Nottinghamshire County Council

Report to the Health and Wellbeing Board

16 January 2013

Agenda Item: 5

REPORT OF DIRECTOR OF PUBLIC HEALTH

TACKLING DOMESTIC VIOLENCE IN NOTTINGHAMSHIRE

Purpose of the Report

1. To inform the Health and Wellbeing Board of the extent to which Domestic Violence affects the people of Nottinghamshire from a Health and Wellbeing perspective and to recommend further action.

Information and Advice

What is Domestic Violence?

2. Throughout the literature a variety of terms are used, Domestic Abuse, Intimate Partner Violence (IPV), partner abuse, physical and sexual violence and Domestic Violence. For the purpose of this paper the term 'Domestic Violence' will be used unless specifically stated. The Government defines Domestic Violence as "any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults (those aged 16 upwards) who are or have been intimate partners or family members, regardless of gender or sexuality."

Why is Domestic Violence a Public Health issue?

3. Whilst it occurs across all sections of society, men are far more likely to be the perpetrators and women the victims. Women are also more likely to experience repeated and severe forms of violence, including sexual violence and are also more likely to have sustained psychological or emotional impact or result in injury or death[1].

4. Women who experience Domestic Violence present more frequently to health services. They are admitted to hospital more often than their non-abused counterparts and are issued with more prescriptions. There is evidence of a linear relationship between severity of Domestic Violence and the use of health services[2]. Survivors of Domestic Violence can have chronic health problems including: gynaecological disorders, chronic pain, neurological symptoms, gastro-intestinal disorders, and self-reported heart disease[3]. The most prevalent effect is on mental health, including post-traumatic stress disorder, depression, anxiety, suicidal thoughts, and substance misuse[4].

5. In addition to this, approximately 75% of children living in households where Domestic Violence occurs are exposed to actual incidents[5]. These children have an increased risk of

developing acute and long term physical and emotional health problems[6]. Many will be traumatised by what they witness, whether it is the violence itself or the emotional and physical effects the behaviour has on someone in the household. It is also associated with an increased risk of abuse, deaths and serious injury for children and young people[7].

6. In addition to the physical and psychological effects there are further consequences for victims of Domestic Violence such as:

- ***Homelessness***. Research carried out by the homeless charity, Shelter; found that Domestic Violence is "the single most quoted reason for becoming homeless". The study found that 40% of all homeless women stated Domestic Violence as a contributor to their homelessness[8].

- ***Loss of income or work***. The British Crime Survey showed that more than one fifth of women (21%) who were employed and who had suffered Domestic Violence took time off work as a result of the worst incident[9].

- ***Isolation*** from friends and family. Feelings of isolation can also occur having left a violent relationship since victims might have had to move to a new area away from friends and family. Building new social networks and pursuing new work or educational opportunities whilst recovering from the effects of a violent relationship can be very hard especially where the victim has experienced mental health issues.

- ***Poverty*** and financial hardship.

At Risk Groups

7. The following have been identified by the World Health Organisation (WHO) and the National Institute of Health and Clinical Excellence (NICE) as risk factors for becoming a victim of Domestic Violence[10] [11]. It is important to note that the potential to become a victim of Domestic Violence increases where a combination of risk factors occurs for an individual.

- being female
- long-term illness or disability (women and men with a long-term illness or disability are almost twice as likely to experience Domestic Violence as others)
- age (women in younger age groups, in particular in those aged 16–24 years are at greatest risk)
- pregnancy (the greatest risk is for teenage mothers and during the period just after a woman has given birth[12])
- marital status (married people had the lowest risk, while those who had previously been married had the highest risk)
- alcohol consumption (alcohol use is associated with a fourfold risk of violence from a partner and is commonly present where sexual violence has occurred[13])
- drug misuse
- witnessing or being a victim of Domestic Violence as a child
- poverty, economic stress and unemployment
- frequent visitor to a nightclub[14].

What are the causes of Domestic Violence?

