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Domestic violence—Policing and health care: collaboration and practice

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The need for effective collaboration when working with survivors of domestic violence is an urgent one. This paper outlines an innovative project that will examine the antecedents of homicide by a current or former partner. The early stages of the project including analysis of closed homicide case records and a survey of police officers' experience of collaboration with health and social care providers is presented. Early findings suggest opportunities where intervention could in future situations prevent homicide.

Key words: accountability; collaborative research; domestic homicide; health care; intimate partner violence; interprofessional practice; information-sharing; prevention; police.

Introduction

There has been much discussion among practitioners and service providers about the importance of collaboration in practice when working with survivors of domestic violence (Home Office and Cabinet Office, 1999; Department of Health, 1999a; Shepherd and Sivarajasingam, 2000; Greater London Authority, 2001). Recent legislation, current government and departmental policies emphasize the importance of partnership in the delivery of human services (Crime and Disorder Act, 1998; Department of Health, 1999b).

Despite this emphasis on collaboration, numerous reports continue to highlight a distinct lack of co-ordination between these groups (Hall and Lynch, 1998; British Medical Association, 1998; Hanmer *et al*., 1999). As a result, new initiatives and research (e.g. Roughton, 2000) has addressed the need to overcome the obstacles to 'joined up thinking and working'. However, a constant theme from this literature is that there continue to be obstacles to developing truly collaborative practice. Examples of this are a reticence to agree protocols for sharing information (although it is acknowledged that there are some locally agreed arrangements) and the lack of understanding between practitioners and the police. This is not necessarily, however, because of unwillingness on the part of those involved in the care of survivors to work in partnership (Chief Medical Officer of England, 1997).

Domestic violence is a major public health and community issue (Stanko, 1998; World Health Organization, 2002). The need to develop collaborative approaches to this often concealed problem has been recognized by the Metropolitan Police Service, London (MPS). Their Domestic Violence Working Group (DVWG) is a well-established example of interagency working in relation to this widespread concern.

In order to address the issues surrounding the prevention of domestic homicide, the Institute of Health Sciences at City University, London and the MPS are collaborating on a research project examining the antecedents of homicide by a current or former partner.

To provide an insight into the nature of this work, this paper initially offers background information related to this study. Specifically, this

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will detail the aims, objectives, underlying assumptions and the nature of interprofessional research team undertaking this work. The paper will then go on to describe the methodological approach that will be taken in this research. Preliminary data which explored the barriers police officers experience when collaborating with health and social care practitioners will then be offered. These initial findings will be discussed and early conclusions will be presented.

The study

Project aims and objectives

This collaborative research project aims to undertake an investigation into the antecedents associated with the homicide by a current or former partner with the purpose of identifying opportunities for preventive intervention.

In achieving this central research aim, the project is based upon three objectives:

1) To track through five 'closed' domestic homicide cases,[1] the sequence of events and ecological factors (Foa *et al*. 2000) associated with the homicide by a current or former partner, with the purpose of identifying antecedents to domestic violence homicide.
2) To identify repeating patterns/themes/issues, some of which might not have been identified in previous research in other countries, such as the USA.
3) To lay the foundations for sound policy and early interdisciplinary intervention (e.g. social workers, general practitioners (GPs), police officers) in practice for the prevention of domestic homicide with people at risk.

Underlying assumptions

The aims and objectives of the project were clarified following initial discussions between the researchers. Firstly, a number of statutory and voluntary agencies were likely to have had indications of domestic abuse/violence prior to the homicide. Secondly, knowledge of these precursors was unlikely to have been shared widely among the other services, if at all. Thirdly, there is currently little co-ordinated response to such knowledge.

Research team

Two researchers involved in the project are experienced in the disciplines of policing and health care. The police officer (KG) is a sergeant with past experience in the Serious Crime Group in the MPS, the health care professional (PS) is a practice-based academic in the Institute of Health Sciences at the City University, London. She is a registered nurse and a counselling psychologist.

The sergeant has a range of policing experience, particularly in intelligence, management information and homicide investigation. He has, however, not worked specifically in domestic violence. The health care professional has wide experience in the community services, which includes work on domestic violence. She had never seen police or Crown Prosecution Service (CPS) records prior to the research and so approached them with a fresh eye.

The rationale for this choice of researchers with different professional backgrounds was to ensure that the data would be analysed from different perspectives. As both researchers were able to review data from their own professional stances and thus identify common and divergent warning signs, as well as opportunities for preventive intervention. This reflects sound practice in interprofessional working in the delivery of services to survivors of domestic violence, and other distressed people in need of assistance.

A third researcher (SR) with a background in sociology will add another perspective on the emerging project analysis. This will deepen further potential insight gained from the data.

Methodological approach

A case study approach has been adopted for this research project. A case study approach was felt to be appropriate as it has an emphasis on investigating a 'contemporary phenomenon within its real life context' (Yin, 1994: 13). This is an important focus within this study. To understand fully the antecedents of homicide by a current or former partner it is necessary to study each case in relation to the contexts that are significant in generating the associated sequence of events that led to that particular homicide.

