



# Warwickshire Domestic Violence and Abuse Needs Assessment 2015-16



**July 2016**

Version 1.2

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# List of Abbreviations (Acronyms)

ACC	Assistant Chief Constable
AHSC	Adult, Health and Social Care
BACP	British Association of Counselling & Psychotherapy
BME	Black and Minority Ethnic
CAF	Common Assessment Framework
CAFCASS	Children and Family Court Advisory and Support Service
CATS	Case Administration and Tracking System
CPS	Crown Prosecution Service
CQS	Casework Quality Standards
CRC	Community Rehabilitation Company
CSE	Child Sexual Exploitation
CSEW	Crime Survey for England and Wales
CSP	Community Safety Partnership
CYP	Children and Young People Service
DA	Domestic Abuse
DACS	Domestic Abuse Counselling Service
DASH	Domestic Abuse, Stalking and Harassment
DAU	Domestic Abuse Unit
DHR	Domestic Homicide Review
DVA	Domestic Violence and Abuse
DVDS	Domestic Violence Disclosure Scheme
DVPN	Domestic Violence Protection Notice
DVPO	Domestic Violence Protection Order
EEA	European Economic Area
FGM	Female Genital Mutilation
FM	Forced Marriage
FMPO	Forced Marriage Protection Order
FMU	Forced Marriage Unit
GU	Genito-Urinary
GUM	Genito-Urinary Medicine
HBV	Honour Based Violence
HMCTS	Her Majesty's Courts and Tribunals Service
HOCR	Home Office Counting Rules
HWB	Health and Wellbeing Board
IDVA	Independent Domestic Violence Advisor
ILE	Indefinite Leave to Enter
ILR	Indefinite Leave to Remain
IRIS	Identification and Referral to Improve Safety
ISVA	Independent Sexual Violence Advisor
LBGT	Lesbian, Bisexual, Gay and Transgender
LSCB	Local Safeguarding Children Board
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference

MASH	Multi-Agency Safeguarding Hub
NCDV	National Centre for Domestic Violence
NCRS	National Crime Recording Standard
NPS	National Probation Service
NUM	National Ugly Mugs
OCC	Operations and Communication Centre
ONS	Office for National Statistics
PCC	Police and Crime Commissioner
PTSD	Post Traumatic Stress Disorder
PVP	Protecting Vulnerable People
SARC	Sexual Assault Referral Centre
SCR	Serious Case Review
SDAC	Specialist Domestic Abuse Court
SDVC	Specialist Domestic Violence Court
SHPO	Sexual Harm Prevention Order
SNT	Safer Neighbourhood Team
SRO	Sexual Risk Order
SROI	Social Return on Investment
SWISH	Sex Workers into Sexual Health
SWPB	Safer Warwickshire Partnership Board
VAWG	Violence Against Women and Girls
WADA	Warwickshire Against Domestic Abuse
WCC	Warwickshire County Council
WCU	Witness Care Unit
WLWS	Warwickshire Local Welfare Scheme
WSCB	Warwickshire Safeguarding Children Board
YPVA	Young Persons Violence Advocate

# 1. Executive Summary

The needs assessment has presented an in-depth analysis of the national and local picture of domestic violence and abuse (DVA). It aims to inform the ongoing development of Warwickshire's response to Violence Against Women and Girls (VAWG) and in particular the re-commissioning of the county's specialist DVA support services.

## Summary of DVA in Warwickshire

The following illustration highlights the key DVA statistics identified by this assessment. The figures are per annum and are the average number based on the period analysed.



Source: Warwickshire Community Safety Team, Warwickshire Police, images: [www.flaticon.com](http://www.flaticon.com)

## Key Findings and Emerging Themes

A summary of the key findings and themes that have emerged from the needs assessment are as follows:

- Current specialist community based support and refuge services are not meeting the estimated DVA need in Warwickshire. This is demonstrated by the statistics and also by victim-survivor and practitioner feedback.
- The existing specialist commissioned provision offers the right service elements but capacity needs increasing to improve quality and meet need.
- The IRIS (Identification and Referral to Improve Safety) programme has proved to be an effective addition to the service provision in 2015/16 and should be maintained.
- Particular gaps are evident in support for children affected by parental DVA and in programmes for perpetrators.
- More and improved (coordinated) training in DVA awareness, identification and safe referral is a common theme.
- An improved and more consistent response to DVA victim-survivors and their families is required in relation to access to housing and move-on accommodation.
- More education for children and young people is needed alongside support for the teachers delivering it.

