BMA President’s Seminar Series
Attlee Room, House of Lords, 15 January 2013

The role of health professionals in identifying and responding to domestic abuse, including child and elder abuse

Speakers

- Chaired by Professor Sheila the Baroness Hollins of Wimbledon and Grenoside, and President of the British Medical Association
- Baroness Scotland of Asthal
- Ms Deborah Jamieson, Chief Executive Officer, The Global Foundation for the Elimination of Domestic Violence
- Chief Constable Carmel Napier, Association of Chief Police Officers lead for domestic abuse, honour based violence, stalking and harassment

In attendance

- Ms Diana Barran, Chief Executive Officer, CAADA
- Dr John Beer, Chair of Action on Elder Abuse
- Baroness Browning
- Dr Fiona Cornish, President, Medical Women’s Federation
- Dr Shantanu Datta, Chair of Consultants Committee Psychiatry Subcommittee, BMA
- Dr Tony Delamothe, Deputy Editor, British Medical Journal
- Ms Mavis Dwaah, Psychological Wellbeing Practitioner, Trust Mentoring Programme – Project Co-lead, Wandsworth Psychological Therapies & Wellbeing Service (PTWbS), South West London & St George’s NHS Mental Health Trust
- Dr Anthony Falconer, President, Royal College of Obstetricians and Gynaecologists
- Dr Gene Feder, Royal College of General Practitioners
- Mr Jeff Gardner, Locality Director London, Victim Support National Centre
- Mr Mark Groves, Operations Manager, National Centre for Domestic Violence
- Ms Marie Hanson, Director, STORM
- Mrs Nicky Jayesinghe, Head of Science and Education, BMA
- Mr William Jarvis, Parliamentary Assistant for Robert Flello MP
- Baroness Jolly
- Ms Jane Keeper, Director of Operations, Refuge
- Professor Averil Mansfield, Chairman, Board of Science, BMA
- Professor Lord McColl of Dulwich
- Dr Andrew McCulloch, Chief Executive, Mental Health Foundation
- Ms Elicia Mollineau, Community Development Worker & BME IAPT Co-ordinator, Wandsworth Psychological Therapies & Wellbeing Service (PTWbS), South West London & St George’s NHS Mental Health Trust
- Professor Vivienne Nathanson, Director of Professional Activities, BMA
- Mr Robert Okunnu, Head of Public Affairs, BMA
- Ms Pragna Patel, Director, Southall Black Sisters
- Dr Mark Porter, Chairman of Council, BMA
- Mr George Roycroft, Deputy Head of Science and Education, BMA
- Ms Jo Todd, Chief Executive Officer, Respect
- Dr Kieran Walsh, Editor, BMJ Learning
**Introduction**

The aim of the seminar was to discuss the role of healthcare professionals in identifying and responding to domestic abuse, including child and elder abuse. Its key focus was to understand the barriers faced by healthcare professionals, and to consider ways to develop an effective, multi-agency approach to reducing the prevalence of this major healthcare concern. In building on the 2007 BMA Board of Science report, *Domestic abuse*,¹ this note explores some of the themes that emerged during the discussion. It is not intended to provide a comprehensive set of policy solutions, but to raise awareness of the many challenges in preventing domestic abuse, and to provide renewed impetus for the medical profession to respond to these challenges.

**The scale of the problem**

Domestic abuse occurs across the globe, affecting millions of people in all parts of society. In the UK it affects one in four women and one in six men in their lifetimes, with 89 per cent of repeat victims being women. Around 30 per cent of domestic abuse against women begins or worsens during pregnancy. In 2010/11, repeat victimisation accounted for 73 per cent of all incidents of domestic abuse. It has been estimated that half a million older people are victims of domestic (elder) abuse in the UK, and disabled individuals including individuals with intellectual disabilities can be more vulnerable to being abused. Approximately 750,000 children in the UK are affected by domestic abuse. The cost of domestic abuse to the UK taxpayer is £3.9 billion per year. There is growing evidence that abuse has severe consequences for victims and their children’s long-term health. It can also lead to devastating economic impacts resulting in social exclusion, worklessness and family poverty. While there is evidence that prevalence rates of domestic abuse are higher among families in lower socioeconomic groups, it occurs across the socioeconomic spectrum. Currently, two women are murdered every week in the UK as a result of domestic abuse, with each crime costing the UK about £1 million.