8. It is very difficult to identify the underlying causes of Domestic Violence as experts in the field do not agree as to what these are. As a result, there are several different, and at times overlapping, theories of causation[15] ranging from biological theories where by violent behaviour can be genetic or occur as a result of head injuries to psychopathological where behaviour is learned and shaped by early childhood experiences and social attitudes to gender and identity. Other theories examine both family and societal structures. Whichever theory is adhered to a commonly held view is that alcohol is a significant risk factor for Domestic Violence. However, a systematic review and meta-analysis[16] designed to assess the magnitude of the association between male alcohol consumption and Domestic Violence against women found the evidence for this to be of low quality. Alcohol is a situational factor that contributes to domestic and sexual violence increasing the severity rather than a primary cause[17].

Drivers for Change

9. In 2010 the coalition government launched a new cross government strategy ***'Call to End Violence against Women and Girls'***. The strategy emphasises four distinct themes:

   A. **Prevention** of violence against women and girls by challenging the attitudes and behaviours which foster it and intervening as early as possible
   B. **Provision** of adequate levels of support where violence does occur
   C. Action to **reduce the risk** to victims and ensure that perpetrators are brought to justice.
   D. **Partnership work** to obtain the best outcome for victims and their families.

10. In 2012 the first National Public Health Outcomes Framework for England was published. The framework has four domains, and the first *improving the wider determinants of health* includes Domestic Abuse. At the time of writing this report, guidance is yet to be published regarding how this will be measured. Further to this the recent Mandate[18] from the government to the NHS Commissioning Board cites the broader role of the NHS in society is to work in partnership to contribute to reducing violence, in particular by improving the way the NHS shares information about violent assaults with partners and supports victims of crime.

11. The high profile of Domestic Violence nationally is reflected in the fact that NICE is now developing guidance on how health services, social care and those they work with can identify, prevent and reduce Domestic Violence between intimate partners and this is due to be published in 2014.

12. Locally, Domestic Violence has been identified as a priority for action both for the Safer Nottinghamshire Board (SNB), the Nottinghamshire Health & Wellbeing Strategy, and for the recently elected Police and Crime Commissioner. The SNB has produced a Domestic Violence Strategic Framework (2011-13), organised around the same four key areas as the national strategy.

Picture of Domestic Violence in Nottinghamshire

13. The majority of Domestic Violence incidents or victims remain hidden, i.e. they are not disclosed to authorities. This makes it a challenge to accurately describe and analyse levels of need across Nottinghamshire. However, it is possible to estimate the numbers of victims

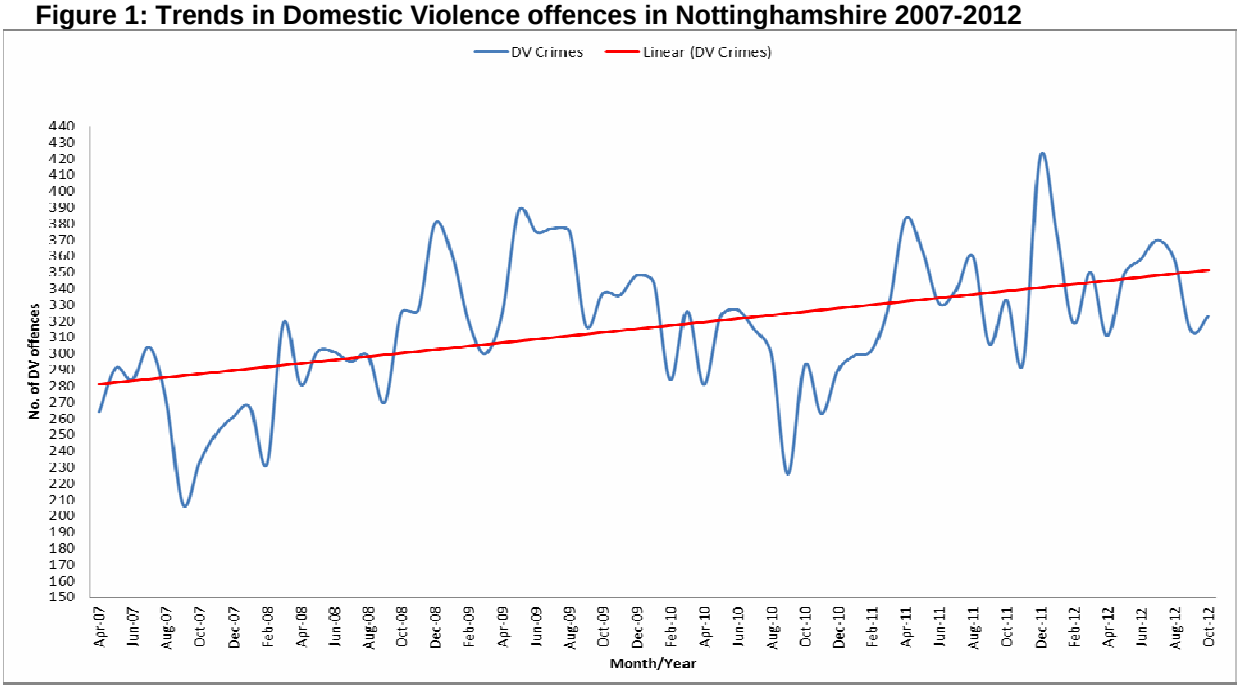
by applying the findings of the British Crime Survey 2011/12 to the Nottinghamshire population and this is shown in Table 1.