## Recommendations for the Warwickshire VAWG Board

The following recommendations are identified for consideration by Warwickshire's VAWG Board:

- Commissioners to take on board the views of victim-survivors and practitioners, and identified best practice, when reviewing the specialist DVA commissioned provision.
- Service providers to take on board the views of victim-survivors and practitioners, and identified best practice, in the ongoing review and development of their service delivery.
- Commissioners to consider incorporating IRIS as a permanent element of the commissioned DVA support services going forward.
- Consideration to be given to developing services for children affected by parental DVA.
- Consideration to be given to developing programmes for perpetrators of DVA.
- A single programme of learning and development to be established for Warwickshire practitioners.
- A workshop with housing authorities and housing providers to be arranged to consider the feedback related to this particular area and develop solutions to the barriers identified.
- A specific needs analysis should be undertaken with regards to DVA education programmes in Warwickshire's schools.



## 2. Purpose and Scope of the Needs Assessment

The purpose of the needs assessment is to assist partners with the ongoing development of their response to domestic violence and abuse (DVA) in Warwickshire. In particular, it aims to inform the review and re-commissioning of Warwickshire's specialist DVA support and refuge services in 2016/17.

The document is focused primarily on those aged 16 and over. However, support for children and young people, and the issue of education have emerged as gaps, and appropriate recommendations are included to reflect this.

Included within the scope for this analysis is the available and accessible national and local data on DVA including information on the use of the existing specialist services available to support adults affected by DVA in Warwickshire.

There are limited references in this analysis to other forms of violence such as female genital mutilation, forced marriage, 'honour' based violence, stalking, harassment and trafficking, as these will be addressed in separate needs assessments in due course.

## 3. Defining Domestic Violence and Abuse

The term domestic violence and abuse (DVA) is used to describe ongoing controlling and coercive behaviours by one person over another. Since March 2013, the Home Office includes those aged 16 and 17 years and coercive control in its definition: ***Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial, and emotional.***

**Controlling behaviour** is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. **Coercive behaviour** is: an act or a pattern of acts of assault, threats, humiliation and intimidation and other abuse that is used to harm, punish or frighten their victim. This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

The main characteristic of DVA is that it is an ongoing pattern of behaviour/s that is intentional and calculated to induce fear and to control every aspect of the victim's life, including over how the victim thinks, feels and behaves. This shifts the focus away from an incident based definition towards a pattern of coercive control. Perpetrators of DVA choose to use abusive behaviour to get what they want and to gain control over intimate partners and/or family members. This intentional behaviour is regarded to originate from a sense of entitlement rooted in patriarchal norms and traditions, which, in turn, support sexist and other discriminatory systems that maintain and reproduce inequality. DVA comprises a range of behaviours, not all of which are inherently 'violent' or criminal offences:

**Physical violence** may include punching; slapping; hitting; biting; pinching; kicking; pulling hair out; pushing; shoving; burning; or strangling. **Psychological and emotional violence** may include, amongst others, constant undermining and criticism; threats; verbal abuse; harassment; isolation; destroying possessions; humiliation and degradation. **Stalking and post-separation abuse and harassment** is an aspect of psychological and emotional abuse and can include a range of behaviours that appear to be isolated incidents but become abusive when they constitute a repeated pattern that generate fear, alarm or distress. This may include repeated texts, emails, letters, cards or 'presents'; following someone and turning up at their home or workplace for no reason; faking someone's identity to contact others; targeting friends, family and neighbours; vandalism of property. **Financial abuse** is one of the key forms of coercive control and abuse, involving three distinct but overlapping dimensions, all of which can have a negative impact on a victim-survivors' economic wellbeing. These include the perpetrator using male privilege to exploit existing economic disadvantage; causing victim-survivors to incur costs/debt as a result of DVA; and using financial abuse to deliberately threaten their economic security. **Sexual violence** within a DVA context (perpetrated by current or former partners and/or family members) includes repeated rape and sexual assault, sexual abuse and exploitation. Although the majority of rape and sexual assault takes place within DVA contexts, this remains poorly understood. There is also a correlation between the existence of physical violence in adult relationships and child sexual abuse within the family.

## 4. Who Experiences DVA?

DVA is recognised as a worldwide issue that occurs across all communities and socio-economic groups irrespective of gender, age, dis/ability, sexuality, nationality and religious belief. However, it often remains hidden and is highly under-reported. Although the incidence of DVA varies little when analysed by geography, class, age, ability, sexuality, ethnicity and nationality, such issues do affect risk and the severity of violence, and victim-survivors from these groups also encounter additional barriers to seeking help.

DVA occurs in all types of intimate relationships - heterosexual, lesbian, gay or bisexual - and there is little difference in terms of prevalence and experience though there are some differences in terms of how it is perpetrated. For example, sexuality can be used as a tool of control and often involves the perpetrator using not being out to control their partner's access to friendships and support networks. Similarly, impairment is used to assert greater and particular types of abuse and control over those who are disabled. DVA also takes place in extended families where, in addition to intimate partners, perpetrators may also be parents, parents-in-law, siblings, other extended family members and ex-partners. Women from BME communities are more likely to experience abuse from multiple perpetrators involving not only a partner but also other family members like mothers-in-law, parents and brothers. In some cases, older children are violent or abusive towards their mothers or other family members, something identified as child-to-parent abuse. DVA also includes violence against adults with support needs and against older people (often subsumed under 'elder abuse') when committed within the family, by an intimate partner or a paid carer.

