010
[2] https://www.nice.org.uk/guidance/qs116/chapter/Introduction
[3] SafeLives (2016) A Cry for Health. Available online
[4] Violence against women and mental health.
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.
[5] Standing Together (2016) Domestic Homicide Review Analysis. Available online
[6] https://safelives.org.uk/insights-national-briefing-children
[7] Radford and Hester (2006) Mothering through Domestic Violence

8. The national Pathfinder Survivor Consultation, which reached over 140 survivors of domestic abuse, captured this and other survivor experiences of health services. One survivor stated:

"My GP is quick to write out a prescription but not listen to what I am saying when I have spoken about the abuse and not offer any counselling just medication."[8]

Another survivor highlighted the inconsistency in service provision: *"This postcode lottery meant I couldn't access any services and also wasn't informed of any, I got my support from the… voluntary sector."*[9]

A consistent theme throughout the consultation was around survivors 'having to re-tell their story' over and over, its retraumatising impact and the need for services to share information safely and effectively.

Women's Aid's 'Law in the Making' expert by experience also highlighted a poor understanding of domestic abuse and trauma: ""*I found that I wasn't taken seriously for a long time because I didn't 'appear' to be sick*."[10]

9. The pandemic has shone a light on the need to protect victims from abuse and ensure they have access to life-saving support. Lockdown and self-isolation measures have exacerbated the isolation and risks experienced by survivors and increased barriers to support.[11] COVID 19 is also having a significant impact on survivors' mental health. Women's Aid's survey of survivors found that two thirds[12] of survivors currently experiencing abuse who need mental health support were unable to access it after the pandemic started, and just over half of survivors[13] who experienced abuse in the past that need mental support were unable to access it[14]. These barriers will be even greater for women facing multiple disadvantage.

10. These unprecedented times have highlighted the important role of health in responding to domestic abuse. As one of the only agencies the public could access the sector has seen a rise in presentations of domestic abuse and referrals to specialist services. It is therefore paramount that all health services have the capacity to respond appropriately and that opportunities are taken to intervene earlier, ensure all survivors of domestic abuse are provided with support, and to prevent harm. 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.

11. DHRs and NHS Confidential Enquiries repeatedly highlight[15] the need for systemic change across the NHS and public health services [16] In addition, these reviews and enquiries highlight the disproportionate impact of domestic abuse on women facing additional forms of discrimination including ethnic minority, deaf and disabled women, 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[17].

A whole-health model response to domestic abuse

12. Most recently, important progress has been made in the areas of health and domestic abuse. Pathfinder[18] 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

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[8] Pathfinder Survivor Consultation

[9] Pathfinder Survivor Consultation

[10] Women's Aid, 2019, Law in the Making Experts by Experience Briefing: Priorities for a Domestic Abuse Bill. Available online

[11] Early impacts of the COVID 19 pandemic on mental health care and on people with mental health conditions: framework synthesis of international experiences and responses, June 2020.

[12] 21 out of 31 survivors

[13] 74 out of 141 survivors

[14] Women's Aid (2020) The Impact of COVID 19 on Survivors. Available online

[15] Mental illness and domestic homicide: a population-based descriptive study.
Oram S, Flynn SM, Shaw J, Appleby L, Howard LM.Psychiatr Serv. 2013 Oct;64(10):1006-11. doi: 10.1176/appi.ps.201200484.

[16] Standing Together (2016) Domestic Homicide Review Analysis. Available online

[17] Ibid

[18] Pathfinder Toolkit (2020) Available online

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 domestic abuse in health is needed in order to make sustainable and meaningful change.

13. A whole-health model 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.

The Strategic Lead for the Royal Borough of Kensington & Chelsea who was involved in Pathfinder commented: '*Health partners play a vital role in ending domestic abuse as part of our wider coordinated community response. The Pathfinder project has provided us with a robust framework to ensure that local authorities, specialist services and health approaches are aligned and effectively coordinated. Building on existing good practice, we have adopted a partnership approach on both a strategic and operational level in a range of health settings to be able to better meet the support needs of victims and survivors of domestic abuse.*'[19]

14. What is needed from Government to establish a whole health response:

The following recommendations provide more detail on what is needed to implement a whole health response.