Table 1: Estimated Number of Female Victims of Domestic Violence (16-59 years of age)[19]

Period	Percentage	Numbers
Across their lifetime	29 - 32	66,410 and 73,280
In the last year	7 - 11	16,030 and 25,190

14. Nottinghamshire Police regularly provide data on reported crime. Figure 1 shows the trends in number of reported offences. This trend may be influenced by the perceived confidence of the victim in the Nottinghamshire Police Force. Indeed it could be argued that increased reporting is a reflection of growing confidence rather than growing prevalence in Violence against the Person (VAP is a performance indicator for the Police and wider Partnership). It is clear that there remains a significant gap between the estimated numbers from Table 1 and the reported numbers in Figure 1.

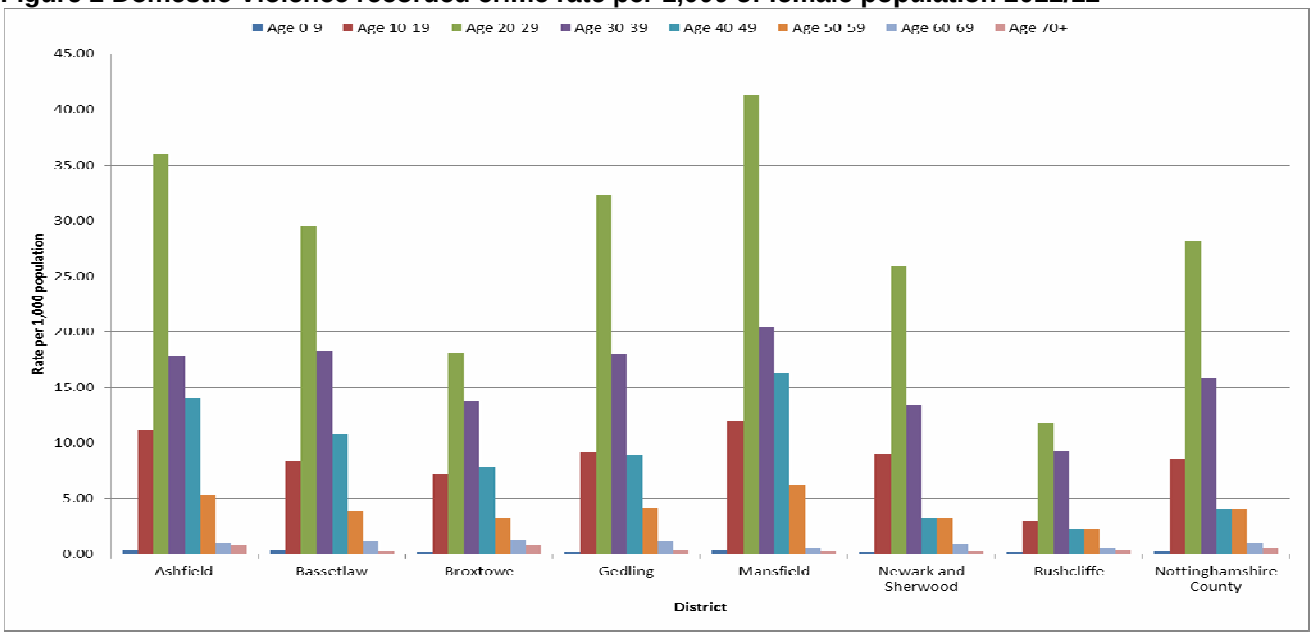
Figure 1: Trends in Domestic Violence offences in Nottinghamshire 2007-2012