The gendered nature of DVA is highlighted by existing evidence which recognises that it impacts disproportionately on women<sup>1</sup>. Evidence indicates that the majority of those who perpetrate violence and abuse in relationships are heterosexual men and most victims are female. Women across all groups are more likely to experience repetitive serious physical assaults, to be raped, seriously injured or to be killed as a result

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<sup>1</sup> Research findings of 'gender symmetry' in domestic violence have been criticised for flawed methods including problems with sampling, a focus on physical violence only, on one-off incidents and ignoring the context in which the violence occurs.

of DVA. In addition, women are also most likely to experience other forms of gendered violence like rape and sexual violence, stalking, sexual harassment, trafficking and commercial sexual exploitation.

It is known that a significant minority of men also experience DVA, whether in heterosexual or same-sex relationships and can be victims of forced marriage, though there exist many barriers to men reporting DVA and being appropriately supported. In supporting men, it is now widely accepted that it is inappropriate to use the same approaches as those used to support women. Although dominant notions of what is considered to be 'masculine' can make it difficult for men to recognise, accept or disclose they are a victim of DVA, for some abusive men, notions of masculine entitlement lead them to see themselves as the victim.

A study exploring 'who does what to whom?' found that whilst both men and women can be violent, there are significant differences in the way in which men and women use DVA against their partners and in the impact of DVA, which needs to be taken into account when determining risk and interventions to increase victim safety. For example, men were found to inflict more violence than women and were significantly more likely than women to use physical violence, threats, harassment and to damage property. Men perpetrated repeat and escalating violence which created intense fear and control. While the majority of male sole perpetrators had more than one incident on record in a six-year period, most female perpetrators had only one incident recorded. In contrast, women were more likely to use verbal abuse or some physical violence, to damage their own property, and to use a weapon, although this was often in order to protect themselves and to stop further violence from their partners. Notably, though men perpetrate more abuse, women are three times more likely to be arrested by the police (during the six years covered by the research men were arrested in one in every 10 incidents and women arrested once in every three incidents). Research also shows that services established to support men who experience DVA find that a substantial number of male (primarily heterosexual) referrals involve counter-allegations, blurring the boundaries between 'victim' and 'perpetrator'<sup>2</sup>. The consequences of incorrect identification are obvious: lack of trust and restricted access to protection for victims-victim-survivors who are deemed to be perpetrators; continuing abuse without consequences; and an increased risk to victim-survivors if perpetrators are deemed victims.

Although the definition of DVA does not include children and young people under 16, it is now widely established that DVA is also experienced by them in a range of ways and that children are a major indicator of risk of DVA. Children and young people experience DVA directly and indirectly and its impact is discernible at a number of levels, including on their emotional, behavioural, cognitive and physical wellbeing. Large numbers of children witness DVA and are likely to be directly abused themselves. Teenagers also experience DVA in their own intimate relationships, with studies indicating that around 40% do so.

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<sup>2</sup> Robinson, A. and Rowlands, J. (2006) noted that '*reports by men of their experience of domestic abuse may be inaccurate*'. Over 1 in 4 men in the 2000 Scottish Crime Survey inaccurately reported experiences of force or threats from a partner (Gadd et al, 2002: 55). Claims of victimisation by men are generally questioned because male perpetrators often present themselves as victims (Hearn, 1998) as part of a strategy of minimisation, denial or blame for their actions.

## 5. Prevalence and Impact of DVA

### The National Picture

#### Key findings:

- 8.2% of women and 4.0% of men experienced DVA in 2014/15 (Crime Survey of England and Wales).
- Women's experience of DVA is different to men's with women more likely to experience intimate violence.
- Prevalence of intimate violence is higher amongst younger age groups.
- Domestic abuse risk factors include gender, relationship inequality, previous experience of DVA, child abuse, pregnancy, separation, disability, sexuality, poverty and social exclusion.
- Victim-survivors from BME communities are less likely to disclose DVA and access support services due to greater isolation issues, language barriers, fear of family and wider community repercussions, racism, stereotyping and discrimination based on religion and insecure immigration status.
- One in three victims of DVA are estimated to be older women, but the majority do not seek professional help due to lack of awareness on their own part and also lack of awareness on the part of professionals.
- One in three children and young people will be exposed to DVA to some degree during their childhood.
- Childhood exposure to DVA is known to impact on mental wellbeing, substance misuse, educational attainment and cognitive development.
- One in 10 disabled women and men are affected by DVA.
- DVA is a feature in one in four LGBT adult relationships, and LGBT victim-survivors' experience of DVA is often compounded by their sexuality or gender identity, abuse from past and present sexual partners, type of relationship, extended family members, as well as abuse from entire communities and wider society.
- DVA victim- survivors are 15 times more likely to use alcohol and nine times more likely to use drugs.
- DVA is associated with a range of physical and mental health problems.
- Women with histories of domestic and sexual violence are significantly over represented in the criminal justice system as offenders or are at risk of offending and have complex needs.
- One in ten people who had experienced DVA had been forced to take time off work because of its effects, 20% of these had been absent for more than a month.

