The Domestic Abuse Act 2021 England and Wales: implications for nurses

Sarah Bekaert, Florence Seemungal, Emma Nott

Abstract

As the Covid pandemic enveloped the globe there was a parallel increase in the incidence of domestic abuse (DA). This has been ascribed to the restrictions in movement and growing tensions during lockdown periods. The Domestic Abuse Act for England and Wales, was about to be passed prior to the Covid outbreak, but progress halted as attention focused on managing infection control and treatment nationally. The unfolding DA 'shadow pandemic' led to pressure groups lobbying for specific changes to the DA Act which, in its revised form, became law in April 2021. This commentary sets out the changes in definition, statutory response and prevention of DA and relates these to nursing practice. Health education and promotion theory is considered and linked to nursing practice with those who are both victims/survivors and perpetrators of DA.

Introduction

This commentary sets out the specific changes in definition, statutory response and prevention of domestic abuse (DA) in England and Wales (E&W) arising from the Domestic Abuse Act 2021, and relates these to nursing practice. This responds to nurses' duty to *practice effectively* (NMC 2020), and research suggesting that nurses often feel ill-informed on the legalities and process of detecting, managing, and reporting DA (Kirk and Bezzant 2020).

Background

In the year ending March 2021 there was an increase of 6% in DA related crimes in the UK. This represented 18% of all offences recorded in that year (ONS 2021). Estimates from the Crime Survey for E&W year ending March 2020 show 5.5% of adults aged 16 to 74 years (2.3 million) experienced DA in the previous 12 months (ONS 2021). This is supported by data from anti- VAWG (Violence Against Women and Girls) organisations who reported 50%

more calls to the national domestic abuse helpline in the first month of lockdown, reaching 80% by the end of June 2020 (HAC 2020) and callers to Respect's Men's Advice Line in the UK who described new and escalating physical violence and violent threat from partners or family members (Westmarland et al 2021). In the US Walsh et al (2022) reported new or more frequent IPV and victimisation for individuals who self-classify as gay, bisexual or men who have sex with men. DA is underreported for reasons such as fear of repercussions, or not being believed or taken seriously (Evans and Feder 2016). Occurrence was further underreported during lockdowns due to lack of freedom to contact those outside the home (Ivandic et al. 2020). Evidence from countries that first imposed virus-containment measures prompted an international UN Women campaign (2020) to raise awareness of the 'shadow pandemic' as DA followed the migration of the pandemic and consequent restrictions (Mlambo-Ngcuka 2020). International organisations have long-standing commitments to reducing DA. However, recognition of DA, and therefore policy and law to prevent and respond to DA, varies across the globe. Seemungal (in press, 2022) examines the varied picture of DA globally; exploring to what extent DA is recognized, national policy and law, and how individual countries were prepared and able to assist those who experienced DA during the pandemic.

The growing picture from before, during, and after the pandemic, highlights a prevalence of DA both globally and nationally. It is predicted that the impact of Covid on DA will be lasting as perpetrators intensify coercive control and abuse, seeking to re-exert a control they see as weakening as 'normality' returns (SCIE 2021). It is likely that nurses, due to the range of settings in which they work, will encounter both adult and child victims/survivors of DA. Disclosure is also more likely in health care settings as these are viewed as trusted

environments (Battaglia et al. 2003). Pregnancy, and having a newborn, are specific times when DA from partners can start or worsen (Cook and Bewley 2008). Midwives and health visitors, who have close contact with the mother and child, are well placed to identify and respond to the identification or disclosure of DA (Bradbury-Jones et al. 2013). Other settings where identification of DA is more likely are the emergency department (McGarry and Nairn 2015), and school nursing (Stafford 2019). In addition, some nurses may themselves be experiencing DA (Ellis 1999). This commentary serves as a summary of the legislation to inform nursing practice. Ongoing, funded training for health staff on the health-related consequences of domestic abuse is essential to ensure law is embedded in action.