Source: Nottinghamshire Police

15. Figure 2 shows the recorded crime rate is highest in the 20-29 age group and this fits with national research regarding the at risk groups. In terms of geography, Mansfield, Ashfield, Gedling and Bassetlaw Districts all exceed the County average. A profile of the victims of recorded Domestic Violence has been compiled based on Nottinghamshire Police data. Details of 3,499 of the 4,222 victims in 2011/12 are available. Of these victims 80% were female, and 16% male with the remaining 4% unknown. Of the female victims the majority (81%) were white or white European.

Figure 2 Domestic Violence recorded crime rate per 1,000 of female population 2011/12



Source: Nottinghamshire Police

16. Figure 3 (map) shows all recorded Domestic Violence crime at ward level compiled from call out locations for Nottinghamshire Police over 2011/12. The profile identifies greater numbers of Domestic Violence offences (red and orange shades) in Mansfield, Sutton in Ashfield, North Central and East, Hucknall, Eastwood, Beeston, Daybrook, Kingswell, Killisick, St. Marys Carlton, Newark town centre, Worksop, Worksop North, West and South East and Harworth. The repeat profile largely mirrors that of the pattern of offences across the county. However, it is important to note that the location of a call out will include household addresses and public premises such as streets or public houses so the repeat location profile presented here does not provide a profile of repeat victimisation. Whilst there may be an issue re how best to interpret increase in reported incidents of Domestic Violence, everyone would aspire to achieving a reduction in repeat victimisation.

17. There have been six Domestic Homicides in Nottinghamshire in the 20 months between March 2011 and November 2012.

18. In addition to presenting crime based data this paper aimed to establish what other data is available from the Health Service. However, although Domestic Violence is recorded when disclosed very little data is readily available electronically and in most services a case note audit would be required.