## Crime Survey of England and Wales

The most reliable national estimation of DVA is derived from the Crime Survey of England and Wales (CSEW), previously the British Crime Survey (BCS), an annual representative sample survey of over 40,000 people which asks about the extent to which people have been victims of crime through a face to face survey and a self-completion module on intimate violence administered to adults aged 16 to 59. The module covers experience of emotional, financial and physical abuse by partners or family members, as well as sexual assaults and stalking by any person. For 2014-15, the module also focused on the nature of partner abuse. The CSEW is widely regarded as providing the most robust prevalence estimates of a crime that is known to be under-reported.

For 2014-15, the CSEW estimated that 8.2% of women and 4.0% of men experienced any type of domestic abuse in the last year (non-sexual partner/ex-partner abuse, family abuse and sexual assault or stalking carried out by a current or former partner or other family member). This equates to around 1.3 million female victims and 600,000 male victims. With regard to any type of partner abuse, 6.5% of women and 2.8% of men had experienced this in the last year, equating to around 1.1 million female victims and 500,000 male victims. Overall, women were twice as likely as men to have experienced domestic abuse since the age of 16 - 27.1% of women and 13.2% of men - equivalent to an estimated 4.5 million female victims and 2.2 million male victims aged 16 to 59.

Women were more likely than men to experience intimate violence across all types of abuse asked about in the CSEW. The most commonly experienced types of intimate violence by women since age 16 were non-sexual partner abuse (20.7%), stalking<sup>3</sup> (20.2%) and sexual assault (19.0%). For men, the most commonly experienced types of abuse were stalking (9.8%) and non-sexual partner abuse (8.6%). Notably, women were five times (19.0%) more likely than men (3.8%) to have experienced sexual assault (including attempts) since the age of 16. Threats within partner abuse shows the largest difference between men and women, with women (14.1%) being four times more likely to be a victim of this type of abuse than men (3.2%) since the age of 16; women (2.9%) were over three times as likely to be a victim of threats in the last year as men (0.8%). Separated women are a heavily victimised group - more likely to experience non-physical partner abuse or threats as well as partner abuse more than once than women who were not separated and are more likely to experience other effects from the abuse, specifically mental or emotional problems. Thus, closer analysis of the CSEW data, as well as other research, indicates emergent gender differences in terms of the experience and consequences of DVA that do not support a hypothesis of gender symmetry and instead show that women are the overwhelming majority of the most heavily abused group.

Although the CSEW shows a small but consistent decline in DVA for women and men since 2004-5, an analysis by Walby et al. suggests that even as violent crime has been on the decrease, domestic abuse and intimate partner violence has been increasing. As well as gender (women more likely to experience intimate violence than men in the last year), the CSEW reveals variations in victimisation based on personal characteristics.

CSEW data found that the characteristics most closely associated with domestic abuse were use of any drug in the last year, marital status, having a long-term illness or disability and gender. The prevalence of intimate

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<sup>3</sup> The definition of stalking applied in the CSEW covers a wider range of actions and behaviours than the legal definition, and includes being followed, being sent unwanted messages that were obscene or threatening and having personal property interfered with.

violence was highest amongst younger age groups - women aged between 16 and 19 (12.6%) and between 20 and 24 (8.9%) were more likely to be victims of any domestic abuse compared with those aged between 55 and 59; similarly, men aged between 16 and 19 (6.6%) and between 20 and 24 (5.0%) were more likely than those aged between 55 and 59 to have experienced domestic abuse in the last year. Separated women had the highest prevalence of any domestic abuse in the last year (19.8%) compared with other marital status groups.

Both disabled (long-term illness or disability) women and men were more likely to be victims of any domestic abuse in the last year than those who were non-disabled (16.0% and 6.8%; 8.8% and 3.2% respectively). Notably, 11.1% of disabled women were likely to be a victim of partner abuse compared with 4.9% of non-disabled women. Women with a higher education (degree or diploma) were less likely to be a victim of any domestic abuse in the last year. Over 1 in 5 women living in lone parent households were victims of domestic abuse in the last year (22.6%). Women in the lowest income households (less than £10,000) were over three times as likely to have experienced any domestic abuse in the last year compared with those in the highest household income bracket of £50,000 and over (16.2% compared with 4.8%).