I. DHSC to ensure that all health services (including NHS Trusts, CCGs and public health services such as health visiting and school nursing) 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:
    I. Specific domestic abuse governance structures
    II. Comprehensive domestic abuse strategy and internal policies
    III. Effective and comprehensive data and information sharing systems
    IV. To mandate that appropriate sharing of information is permitted and to ensure that the complexities of Information Governance (Data Protection) requirements are not a barrier to effective service delivery

II. Sustainable and significant government investment, over a minimum of 5 years, is required to ensure that all CCG and public health areas adopt the whole health model endorsed by the Pathfinder project including evidence-based interventions such as IRIS in GP practices, Health IDVAs in acute and mental health settings and a specialist coordination work to ensure this work is consistently embedded at a strategic level as well as operationally. 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:

    I. 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 nationally recognised as best practice and has informed NICE guidance.

[19] Pathfinder Toolkit (2020) Available online

II. 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[20] find similar results when specialists are located in mental health settings[21]. Other health services should set up robust care pathways into community IDVA services.

III. The establishment of a Domestic Abuse Coordinator or Lead within a Health Trust or CCG. This role is critical as it will lead on the delivery of the local health services' strategy on domestic abuse and will support the smooth running of all interventions. It will ensure that the whole-health response is embedded at a strategic level, it is sustainable in the long-term and consistent across the whole health economy.

IV. 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[22], there is a need for public authorities to ensure frontline staff in our public services are making trained enquiries into domestic abuse to ensure they are Making Every Contact Count. 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, primary care and public health settings, as well as embed specialist workers within health settings. Furthermore, the Department of Health and Social Care should influence the Medical Royal Colleges to include bespoke competencies for domestic abuse within the intercollegiate documents for child, looked after child and adult safeguarding given that they provide the current level of training and competence required for all health staff. Training and the development of further guidance should be led by or in consultation with specialists, trauma-informed and should take an intersectional approach.

V. 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.[23] Interventions such as the evidence-based programme Drive[24] which works with high-harm perpetrators has demonstrated a significant reduction in abuse.

VI. 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[25].

VII. A long-term public health campaign to help transform public attitudes to domestic abuse.

VIII. Representation from mental health services on the Domestic Abuse Commissioner's advisory panel, in addition to the wider health service representation.

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[20] Linking abuse and recovery through advocacy: an observational study.
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

[21] SafeLives (2018) Barnet, Enfield and Haringey Mental Health Trust: Mental Health Idva pilot evaluation. Available online

[22] Agenda (2020) Ask and Take Action Briefing. Available online

[23] NICE (2016) Domestic Violence and Abuse Quality Standard Guidance. Available online

[24] http://driveproject.org.uk/

[25] Law in the Making (2019) Experts by Experience Briefing: priorities for the Domestic Abuse Bill. Available online

IX. The Bill recognises that domestic abuse is gendered in order to challenge existing myths about domestic abuse and its effects. This needs to be enshrined in legislation in order to address the root cause of domestic abuse.

15. As well as saving lives and improving outcomes for adults and children, a whole health response to domestic abuse will also reduce costs within the healthcare system. **The Home Office has estimated that every year domestic abuse costs the healthcare system over £2.3 billion**[26]. In comparison, the cost implication of some of our recommendations are significantly smaller; 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[27] and the IRIS programme[28] are highly cost-effective and cost-saving for the NHS.

16. Now more than ever, in light of the ongoing 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.

17. If the Bill is to 'transform the response to domestic abuse', it must effect meaningful change in the health system's response to domestic abuse, and this requires strategic commitment and leadership at a national and local level and the funding of practical interventions and services.

[26] Oliver, R., Alexander, B., Roe, S. & Wlasny, M. (2019) The economic and social costs of domestic abuse Research Report 107. London: The Home Office

[27] SafeLives (2016) A Cry for Health. Available online

[28] 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.