The Domestic Abuse Act 2021 England and Wales[1]

The Domestic Abuse Act 2021 E&W received Royal Assent on 29 April 2021. Most, but not all, of the provisions in the Act are in force, with the remainder due to be law by Spring 2023. The original bill was drafted prior to the pandemic but delayed due to parliamentary focus on managing the national response to Covid. Evidence emerging from the pandemic led to changes. These will be highlighted in the commentary. The Act has seven parts. Part 1 offers a legal definition of DA. Part 2 sets out the new role of Domestic Abuse Commissioner. Part 3, due to come into force in 2023, introduces a single protective order enabling police, criminal, family and civil courts to evict and restrain DA perpetrators, with breach a criminal offence. Part 4 relates to the responsibility of local authorities to provide support and refuge to DA victims. Part 5 sets out provisions to reduce the trauma of the

[1] Scotland has the Domestic Abuse (Scotland) Act 2018, and Ireland the Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021.

criminal process for those pursuing legal proceedings in relation to DA. Part 6 extends the extraterritorial jurisdiction of criminal courts for criminal offences associated with DA and creates new offences relating to acts often perpetrated by abusers. Part 7 prohibits charging to provide medical evidence, extends 'polygraph conditions' to DA offenders released on licence, and places the Domestic Violence Disclosure Scheme (or 'Clare's Law') on a statutory footing. Each part will be discussed, highlighting the specific change in relation to nursing practice.

Part 1 offers a definition of DA. Before this Act DA did not have a legal definition in E&W, although working definitions were in use. The Act defines DA as follows:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—
A and B are each aged 16 or over and are personally connected to each other, and the behaviour is abusive. Behaviour is "abusive" if it consists of any of the following— physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour[2], economic abuse (see subsection); psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct. "Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to— acquire, use or maintain money or other property, or obtain goods or services. For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child). (Domestic Abuse Act 2021)

[2] The offence of controlling and coercive behaviour is extended to include post-separation abuse (section 68 DA 2021)

The clear delineation in age when defining DA ensures accuracy of recording and data analysis. DA as a legal concept applies to those aged 16 or older; those below 16 are recorded as victims of child abuse, through witnessing or experiencing the effects of DA. This is a clear call to child safeguarding services where children are present in a DA situation. While intimate partner violence (IPV) does occur between minors (Bekaert and Appleton 2021) the age specification aims to distinguish DA from child abuse in legal terms, while acknowledging the impact of DA on others within the household. This should strengthen the powers of nurses with safeguarding responsibilities – such as school nurses and health visitors - to mobilise the child safeguarding process accordingly. Recognising children who witness DA, as victims/survivors adds weight to practitioners' call for support, such as mental health input. It is noteworthy too, for nurses working with adults with disabilities that this definition includes the abuse of disabled people by their carers, whether paid or voluntary. This links to legislation relating to safeguarding adults (Care Act 2014).

Part 2 establishes a Domestic Abuse Commissioner as a statutory office holder, giving the issue of DA greater prominence in parliament. The Commissioner has statutory powers to hold both government and agencies to account regarding DA. The Commissioner oversees a strategic plan, formed by an expert panel drawn from agencies including Women's Aid, SafeLives, Respect, the police, housing, and children's services. There is now a direct link via this group between those who experience DA and those who direct legislation and policy in parliament. There is provision on the panel for a health care representative, acknowledging the role of the health care sector in empowering the abused/survivors. The nurse should act as legislative advocate in relation to patient safety and care quality within

their public health role (Lockhart 2017). The Commissioner is a route by which nurses can lobby for change and share good practice in relation to DA. This complements the role of the Law Commission, which conducts research and consultation, to make systematic recommendations for parliamentary consideration.

Parts 3 and 4 simplify and speed up legislative action to protect the victim/survivor of DA. Part 3 creates Domestic Abuse Protection Notices (DAPNs) and Domestic Abuse Protection Orders (DAPOs), replacing and strengthening the current regime of Domestic Violence Prevention Orders, and consolidating the various protective orders that can be made in civil, family and criminal jurisdictions with a single order The police, often first responders to an incident, can issue DAPNs and then swiftly seek a DAPO – essentially an eviction and/or non-molestation order - through the magistrates' Court. The new order can be made without limit of time and breach is an offence punishable by five years' imprisonment. Previously there was no single order accessible across the criminal, family and civil courts creating confusion and problems with enforcement. The new order gives clarity, immediate and long-term protection., and credibility to the criminal nature of DA.

Part 4 requires local authorities to provide support and refuge to DA victims/survivors, including children, making them a priority for social housing. This legal obligation to provide housing protects victims/survivors and their children immediately after disclosure or incident, as they are no longer forced into returning to an abusive situation for want of alternative accommodation (Murray et al. 2015). Abuse can escalate in the immediate aftermath of disclosure (Heron and Eisma 2021). It is a crucial moment for legal and practical support. This rationalisation and sensitisation of the system gives victims/survivors

confidence to disclose, and practitioners confidence to report and act, knowing that there is immediate and effective protective legislative action that can be taken, and that refuge will be provided.