The self-completion section of the CSEW included questions about attitudes to partner violence. It was found that 77% of respondents felt that it was always unacceptable to hit or slap their partner in response to their partner having an affair, whereas less than 1 in 10 felt that it is mostly or sometimes acceptable (8%). Younger people were more likely to think that it was acceptable at least some of the time – those aged between 16 and 19 (13%) and 20 to 34 (13%) were more likely to think that it was acceptable than those between 55 and 64 (5%).

The CSEW is acknowledged to be an under-estimate of the prevalence of DVA, particularly as it excludes certain groups where DVA is over represented (such as homeless and prison populations); it is only conducted in English and in written form so excludes those who are not fluent in English, and it only includes those aged between 16 and 59 years.

## Risk factors including risk of homicide

DVA has a devastating impact not only on the lives of those who experience it, but also their families and friends, and indeed wider society. Victim-survivors of DVA are more likely to be repeat victims and abuse is likely to become more frequent and more serious the longer it continues. Research in the UK has identified significant risk factors associated with intimate partner DVA, in terms of it starting, escalating and resulting in homicide. The risk factors<sup>4</sup> below are drawn from extensive research on domestic homicides, 'near misses' and lower level incidents.

**Gender and gender identity:** While both women and men experience DVA, gender is a significant risk factor as women are more likely than men to experience DVA, especially severe, repeated, and often life-threatening incidents of violence. The CSEW highlights that younger women under 30 are at greater risk and coercive

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<sup>4</sup> These risk factors have also informed the development of the Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model, which is now widely used by the police and all key agencies working with DVA victims across the UK to identify and assess risk and to decide which cases should be referred to a Multi-Agency Risk Assessment Conference and what other support might be required. Perpetrator guidance is available from Respect at: [www.respect.uk.net](http://www.respect.uk.net)

control is a key indicator of domestic homicide. Gender is a significant risk factor for the following, where the majority of victims are women and the majority of perpetrators are men:

- Onset of intimate partner violence
- Risk of homicide
- Risk of injury and fear
- Risk of ongoing intimate partner violence involving more than four incidents of physical violence
- Risk of rape and sexual assault
- Risk of post separation violence

**Relationship inequality:** the risk of DVA is lower in egalitarian relationships and is increased by a lack of economic resources and dependency (unemployed women and housewives have a higher risk of DVA). A correlation has been found between reduced patriarchal attitudes and a reduction in the extent to which men use violence against their partner.

**Rape and sexual violence:** Analysis of domestic sexual assaults indicates that those who are sexually assaulted are subjected to more serious injury, and those who report a domestic sexual assault tend to have a history of DVA whether or not it has been reported previously. Rape is associated with the most severe cases of DVA and is a risk factor for domestic homicide.

**Previous assault:** Previous physical domestic assault is the most robust risk marker of subsequent assault. Repeat DVA is a predictor of escalation to severe violence.

**Stalking:** Stalkers are more likely to be violent if they have had an intimate relationship with the victim. Stalking and physical assault, are significantly associated with murder and attempted murder.

**Child abuse:** The co-occurrence of DVA and child abuse is highlighted by research and child abuse is considered to be an indicator of DVA and vice versa.

**Pregnancy:** There is a correlation between pregnancy and DVA and research shows that DVA can start or escalate during pregnancy. This correlation may exist because younger women are at higher risk of DVA and pregnancy is associated with this age group; the risk of DVA is also higher in the immediate post-partum period.

**Separation:** Women who are separating from their partner are at much higher risk of DVA. Those attempting to leave an abusive relationship are at higher risk of greater violence and/or of being killed. Much of this abuse occurs in the context of child contact or disputes over children.

**Discrimination, isolation, barriers to accessing services:** Women who are disabled or have additional support needs, women who are isolated from friends, family, or community networks, or those who live in rural or isolated communities are more vulnerable to escalating violence as a result of their isolation. While DVA affects women from all minority ethnic groups and similar levels of violence are experienced, women from BME communities face additional issues and risks. They are subjected to DVA by multiple perpetrators, such as parents or parents-in-law, siblings, other in-laws as well as an intimate partner. They are also likely to experience greater isolation, which, along with language, fear of repercussions from the family and wider community, and inappropriate responses and racism from mainstream agencies are all factors that make it more difficult for BME women and children to disclose DVA and access support.