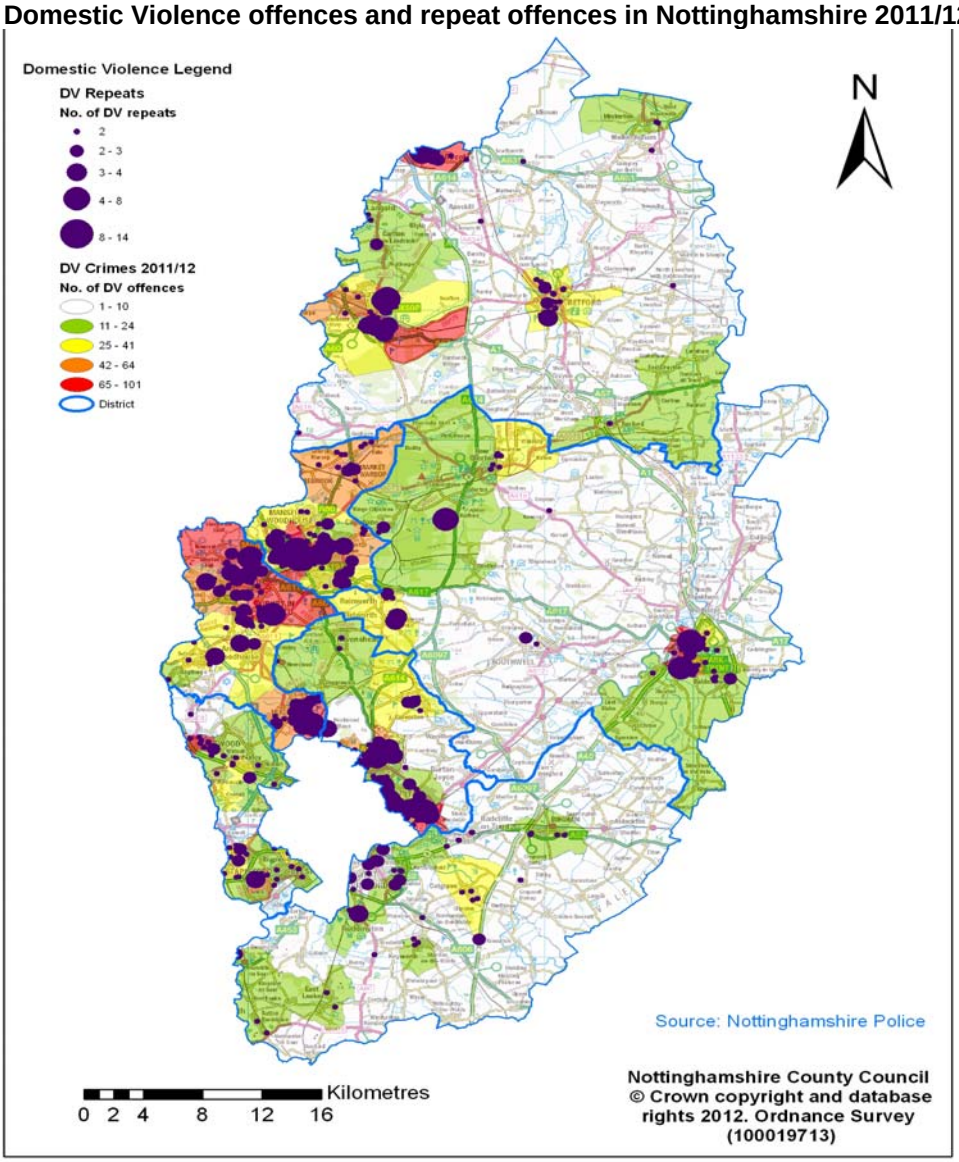
19. Many victims of Domestic Violence will attend their GP presenting with both physical and/or emotional symptoms but this data is not systematically available. Another cohort may present at A&E with trauma injuries. From November 2011 to October 2012 235 patients disclosed Domestic Violence whilst attending the A&E at Kings Mill Hospital and this information is shown in Table 2.

Table 2: SFHT A&E attendees disclosing Domestic Violence Nov 2011-Oct 2012 regardless of residency

Criteria	Number of patients
Disclosed Domestic Violence	235
Of which	
Are living with children	98 (41%)
Are pregnant	26 (11%)
Repeat attendance (previously attended for DV reasons in the last year)	50 (21%)
Registered with Nottinghamshire GP	168 (71%)
Registered with Nottinghamshire GP and referred to MARAC	57

Source: Accident and Emergency Department at Kings Mill Hospital

Figure 3 Domestic Violence offences and repeat offences in Nottinghamshire 2011/12



20. Some victims will use the emergency ambulance service. East Midlands Ambulance Service does not have a specific Domestic Violence category; instead they use an 'assault' category which covers a wide range of issues. So although EMAS will be called out to attend to victims of Domestic Violence we do not have statistics to present here.

21. All women receiving antenatal care are routinely asked about Domestic Violence by their midwife. Data from Sherwood Forest Hospital Trust (SFHT) for 2011-12 identified that 6.4% of pregnant women disclosed Domestic Violence. Despite this proactive approach the figure

falls short of the estimated numbers in Table 1. It is, therefore, a working assumption that some women still do not disclose when asked.

Table 3: Women disclosing Domestic Violence to SFHT midwifery services in 2011-12

Area	Yes	No	Total	% with DV Disclosure
Ashfield	84	1,121	1,205	6.97
Bassetlaw	0	4	4	0.00
Mansfield	79	1,337	1,416	5.58
Newark & Sherwood	123	1459	1582	7.78
North Derbyshire	3	156	159	1.89
Nottingham	1	28	29	3.45
South Derbyshire	0	65	65	0.00
(blank)	0	69	69	0.00
Total	**290**	**4,239**	**4,529**	**6.40**

Source: Midwifery Department at SFHT

22. Multi Agency Risk Assessment Conferences (MARACs) are convened fortnightly to share information on 'High Risk' cases and agree interventions to reduce the risk of harm to victims and their children. In the 12 months prior to 30th September 2012 there were 688 cases referred to MARACs in Nottinghamshire of which 88 (13%) were from Health agencies (primarily A&E, Substance Misuse and Mental Health services and Child Health Services).