[1]A 'closed' case is where the offender(s) have been convicted and the case is not subject to appeal.

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It was decided to focus upon five closed domestic homicide investigations. It was considered that this number of cases would produce data saturation. This would patterns, themes and issues related to homicide by a current or former partner.

Selection of cases

The process of selecting cases for the study initially involved a search for all closed homicide cases from April 1999 to December 2000. This produced 41 domestic homicide offences that could potentially be included in the research. To select suitable cases for this study, each underwent further scrutiny in order to meet the following five criteria:

1) Each case had been identified as domestic homicide in the Crime Reporting Information System (CRIS) and/or the Major Investigation Management Information system (MIMI).
2) Conviction had resulted in each case.
3) None of the cases were subject to appeal, therefore they were closed cases.
4) In each case the victim had been the intimate partner of the convicted offender at the time of the offence or at some time previously.
5) Investigating officers were able to give further details of the history behind each case (e.g. there may have been GP or family knowledge of violence).

This process produced 23 'provisional' cases. Of these, KG identified 12–20 cases from which were chosen those homicides which, as far as possible, represented a cross-section of society. Cases that represented different ethnic groups, ages and sexual orientation were chosen. KG then further reduced the cases by reviewing the computer records of each with the outcome of discussions he had with the senior investigating officers (SIO) concerned with each case. This process identified five cases that met the above criteria.

Analysis

The case records are currently being analysed separately by PS and KG each of whom keeps clear notes of the issues raised, and confer at regular intervals. Open coding is being used to identify themes in each case. These themes are defined clearly to facilitate collapsing them into categories.

As the study progresses, a matrix of descriptive statistics will be used to identify age, length of the relationship (if retrievable), gender (if not heterosexual), ethnic group and religion (if this too is retrievable).

Triangulation

In clarifying the antecedents to domestic homicide, the study will draw upon a number of other data sources to triangulate with the data from the five closed homicide cases. This will include:

- A survey of police officers working with domestic violence. This will provide a quantitative insight into the issues related to the work police officers undertake in this area with colleagues from health and social care. (Findings from this part of the project are presented and discussed below.)
- Providing the relevant police officers with the data analysis of their own investigations and asking them for observations and feedback. This will provide a detailed understanding of the issues from the perspective of these officers.
- Review of CPS records pertaining to one of the cases by both researchers.

Quality

The emerging project findings will be scrutinized to ensure sound quality. A senior officer from the Association of Chief Police Officers has audited the analysis undertaken with one case. This audit has highlighted no discrepancies in the thematic analysis and has ensured that both researchers and independent 'auditor' agree with the evolving project analysis. Comments made by the auditor have clarified issues related to incidents preceding the homicide in the audited case, although no new themes emerged.

Preliminary work

In order to obtain a better idea of officers' individual experiences of working and collaborating with health and social care providers, a preliminary survey was undertaken.

Based upon reports from the literature (e.g. Roughton, 2000) and verbal accounts from

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officers about difficulties they encountered around obtaining information from health and social care providers, this work had three goals. These were to identify the:

- range of agencies that the police liaised with on a regular basis in their work with domestic violence.
- type of information officers required from these agencies in the course of their investigations.
- reasons agencies gave for not sharing information.

All the officers involved worked with victims of domestic violence. In total, responses from 76 police officers based in London were obtained at a one-day training seminar, which included a short presentation of the wider research project.

Initial findings

The findings from this phase of the research were striking. Although 80 per cent ($n = 61$) of these police officers reported that they regularly required medical information from GPs and hospital doctors when investigating cases of domestic violence, 75% ($n = 57$) reported recurrent problems with obtaining the information they requested. In their responses, 79%, identified that patient confidentiality and consent were the reasons given to them for withholding information. Similar problems were reported with obtaining information from social services, housing and voluntary agencies.

From these early findings, it is possible to identify a range of potentially important issues which could be used to overcome problems of 'seamless working' with domestic violence victims. There appears to be a significant lack of information-sharing between hospital doctors and GPs with the police.

As hoped, this survey provided the project with a useful outline of the interagency contexts in which MPS police officers specializing in work with survivors of domestic violence, practised. Although brief, it has raised some very important practice implications for the way the medical profession, the police service and other health and social welfare practitioners currently work together in cases of domestic violence.

To date

After the in-depth analysis of two cases a number of clear themes are emerging. These include attributes relating to the victim, the suspect, the scene of the crime, the family and the local community. Importantly these preliminary findings are highlighting failures of interagency collaboration. In both cases the suspects had had fairly frequent contact with statutory and other agencies and the difficulties in these relationships were known in a number of arenas.

Discussion

As well as informing the later stages of the project (e.g. analysis of the homicide cases, semi-structured interviews), this early work could also be used as a starting point for discussing closer links between health and social service practitioners and the police. These data suggest that the development of protocols such as the Caldicott protocols (Home Office 1997), as well as staff training, would help to overcome the genuine anxieties of all involved around the sharing of client information.