In addition, women with insecure immigration status who have '*no recourse to public funds*' (NRPF) and who often experience high levels of DVA, are unable to use public funds to access refuge support or safe housing that could allow them to flee their abuser. From April 2012, the government launched the Destitution Domestic Violence (DDV) Concession under which women with NRPF on spousal visas whose relationship has broken down because of DVA, and who are destitute and planning to apply for indefinite leave to remain are granted benefits for a three month period, during which they are expected to submit their application. The concession is aimed at helping women leave abuse safely and to secure their immigration status in the UK.

**Sexuality:** Existing research indicates that gay men (and heterosexual women) are at greater risk of serious injury or homicide. Findings from risk assessments conducted in a service for male victims (heterosexual and GBT) showed marked differences from the risk factors present for female victims. It was found that psychological risk factors (threats to kill, suicide attempts, stalking) did not feature as prominently for men as they did for women, and that male victims' reports of extreme jealousy/control by their partners were less frequent than has been found for female victims. Cases where those presenting as victims were also identified to be perpetrators of violence appeared to be at highest risk, while those identified as 'legitimate' victims (gay or heterosexual) appeared to be at lower overall risk. Almost one in three gay victims were assessed as high or very high risk (twice that of heterosexual men), and over a quarter (27%) were repeat referrals compared to 4% of heterosexual victims.

**Poverty and social exclusion:** Those living in poverty and low income households have a higher risk of DVA, as found by the CSEW. However, this does not mean that DVA is not found in higher income households. DVA itself can result in poverty as it is often harder for victim-survivors to maintain employment and can increase the likelihood of poor health. Furthermore, unemployment and lack of economic resources may make it harder for victim-survivors to leave a violent partner.

## DVA and gender

DVA is considered to be both a cause and consequence of gender inequality. Women and girls are more likely to be victims than men and boys, and young women in particular suffer higher levels of victimisation. It originates from a sense of entitlement, rooted in patriarchal traditions though these may find expression in differing ways, and supported by discriminatory systems, attitudes and behaviours that maintain and re/produce inequality (based on gender, race, age, dis/ability, sexuality). Addressing DVA is central to the delivery of gender, as well as other equality duties<sup>5</sup>.

DVA, as a form of VAWG/gender-based violence, constitutes a major form of inequality faced by women and girls in the UK. It is recognised as a fundamental violation of human rights, a consequence of gender inequality, and of broader social, economic and cultural discrimination experienced by women. There are commonalities and connections between DVA and other intersecting forms of violence women experience, including myths and stereotypes that justify or excuse the abuse; the dynamics of power and control; high levels of under-reporting and low conviction rates; the extent of repeat victimisation; and the long-term social, psychological and economic consequences for victims.

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<sup>5</sup> See Kelly L., (2005) *How violence is constitutive of women's inequality and the implications for equalities work*, CWASU. <http://eac.eu/ess/socialwork/dvforum/LizKelly.pdf>



Although the incidences of DVA show only marginal variations across different groups, the experience of victim-survivors from marginalised groups is compounded by additional barriers to seeking help. Many services are inaccessible and/or unable to respond effectively to victim-survivors with diverse or complex needs; specialist BME VAWG services are non-existent, under-developed or increasingly impacted by funding cuts. However, research widely highlights the ways in which DVA experiences are exacerbated for some groups by discrimination, particularly those from BME communities, including Gypsy and Traveller communities and women seeking asylum; disabled women/people; older or younger people; LGBT people; and people with mental health needs or who have problematic substance use. Available research on transgender people's experiences of DVA in the UK shows that large numbers experience high levels of physical and sexual abuse from a partner or ex-partner but few identify this as DVA, tell anyone about it or seek formal help. In addition, high numbers, reported to be almost a three quarter, experience transphobic harassment.

Since 2007, all Government departments and public services have obligations under the Gender Equality Duty (incorporated into the Equality Act 2010) to eliminate unlawful sex discrimination and promote equality of opportunity between women and men as part of policy, commissioning and service development. All public authorities must also provide evidence that they have consulted widely with relevant service users and stakeholders in the development and delivery of policies and services. Since the introduction of the Equality Act 2010, public authorities are subject to a public sector equality duty, which replaces and brings together the three existing race, gender and disability equality duties, and extends those duties to the protected characteristics of age, gender reassignment, pregnancy and maternity, religion or belief, and sexual orientation.

Under the Gender Equality Duty, local authorities have a legal obligation to take a lead on assisting women who have experienced violence<sup>6</sup>. The Equality and Human Rights Commission (EHRC), in its guidance of 2010, identified tackling the causes and consequences of VAWG, given its significance to realising equality of opportunity and tackling disadvantage, as one of four key issues that requires specific action by local authorities. The provision of specialist support services for women through statutory and non-statutory agencies, perpetrator programmes, specialist domestic violence courts, sexual assault referral centres, rape crisis centres, and services specifically for minority ethnic women was identified among the action that was required.