23. The specialist Domestic Violence service working in the north of the County routinely asks their service users about their health and how they believe Domestic Violence has impacted on this. Of the 95 women surveyed in 2011 64% (61) disclosed having mental health issues of which 77% (47) had sought support from their GP and 62% (38) were prescribed medication. 87% (53) thought that their mental health issue was directly related to their experience of Domestic Violence. In addition to this 46% (44) of women disclosed physical health issues of which 75% (33) had sought support from their GP regarding their physical health. 99% (94) disclosed physical injury caused by assault of which 27% sought treatment from their GP and 33% via A&E.

Action being taken – Prevention

24. Schools provide a good setting for preventing the problem occurring in the first instance[20]. Directing resources at groups such as school age children can introduce new values, thinking and relationship skills that promote healthy relationships. In Nottinghamshire school based programmes such as Social and Emotional Aspects of Learning and Personal Social and Health Education contributes to children and young people's understanding of what constitutes a healthier relationship. A more targeted Domestic Violence prevention programmes called the GREAT project commissioned by the Safer Nottinghamshire Board is being implemented in schools within Partnership Plus locations (communities which experience very high levels of crime). Funded for 2 years the first year evaluation demonstrates positive outcomes and the programme appears to be an effective tool in changing knowledge, attitude and behaviour. This local evaluation is in line with emerging findings from published literature which has found that school based violence prevention programmes are effective at increasing students' knowledge, have positive effects on attitudes, increase skills and even self-reported decreases in perpetration of teen dating violence.

25. In 2009 the government consulted[21] with over 300 women. These women reported that school and community-based prevention programmes which focused on healthy

relationships and skill development would help with prevention. So in addition to school based programmes, community based programmes for adults exist. In Nottinghamshire the Freedom Programme is available to any woman who wishes to learn more about the reality of Domestic Violence.

26. Most of the action taken to reduce Domestic Violence has focused on secondary prevention, in other words action to prevent further incidents of Domestic Violence amongst those who have experienced it and or are at risk of it e.g. training staff on Domestic Violence awareness and how to ask the question. Locally there are examples across the Health Service where key personnel (e.g. accident and emergency staff) are in regular contact with women from the 'at risk' groups. All these staff receive training in Domestic Violence awareness. This is in line with the findings of a systematic review which found that 7 out of 8 studies in healthcare settings identified that structured training led to an increase in appropriate referral to other health services or support agencies. Our main community service provider, County Health Partnerships (CHP) is currently incentivised through their contract (via CQUIN) to provide training to community service staff (health visitors, schools nurses and community nurses) in Domestic Violence awareness and routine enquiry. CHP are training their staff in collaboration with Nottinghamshire Women's Aid.

27. Locally commissioned Domestic Violence service providers support children who have been affected by Domestic Violence, both on a one to one and small group basis. Staff that fulfil this role often have a dual role as a Domestic Abuse Link Worker whereby they also work within Social Care advising social workers about Domestic Violence and making contact with families to offer support.

Work in Progress – Provision

28. Nottinghamshire County Council and NHS Nottinghamshire County jointly commission two specialist Domestic Violence services to provide refuge services to women. Refuge is a critical feature of the service providing a safe place for women and children escaping Domestic Violence. Refuge offers safe 24 hour emergency accommodation for women and children escaping Domestic Violence. They have specialised staff that help and support women and children to deal with their practical needs. Evaluations of Refuge (referred to as Shelter in the literature) indicate that a stay in a Refuge can reduce the frequency and intensity of new violence[22], increase victims feeling of being safe[23] and that after two weeks of living in a Refuge women were less depressed and more hopeful[24].

29. Advocacy usually accompanies Refuge use but is also available to victims without them leaving their own home (in Nottinghamshire this is via outreach, floating support, supported accommodation and drop-in sessions). Advocacy involves the provision of advice, safety planning, support, information and liaison between victims and institutions and organisations to negotiate access to and the use of community resources (such as police, health, criminal justice, housing and legal services). Evidence from peer review journals concluded that intensive advocacy (12 hours or more duration) can help reduce physical abuse one to two years after the intervention and that brief advocacy (less than 12 hours duration) increased the use of safety behaviours both up to and beyond one year after the intervention.