Sections 5 seeks to reduce the trauma of the criminal process for those pursuing legal proceedings in relation to DA. This section recognises the vulnerability of witnesses in court, the trauma of the court process, and of facing the perpetrator. Witnesses are afforded special measures such as video-link or screens for cross-examination, although pre-recorded interviews are not yet permitted. This is akin to special measures currently afforded to complainants in sexual offence trials with vulnerable witnesses (s17 YJCEA 1999). It also grants vulnerable parties in family and civil proceedings similar protections to those in criminal courts. For example, lay cross-examination is now prohibited in the civil and family courts. If either party is not legally represented, the court can instruct an advocate under public funds to conduct the cross-examination. These added protections during the court proceedings take a trauma-informed approach. Individual historic trauma is recognised, and the Act mitigates re-traumatisation through the retelling of events, public and/or hostile cross-examination, and by the person alleged to have caused trauma. Trauma-informed care is a lens with which nurses are familiar. It is a patient-centred approach, attuned to the individual's distinct experience, and recognises the cumulative effect of trauma, and how this negatively impacts a person's health and well-being (Bekaert and SmithBattle 2016, Fleishman et al. 2019).

Part 6 extends the extraterritorial jurisdiction of criminal courts to murder, manslaughter, assault offences, harassment, rape, sexual assault, and controlling and coercive behaviour.

This already applies in respect of child sexual abuse. UK citizens, and those habitually resident in the UK, who commit these offences abroad are now liable to prosecution in the UK courts. This section also enshrines the common-law principle that consent to serious harm for sexual gratification is not a defence, responding to growing evidence regarding non-fatal strangulation (NFS). This was an addition to the Act following consultation and parliamentary debate during the pandemic. NFS can be a significant feature of coercion and control, and common in relationships where there is IPV (Edwards and Douglas 2021). It often leaves no visible external injury (Sorensen et al. 2014), and is recognised as a gateway crime to fatal strangulation (Glass et al. 2008). Nurses should be particularly aware of this as NFS is significantly under-reported by victims/survivors, requiring the use of careful open questions to elicit disclosure. Part 6 also amends the Criminal Justice and Courts Act 2015 to make it an offence not only to disclose private sexual photographs and films without consent and to cause distress (so-called 'revenge porn' offences), but to threaten to do so. These areas support nurses in their discussions with victims/survivors regarding the legal definitions of specific coercive acts or threats, particularly where the victim/survivor may see the boundaries of consent as blurred.

Part 7 of the Act tackles a range of areas that reduce barriers for victims/survivors seeking legal support, tightens control on those who are convicted of DA when released from prison on licence, and makes statutory provision for preventive action through 'Clare's law'. An addition to Part 7 made during the pandemic is a prohibition on NHS medical professionals from charging for the provision of evidence of DA. The costs involved in obtaining such evidence has been a barrier to many victims/survivors pursuing proceedings in the civil and family court (Nott 2022). This enshrines the *duty of care* of health practitioners (Young

2009). ‘Polygraph conditions’ applicable to certain sexual offenders on licence from prison, are extended to DA offenders released on licence and required to adhere to conditions for the duration of their sentence. Polygraph sessions establish whether an offender is complying with their licence conditions, and can be used to evidence breach, justifying recall to prison. Finally, the Act provides a statutory framework for the provision guidance surrounding the Domestic Violence Disclosure Scheme (or ‘Clare’s Law’) . Under this scheme an individual has a right to ask police to check whether a current or ex-partner has a violent or abusive past, and the police must consider whether to provide the requested information. In tandem, where police receive information about a violent or abusive individual that might impact upon the safety of their current or ex-partner, they have a duty to act proactively and make relevant disclosures to those at risk of harm.

Discussion

The Domestic Abuse Act 2021 E&W, facilitates nurses’ health promotion and public health role with victims/survivors and perpetrators of DA. The Ottowa Charter (WHO 1986) stresses the importance of building healthy public policy, creating supportive environments, strengthening community actions, reorienting health care services, as well as developing personal skills. Much of nursing operates in the health education realm – supporting individuals in healthy behaviours. However, the nurse’s health promotion role also considers the social determinants of health with the family, specific groups and community, and policy and law (Whitehead 2018). Two theoretical models help to illustrate the nurse’s role in health promotion. Brofenbrenner’s (1986) ecological model clarifies the person in context, and Beattie’s (1991) health promotion model sets out the four broad areas of health education and health promotion activity across these contextual layers.