## **DVA and BME communities**

There is little difference in the prevalence of DVA by ethnicity though the cultural contexts in which DVA occurs affects the way it is viewed, experienced and responded to. As noted, victim-survivors of DVA in BME communities face a range of additional barriers in seeking help, such as racism, stereotyping and discrimination based on religion, fear of community 'dishonour' and rejection, language barriers and insecure immigration

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<sup>6</sup> The duty also requires public bodies to promote equality through public procurement. Section 149(1) of the Equality Act 2010 stipulates that: 'a public authority must, in the exercise of its functions, have due regard to the need to (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act; (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.'

status, which can prevent them from accessing support and protection. As a result they often remain in an abusive relationship for longer, endure severe abuse and are less likely to seek help<sup>7</sup>.

Given the differences within and between BME communities, in terms of language, histories of migration, settlement patterns and integration into the labour market, which impact on service needs, it is important not to adopt a one-size-fits-all approach to victim-survivors from different communities. Amongst the variations reported by research are: significant differences in help-seeking, especially from the police, across BME communities; women from some groups being less likely to report DVA and access existing services; a low level of awareness of DVA services among large numbers of BME women which leads them to endure abuse for longer periods; women from some communities being more likely to suffer from ongoing post-separation violence, including threats through child contact arrangements and child abduction. Women with insecure immigration status may feel trapped and unable to seek help in case they are deported, something that is used as a threat by perpetrators to control women's actions. They are also likely to have 'no recourse to public funds', which means they cannot claim most state benefits, though the DDV concession provides three months' support to women in such situations to apply for indefinite leave to remain. Women who are trafficked or migrant workers continue to remain unprotected from abuse and exploitation. Limited knowledge and misconceptions about DVA services, inadequate responses from agencies, language issues, and personal and psychological barriers to reporting, are among the key reasons for women remaining in situations of abuse and under-accessing support services. Women are often reluctant to access or approach services considered to lack an understanding of their experiences and needs; indeed women may be reluctant to fully recount their experiences of abuse to a stranger with whom they have no relationship of trust, or to an interpreter who is also a member of the local community.

The experience of DVA amongst many BME women can be further compounded by abuse from extended family, and may include forced marriage, female genital mutilation and so-called 'honour-based violence'. In addition, the experiences of women asylum seekers who experience DVA highlight that the implementation of government policies and lack of access to safety, support and healthcare in many local areas make them particularly vulnerable to sexual violence, exploitation and prostitution. It has been estimated that between 60-80% of Gypsy or Traveller women have experienced DVA. They also face additional barriers to seeking help, including discriminatory attitudes and responses which leave women feeling unable to contact the police or other agencies for support. The prospect of leaving their family and community and losing their way of life because of DVA, as well as the prospect of encountering prejudice from the settled population, can result in such women opting to remain in abusive contexts.

## DVA and older people

DVA against older people is subsumed under 'elder abuse', and there is limited data about the extent of DVA and how it is experienced by older people, with the CSEW covering only people aged 16 to 59. The needs of this group are often over looked and the perception that DVA primarily occurs among younger people creates barriers to accessing support. Research suggests that older women who experience DVA are less likely to come to the attention of statutory agencies or specialist DVA services; that awareness of DVA services among older women is lower than even for younger women; and that some older women think DVA services are only for

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<sup>7</sup> For further research evidence about the needs and experiences of different BME communities see the section on Black, Asian minority ethnic and refugee victim-victim-survivors at the Coordinated Community Response online toolkit: [http://www.ccrm.org.uk/index.php?option=com\\_content&view=article&id=79&Itemid=101](http://www.ccrm.org.uk/index.php?option=com_content&view=article&id=79&Itemid=101)

younger women or for women with children. DVA is often not considered by professionals as an issue for older women and they tend not to ask them about it, assuming that injuries are the result of age-related conditions. Older men, despite inflicting serious injuries, are assumed not to be a threat. Clearly, there is a widespread assumption that DVA does not happen amongst older people or that it reduces with age. It has been estimated by the Department of Health that 227,000 older people are neglected or abused in their own home each year and DVA was a significant dimension in this. Australian research indicates that one-third of all current victims of DVA are older women, but over 60% did not seek professional help.

## **DVA and its impact on children and young people**

Whilst this needs assessment focuses on adults, it is helpful to summarise the impact of DVA on children and young people, particularly as it has links to parenting capacity.