**Progress in reducing the prevalence of domestic abuse**

The work of the *Global Foundation for the Elimination of Domestic Violence* (which includes over 200 organisations representing over 85 countries) is estimated to have reached over 280 million people worldwide, and has reduced the cost of domestic abuse in the UK by £7 billion per year. According to the British Crime Survey (BCS), between 1995 and 2010/11, the total number of recorded domestic abuse incidents declined by 60 per cent. There has also been a significant decline in domestic abuse homicides, and an increase in successful prosecutions. A number of improvements (primarily in the criminal justice and voluntary sectors) have contributed to this reduction in the prevalence of domestic abuse in the UK:

- **a stronger legislative and regulatory framework** – introduction of the Domestic Violence, Crime and Victims Act 2004; development of strategies focused on violence against women; a national change in the definition of domestic abuse to include 16 and 17 year olds; systems to facilitate civil prosecutions alongside the criminal prosecution process; introduction of domestic abuse coordinator teams; pilots on domestic violence protection orders / protection notices
- **a more cohesive approach to identifying and managing high risk victims** – training for all front line staff across the public, private and voluntary sectors (including educational initiatives for groups such as taxi drivers and locksmiths as they typically come in contact with victims); funding for Independent Domestic Violence Advisors (IDVAs); establishment of over 150 Specialist Domestic Violence Courts; improved information sharing between local public agencies via Multi-Agency Risk Assessment Conferences (MARACs) meetings
- **improved risk assessment and evaluation** – centralisation of the Sexually Violent Delinquent Child (SVDC) and MARACs systems; development of a police service domestic abuse stalking and harassment evidence-based risk assessment tool.

Despite this progress, domestic abuse continues to occur in one in 10 households at any given time, while two women per week, one man every 17 days, and an increasing number of children are murdered as a result of domestic abuse. Repeat offending and repeat victimisation are also increasing, and data from the BCS found a 35 per cent increase in reported domestic abuse incidents between 2009/10 and 2010/11. These figures are particularly concerning in light of the funding and resource cuts that are affecting the provision of frontline services and the viability of voluntary sector agencies.

Time for a shift in the approach to domestic abuse?

Across all sectors, there continues to be a significant level of unstructured investment, as well as overlapping and duplicated use of resources. This can make services very difficult to access for victims (who commonly give up trying to get help), as well as for perpetrators of domestic abuse who are trying to change their behaviour. In building on the improvements outlined in this note, there needs to be a shift from a reactive crisis management approach, to proactive detection of the early signs of domestic abuse. This will help prevent incidents escalating further, and is particularly relevant for cases of repeat victimisation and for tackling serial perpetrators. Key to achieving this shift is developing a system for holistic risk assessment in which all partner services/agencies work collectively to share information on a timely basis – round the clock multi-agency working. This will provide the ability to build up a comprehensive picture of domestic abuse incidents, and will ensure joint accountability in making decisions about when and how to intervene.

Why is the medical profession so important?

More effective multi-agency working, where the medical profession is fully engaged in a holistic risk assessment process, would significantly improve the approach to tackling domestic abuse in the UK. Healthcare professionals are in an ideal position to identify signs of domestic abuse before a ‘crisis point’ is reached. On average, female victims of domestic abuse are subjected to 37 beatings before they involve the police. Many of these may have come in contact with their GP long before seeking help from the police, and at a time when they have been hurt significantly less often. Data also show that only 23 per cent of domestic abuse incidents are reported to the police. A significant proportion of the victims of the other 77 per cent of incidents are likely to present to healthcare professionals (including GPs, accident and emergency doctors, obstetricians, midwives and nurses), which provides the opportunity for interventions.

How should the medical profession respond?

There are a number of key challenges for the medical profession:

- **Training** – do all healthcare professionals feel confident in identifying and providing appropriate support for the victims and perpetrators of domestic abuse? Anecdotal evidence suggests many are unsure about getting involved, and have concerns about when it is appropriate to breach a patient’s confidentiality. Is there a need for more specialists in domestic abuse in the healthcare setting? Do they know how to ask questions and the circumstances in which asking questions or considering domestic abuse is especially important?

- **Raising awareness** – female victims of domestic abuse typically see a healthcare professional (in particular their GP) long before a ‘crisis point’ has been reached. How can awareness about this opportunity for early intervention be improved?

- **Supporting vulnerable groups** – how best can the needs of vulnerable adults (including disabled people and people with intellectual disabilities) who are victims of domestic abuse be met? What improvements are needed for the care of older people affected by domestic abuse?

- **Developing best practice** – there is a poor evidence base for interventions to identify and manage domestic abuse in the healthcare setting. What opportunities are there to develop and share best practice? What are the key research needs?

- **Referral services** – how can the provision of local support services for victims and perpetrators be improved? How can the impact of funding and resource cuts be minimised?

- **Collecting and sharing data** – effective multi-agency working will require robust systems to collect, record and share data for patients identified as victims or perpetrators of domestic abuse, as well as agreement on the type of data to be recorded.

- **Responsive service provision** – when domestic abuse incidents typically peak (over weekends and on bank holidays), the support available to victims is restricted to the emergency services and voluntary sector charities. This limits the ability to support victims, as well as the collection of real-time data. How can mainstream healthcare services for domestic abuse victims be better provided at the time of demand and need?

- **Practical considerations** – speaking to patients away from any partner or family member is of paramount importance in being able to discuss any potential domestic abuse incidents. This can be extremely difficult in practice, in particular with female patients. How can healthcare professionals be supported with this?

January 2013