Brofenbrenner's (1986) integrative model has four distinct 'system' levels: the microsystem, mesosystem, exosystem and macrosystem. Each layer has an influence on an individual's health and well-being. Support at each of these levels is needed to optimise personal and public health. The microsystem is the interactional system experienced by an individual. In relation to DA this would be the two individuals involved, ie the parent-child relationship. The mesosystem is the system of linkages between an individual's microsystems; for example, the relationship between mother and child/ren, father and child/ren, previous or subsequent partners. The exosystem refers to those settings that affect an individual's microsystems, for example their social network, local health and social care organisations and workplace. This would include a wider network, such as friends, parents, local groups etc. The macrosystem is the cultural, political and ideological factors that shape and influence the microsystems. This includes aspects such as intergenerational acceptance of violence, moving DA into the legal realm through legislative action, and encouraging a cultural shift towards the unacceptability of gender based violence. There is also a fifth aspect to this model, the chronosystem, which reflects the interaction of these four layers over time –which links to the effects of cumulative trauma, and the importance of trauma-informed care. Beattie's (1991) health promotion model sets out four aspects to health promotion activity: personal counselling, and health persuasion which represent health education; and community action and legislation, representing health promotion (Whitehead 2018). Similar to Brofenbrenner's (1986) model, support in all four areas optimises personal and public health.

These theories articulate a move from a solely bio-medical individualised model of health towards a wider socio-ecological population model through supporting action 'upstream' in law, policy and community practice alongside individual counselling and therapeutic intervention (Bekaert and SmithBattle 2016). The Domestic Abuse Act 2021 E&W has tightened the legal framework for responding to the identification of DA which gives practitioners legal weight to underpin safeguarding and forensic assessment, and support for those experiencing DA. With regard to Brofenbrenner and Beattie, the Act sits within the macrosystem and legislative action respectively. The Act gives a clear, legal starting point regarding thresholds for action, plans, roles and responsibilities across the multidisciplinary team.

This commentary has set out the specific changes in definition, statutory response and prevention of DA arising from the Domestic Abuse Act 2021 E&W, and located this in public health and health promotion theory and nursing practice. The legislation facilitates supporting process and therapeutic input for both victims/survivors and perpetrators of DA. In-line with the theory, however, legislation needs to be accompanied by a wider supporting non-legislative framework. This might include funding for training, provision of specialist co-located DA services, sustainable funding for child and adult support, funded support for perpetrators, a long-term public health campaign to challenge public attitudes to DA, and representation from mental health services on the DA Commissioner's advisory panel, as detailed in a letter to the health secretary from an expert group (Marshall et al. 2021).

Conclusion

DA was endemic before the pandemic; the increase as a result of the pandemic raised awareness of this public health challenge. The DA bill produced pre-pandemic, was delayed. During this time however, several changes were made through lobbying from specific pressure groups and might be said to have 'sharpened its teeth' (Nott, [2022] Crim LR 525). Nurses are likely to have contact with those who have experienced DA due to its prevalence and the range of settings in which they work. Integrating this new knowledge is vital to nurses' health promotion and health education activity with victims/survivors and perpetrators of DA.

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Key words

Domestic abuse

Covid-19

Safeguarding

Health education

Health promotion

Trauma-informed care

Key points

DA increased during the Covid-19 pandemic and is likely to further escalate as perpetrator 'power' is challenged with freedom of movement returning.

The Domestic Abuse Act, England and Wales, 2021 sets out the legal definition of DA and specificities of statutory response and prevention.

Knowledge of legislative changes empowers nurses to practice effectively with victims/survivors and perpetrators of DA.

An examination of the theory of health education and promotion in relation to nursing practice and DA illuminates the ways in which nurses can practice effectively in this area.

Reflective questions

Consider how each section of the Domestic Abuse Act, England and Wales 2021 might relate to your specific practice area.

How might this influence or change your interaction with, and assessment of, individuals and families?

How might this influence your communication and work with the wider interdisciplinary team in relation to supporting victims/survivors and perpetrators of DA?

Does your area of work have a list of organisations, both local and national, that support victims/survivors of DA? Consider compiling this list and sharing this within your team as appropriate.