30. In Nottinghamshire there is a confidential 24 hour 7 days a week telephone helpline for those affected by Domestic Violence. It offers advice, information and support on issues such as housing, child protection, immigration, welfare rights and health issues. This helpline also offers advice to professionals who may be supporting women and children experiencing

Domestic Violence. An evaluation[24] demonstrates victims gain important information and access increased levels of support through their use of Domestic Violence helpline services.

31. Counselling services are available from the specialist Domestic Violence services to anyone who may be finding it difficult to cope with their emotions and anyone who may be experiencing abuse, anxiety, fear, helplessness, shame, sadness, guilt, blame, grief and emotional loss. Victims of Domestic Violence who receive counselling can gain important information about Domestic Violence, increase their levels of support, perceive improvement in their decision making ability and experience increased self-efficacy and improved coping skills. In addition a review[25] by Barts and The London Queen Mary's School of Medicine and Dentistry recommends psychological interventions for women who have left the abusive relationship for improvement of depression and self-esteem.

Work in Progress - Reducing the risk

32. Currently there is insufficient evidence for or against the implementation of screening for Domestic Violence in all healthcare settings[26] [27] when the primary outcome goal is to prevent Domestic Violence morbidity and mortality. However, when considering secondary outcome goals such as increasing case findings (identifying those who are being abused), improving health status, decreasing subsequent abuse and utilisation of community resources such as referral to Domestic Violence services (so as to access refuge, advocacy, safety planning etc where there is evidence of benefit) then a greater case for screening arises. Some parts of the health service in Nottinghamshire (e.g. midwifery, health visitors and drug and alcohol teams) routinely screen for Domestic Violence.

33. Accident and Emergency departments at Sherwood Forest Hospitals Foundation Trust (SFHT) and Nottingham University Hospitals Trust (NUHT) currently adopt clinical enquiry where by staff ask everyone where there is clinical indication that Domestic Violence may be taking place. Both of these A&E departments have a lead Domestic Violence nurse who co-ordinates training, advises staff, oversees risk assessment and referral of patients who disclose Domestic Violence. Now that both these lead nurses are well established they are frequently called upon to support other departments within the hospital. A development at NUHT over the next year will be the appointment of a second specialist Domestic Violence post funded for up to three years by the NUHT Charitable Trust to extend the advice and training beyond A&E to other departments and to provide input into the County MARAC process.

34. Following disclosure of Domestic Violence a risk assessment is undertaken and all those who are deemed high risk are referred to the Multi Agency Risk Assessment Conference (MARAC). A 2011 review[28] of existing literature on the effectiveness of MARACs found emerging evidence that MARACs have the potential to improve victim safety and reduce re-victimisation and therefore may be a highly cost-effective measure. The three areas perceived as core to MARACs effectiveness are - enhanced information sharing; appropriate agency representation; and the role of the Independent Domestic Violence Advocate (IDVA) in representing and engaging the victim in the process. Factors which were seen as supporting effective practice included having: strong partnership links (including a commitment from agencies to tackle Domestic Violence in general); strong leadership (through the MARAC chair); good co-ordination (through a MARAC co-ordinator); and the availability of training and induction to the MARAC process.

35. Independent Domestic Violence Advocates (IDVAs) are specialist case workers who focus on working with victims who have been assessed as high risk i.e. those at most risk of harm

and or homicide. IDVAs work in partnership with other agencies to promote safety, provide emotional and practical support and reduce further risk. In 2009 the first large scale multi-site evaluation[29] of the IDVA services across England and Wales reported that of the 2,500 women studied over a 2 year period domestic abuse stopped completely in over two thirds of cases where there was intensive support from an IDVA and for those where abuse continued levels were considerably reduced. The report recommends that the number of IDVAs needs to double to achieve national coverage and that the cost of providing an IDVA to a high risk victim per successful outcome is cost effective.