There may be a number of social, cultural and ethical reasons for practitioners preserving the confidentiality of their clients. That they guard the rule of confidentiality so closely demonstrates their deep concern for client welfare. This concern could also be about sensitivity to violating client's rights to privacy, because disclosure without consent or when a client agrees at a time of crisis, might perpetuate a cycle of disempowerment and inadvertent repeat victimization. However, the client's safety is crucial. This is supported by the General Medical Council's guidance to doctors on disclosure of patient information (General Medical Council, 2000).

Practice

That sharing information would help promote more effective interdisciplinary collaboration between service providers is well documented in the literature (e.g. West, 1994; Øvretveit *et al.*, 1997; Poulton and West, 1999; Schmitt, 2001). This survey of police officers suggests that doctors and practitioners in health and social care are not sharing vital information. This is a

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problem that has the potential to create a 'revolving door syndrome' where victims, at further risk of injury, may make further visits to doctors' surgeries or hospitals for medical treatment.

By not liaising with other professionals because of confidentiality, practitioners can also inadvertently *collude* with the offender, by not helping to set in motion strategies that could reduce the victim's isolation as well as call the abuser to account.

The wider study implies that there may be lack of awareness among practitioners in a number of disciplines of the manifestations of domestic violence, both in the behaviour of the offender and in the presentation of the victim. Loue (2002: 84–85) cites research into the awareness of health care workers that supports this view. Victims need not show evidence of overt injury, but may present with other health problems, which on closer scrutiny would uncover violence. Research cited by the WHO (2002: 100–103) indicates that women abused by their partners are more likely to use health care services than nonabused women. They seek help for their injuries as well as for 'functional disorders' such as irritable bowel syndrome and other chronic problems.

It is important, therefore, that primary health care practitioners are aware of this phenomenon and are alert to appropriate client assessment in the light of this knowledge. If necessary, further education and training in the manifestations of domestic violence may be required, particularly as despite the significance of violence as a major health care issue, relatively little emphasis is put in nursing curricula on caring for survivors (Ross *et al.*, 1998).

Offenders are frequently charming (Horley, 2000) and seem particularly solicitous towards their partner when in public. Insistence on staying with a woman during consultations of all sorts can be readily interpreted by practitioners as care, but could well be a warning sign of controlling behaviour and violence. This behaviour stops the victim from being in a position to disclose any violence.

Sharing information

The WHO (2002: 3) argues that a public health approach to health problems is 'interdisciplinary and science-based' allowing for innovation and responsiveness in public health practice. However, this preliminary study raises a question about interdisciplinary working in health and social care. Do agencies *really* want to participate in information-sharing? It could be argued that there is much rhetoric about sharing knowledge and expertise to the benefit of clients. This background study shows that there is reticence among health care practitioners about sharing information. Some of the reasons for this are discussed above. Research has also shown a need to establish clear administrative and operational procedures 'to translate policy into practice' (Taylor, 1998: 351).

Health practitioners' awareness of violence in families is crucial information, which has the potential to prevent homicide (Greenaway *et al.*, 2001). At the very least, sharing information can go some way to ensuring that survivors are offered appropriate help and support should they choose to accept it. While practitioners arguably do not want to be seen to condone violence, they can also be caught up in a sense of betraying confidences if they pass information on. How much worse is it not to share information and then find a client has suffered serious injury or even death?

The safety of practitioners as well as the well-being of clients, is an issue which needs careful consideration too. However, much can be learnt from the police service about protecting information sources. The use of their secure systems and established protocols to protect sensitive information, could do much to overcome risk to practitioners as well as survivors.

There is no need to create an extra burden of bureaucracy. The police are already practised in keeping information secure. There already exists a system for the use of confidential information whilst protecting the sensitivity of these issues. Third party reporting to the police service of domestic as well as homophobic and racial crimes, is an acceptable process. While it protects survivors from putting themselves at further risk by, for example, going directly to the police or a solicitor, it also allows for the sharing of information between concerned health care practitioners and the police. Discussions with colleagues in the police and health services have suggested a positive reception for these ideas.

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Processes

The processes involved in setting up the research project and in developing formal protocols by which the researchers from different disciplines can gain access to relevant confidential information, mirrors sound interdisciplinary collaborative practice with survivors of violence (Hoff, 2001).

Part of these processes has been to clarify terms used and the systems for information storage and retrieval. The significance of legal processes was brought into sharp focus when application was made for the health care practitioner to gain access to CPS documents. This seeking clarification of systems, as well as practice specific language, is integral to the success of 'joined up thinking and working' in domestic violence.

Concluding comments

This initial work undertaken by the survey of police officers has begun to identify areas that could present opportunities for early intervention, for the statutory and voluntary agencies. It has also highlighted opportunities for the police service in terms of risk assessment criteria. Likewise it may clarify difficulties in how the police gain early access to declining domestic situations, that have the potential for resulting in homicide.

The safety of survivors of domestic violence is the central tenet of this research project. In order to save people's lives it is increasingly evident that formal and flexible ways to share information and work in partnership across disciplines must be established.

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