domestic abuse commissioner

Manchester Metropolitan University

Briefing Paper

Domestic Homicide Oversight Mechanism for Physical and Mental Health

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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.

Aims

The study focused on understanding the types of recommendations made in Domestic Homicide Reviews (DHRs) for Health relating to intimate partner homicide (IPH) and adult family homicide (AFH). The study findings will help inform the Domestic Homicide Oversight Mechanism for Physical and Mental Health.

Methods

The sample comprised 58 DHRs published between 2017 and 2019. A mixed methods approach was used, with the qualitative analysis informing the structure of the quantitative framework. The qualitative methods comprised the creation of a template to extract information systematically, identifying examples of good practice, areas for development and learning, and an analysis of the recommendations made in relation to physical and mental health services. After extraction, a thematic approach was utilised (Braun & Clarke, 2022).

Findings

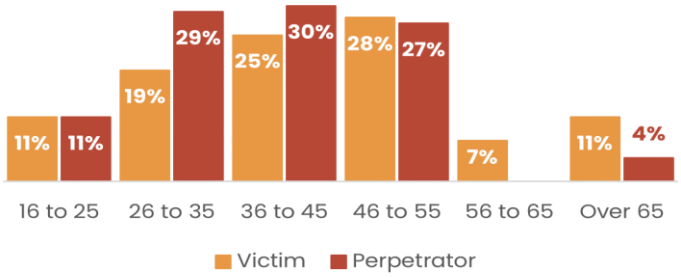
Forty-six of the 58 homicides (79%) were intimate partner homicides (IPH), and 11 (19%) were adult family homicides (AFH). One was an amicicide (killing of a friend) – in this case a victim killed by the sons of a woman she cohabited with.

Victim and perpetrator demographics

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

Ethnicity: Victims (43/57, 75%) and perpetrators (40/58, 69%) were White British, with the remainder coming from Minoritised backgrounds (including White Europeans).

Age: Victims ranged in age from 20 to 85 years and perpetrators 21 to 86 years.



The victim-perpetrator relationship and context

- The most common contextual or escalating factor leading up to the homicides appeared to be victims' attempts to end the relationship with the perpetrator (26%).
- Over three-quarters of DHRs (44/58, 76%) reported prior domestic abuse within the victim-perpetrator relationship.
- In 43% of cases (25/58) no single escalating feature could be identified, although intersecting factors of entrenched and escalating domestic abuse (particularly physical and coercive/controlling behaviour), perpetrator criminality and serial IPVA perpetration, victim and perpetrator poverty, mental ill health, and substance use (both alcohol and drugs) appeared to shape the homicide context.

Thematic Analysis of Recommendations

Theme 1: Lack of multi-agency working and information management

67% of the DHRs highlighted the need for better multi-agency working, specifically regarding information management and the improved gathering, reporting, sharing, and recording of information, co-ordinated care, strengthening midwives' involvement in MARACs, and appropriate detail to be given when patients transfer from one health service to another.

Theme 2: Improving assessments

38% of the DHRs included recommendations for better assessment processes, including routine enquiry re: DVA, carrying out (and embedding) DVA assessments or other assessments of relational risk; carrying out mental health assessments; auditing carers assessments; and ensuring regular healthcare reviews for those with long-term health conditions.

Theme 3: Developing practice

Recommendations for developing practice were found in 57% of the DHRs. These included the need to increase professional curiosity and assertiveness; thinking holistically and systemically, ensuring family needs and risks are considered, as well as patterns of behaviours over time (for example frequent attenders, repeat non-attenders etc.). There were clear recommendations to improve the continuity of care that includes expanding the capacity of services to address co-morbid conditions such as alcohol dependency and suicidal ideation. Interpreting services and providing DVA information in alternative languages should be easily accessible. Extending the IRIS programme to GP surgeries where this is not currently offered and ensuring hospitals have an IDVA was also recommended.

Theme 4: Training and development for staff

72% of the DHRs included recommendations for staff training and development:

- increasing or developing domestic abuse training including coercive control, approaches to discussing DVA with clients and utilising tools and processes such as the DASH and MARAC,
- increasing or developing adult safeguarding training and child protection training,
- training in record keeping/information sharing, including on immigration issues,
- monitoring the effectiveness of changes made to training,
- utilising supervision as a forum for raising any concerns of practitioners.

Theme 5: 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%):

- develop or amend domestic abuse policy,
- use and share the learning from the DHR process,
- develop and implement new specialist services or DVA champions,
- evaluate or audit current provisions, pathways, interventions, or responses,
- review or comply with adult safeguarding policy and process,
- develop protocols and policies for information sharing,
- meet NICE or RCGP guidance on DVA.

Theme 6: Good practices

Examples of good practice were found in 27 of the 58 DHRs (47%). Good practices most often focused on timely communication and/or safe methods of communication being established, the effective sharing of information between agencies, the effective identification of risk and steps being taken to mitigate those risks and making safeguarding and specialist DVA referrals. Good practices were most often flagged in relation to GPs, A&E departments, mental health services, and nursing.

Theme 7: National Recommendations

National recommendations were made in 21 of the 58 DHRs (36%). 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 and appropriate sharing of information.

Key messages

- The DHRs show that routine inquiry in a range of health settings is absent, with lost opportunities for intervention. Recommendations for improvement were targeted most often at Health Trusts, CCGs (now ICBs) and GPs.
- 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.
- A lack of multi-agency working and poor information management was recorded in 39 of the 58 DHRs (67%).
- 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.
- Co-ordinated care is also hampered by non-aligned IT systems or not using IT capacity - to 'flag' DVA perpetrators, victims, and frequent or non-attenders.
- The key challenges to practice are to develop skills to engage with those who are constructed as 'difficult'; to consider the possibility of DVA in 'devoted' relationships pertaining to older couples; working holistically; awareness of symptoms that may not appear related to DVA (e.g. unexplained pelvic pain, headaches); frequent attenders at GPs and non-attenders where DVA might be masked.