Partnership working

36. The prevention and reduction of Domestic Violence in Nottinghamshire relies heavily on the successful engagement of a range of stakeholders both statutory and voluntary including engagement with the victims of Domestic Violence. A review conducted by an external consultant on behalf of the Home Office scored the SNB Domestic Violence Partnership arrangements as 'good'.

37. The new Nottinghamshire Multi-Agency Safeguarding Hub (MASH) is designed to improve and accelerate information sharing between agencies. It will involve collaboration between Police, the Local Authority, Probation and the NHS to respond to safeguarding enquiries from professionals or the public which relate to children and vulnerable adults. Information on previous Domestic Violence and related risk assessments will be some of the information that can be shared by partners within the MASH to inform safety planning and signposting to support services. It is anticipated that safeguarding interventions will be implemented more quickly and effectively as a result of the MASH process.

Current Gaps or Challenges

38. Currently NICE are compiling guidance on preventative approaches to reducing Domestic Violence which is due in 2014. However, pending its recommendations there are some current noticeable gaps in service provision in Nottinghamshire which commissioners should seek to address.

39. Despite Domestic Violence being such a sizable public health issue Ramsay et al[25] identifies that there is a lack of evidence based treatment approaches in primary care. Evidence[30] from Domestic Violence service users is that the response they have received from primary care clinicians is inconsistent. Yet primary care can be victims first or only point of contact with professionals[31]. GP practices and Clinical Commissioning Groups are not currently engaged in the Multi Agency Risk Assessment Conferences (MARACs). General Practice does not routinely refer patients to MARAC or have a systematic way of exchanging information and actions on patients who have been party to MARAC unless children are involved (where information exchange is managed by County Health Partnership staff).

40. Following the publication of a UK based randomised controlled trial[3] in 2011 a new approach called Identification and Referral to Improve Safety (IRIS) is being adopted within Primary Care in some parts of the England. The programme includes practice based training sessions, a prompt within the medical records to ask about abuse and a referral pathway to a named Domestic Violence advocate who also delivers the training and provides further consultancy to practices. The primary outcome was recorded referral of patients to the Domestic Violence advocacy service. The results show that 12 months after the intervention training 21 times as many victims of domestic abuse had been referred in the intervention practices than in the control group. This provides evidence that the intervention improves

the response of clinicians to women experiencing Domestic Violence. The IRIS approach is currently being implemented in Nottingham City but not in Nottinghamshire.

41. Emerging themes from the six DHRs to date identify gaps in how Domestic Violence is being addressed in Nottinghamshire. These include:

- Gaps in staff Domestic Violence awareness leading to the need to revise or revisit their training programmes
- Information sharing has not been effective both within and between agencies leading to failure to see the whole picture and complexity of a case. In particular linkage between criminal justice agencies and health service providers has been poor in some instances
- Risk Assessment and referral procedures have not always been followed correctly or recorded adequately.

42. Despite attempts to more systematically identify and risk assess victims of Domestic Violence at A&E departments across Nottinghamshire inconsistencies remain in whether this information is communicated back to the victim's GP. A letter to the GP will describe the presenting reason e.g. 'head injury' but rarely gives a fuller explanation e.g. physical assault by partner.

43. Owing to the increase in reporting of domestic violence and the potential for this to increase further, there is a need to ensure that there is sufficient capacity within both MARACs and the Independent Domestic Violence Advocates (IDVAs) service to meet needs.

44. There is limited provision for those identified at 'medium risk' of Domestic Violence.

45. Primary prevention programmes in schools (the GREAT Project) has been targeted to Partnership Plus areas as priority in 2011 and 2012. This means that there is currently an absence of prevention programmes in areas where domestic violence will be prevalent yet under reported (hidden need). The funding for the GREAT Project is short term.

Statutory and Policy Implications

46. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Recommendations

It is recommended that the Health and Wellbeing Board:

1) note the content of this report

2) approve that the Domestic Violence Strategy group develops a plan of action to address the challenges identified above and presents a follow up report to the Health & wellbeing Implementation Group in 3 months time.

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Constitutional Comments (SG 11/12/2012)

47. The Board is the appropriate body to consider the issues set out in this report.

Financial Comments (NDR 07/01/2013)

48. There are no financial implications arising directly from the report

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All.

HWB50

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