There is considerable evidence to indicate that substantial numbers of children are exposed to DVA, which places them at an increased risk of direct abuse, serious injury or death, and that prolonged and/or regular exposure has a serious impact on children's safety, development, educational attainment, and health and wellbeing. Possibly one in three children and young people will be exposed to DVA to some degree during their childhood with a national prevalence study conducted by the NSPCC finding that childhood exposure to DVA was higher than childhood experiences of other forms of maltreatment, including child neglect. It found that: 12% of under 11 year olds, 17.5% of 11-17 year olds and 23.7% of 18-24 year olds had been exposed to DVA between adults in their homes in their childhood; where a child or young person had seen a parent beating up another parent, men were the perpetrators in the vast majority (96%) of cases. Others estimate that around 200,000 children in England live in households where there is a known risk of DVA and a national analysis of Serious Case Reviews found evidence of past or present DVA in over half (53%) of the cases. Research studies indicate that many children are directly abused - in 30% to 60% of cases – and that many are displaced as a result of leaving abuse or removed into care, and many are placed by the courts into unsafe contact arrangements on separation. Despite efforts by the non-abusing parent to protect them, the profound physical and emotional effects of DVA on children and young people are now widely documented.

Under the Adoption and Children Act 2002, children living in households where DVA is occurring are identified as 'at risk' (Section 120 of the Act extended the legal definition of harm to include harm suffered by seeing or hearing ill treatment of others).

Concerningly, children and young people living with DVA may use (or increase the use of) alcohol or drugs or self-harming behaviours to deal with the fear, anxiety, depression, trauma and other effects of living with DVA. For some, especially those who are also directly abused, DVA impacts on their mental wellbeing, resulting in depression, anxiety, self-harm or suicide attempts, and other trauma symptoms though the effects are dependent on their age and stage of development. If they hide these effects and negative coping behaviours from the non-abusing parent, they are unlikely to get the support they need though support services for children and young people affected by DVA are extremely under-developed. Research shows that exposure to DVA can also impact on children's educational attainment as it is shown to be associated with difficulties in cognitive processes and development and academic functioning.

## Parenting

Given the focus within the family courts and social policy on separated fathers having a relationship with their children, some research has been conducted on how and if abusive men can parent, and shows that using violence impacts on men's ability to parent in negative ways. Findings indicate that some fathers are less engaged with their children, disregard children when being abusive, provide inconsistent physical care and can be more authoritarian and more volatile than fathers who are not perpetrators of DVA. Men also manipulate children in the post-separation period, especially if there are issues of child contact, and thus continue to undermine women's mothering and their relationship with their children. In denying or minimizing their violence, very few fathers define violence against mothers as emotionally abusive of their children, even when they used the children in the abuse. It has been found that men: justified their violence/coercive control on the basis of their partner's poor standards or disinclination for housework/childcare; explained violence during pregnancy through claims that they did not want the child; generally brought children into their accounts only when making claims to being a 'good father' rather than in their discussions of violence; rather than being able to empathise with children, there was a failure to see them as human beings in their own right, where even very young children were regarded as provoking the abuse; presented violent/controlling actions as indications of how much they 'loved' their children, that their children preferred them over their mothers and that they were better parents. Other research has shown that fathers' declarations of love and pride in children were not expressions of a commitment to the child's wellbeing but were instead viewed as possessions/objects that fulfilled the fathers' needs and were seen as 'emotional property' existing for fathers' benefit.

DVA also impacts on the parenting capacity of the victim-victim-survivor (often mothers). Exposure to psychological and emotional abuse has profoundly negative effects on women's mental wellbeing, resulting in an erosion of confidence and self-esteem, depression and anxiety and a general sense of being out of control. Consequently, women's ability to parent children who themselves are negatively affected and demanding to look after is impaired by DVA. This is especially so as undermining women's mothering and the mother-child relationship are key strategies adopted by abusive partners. With regard to the latter, perpetrators use a range of methods to do this, including degrading women in front of the children in order to undermine their authority, involving children in the abuse, undercutting her control of children and her ability as a mother. The result can be the maintenance of the 'conspiracy of silence' where mothers and children rarely talk about what is happening, a distancing of mothers from their children and a sense that she is failing as a mother. Whilst many children attempt to support and protect their mothers, some children may blame them for the violence or their inability to prevent it and can distance themselves from their mothers. This results in what has been referred to as 'maternal alienation', which many professionals fail to recognise as a consequence of intentional actions by the perpetrator. Research has also highlighted the ways in which the 'absent presence' of the abuser continues to cast a shadow in the lives of children and women even after they have left DVA, something that is also poorly understood by professionals.

Research indicates that DVA and substance use often co-exist, and some children and young people may be exposed to substances (prescribed or illegal) by the perpetrator, victim-survivor or both. This may be deliberate, as part of the perpetrator's way of controlling the whole family or part of the abuser's lack of care about children's needs. It may be unintentional if the child witnesses the non-abusing parent using drugs or alcohol as a way of coping with the abuse. Children living with either one or both parents with problematic substance use show heightened rates of distress and the description of emotional and behavioural problems are very similar to the patterns which are seen for children living with DVA. Although the non-abusing parent

often makes a great effort to keep their own or their partner's substance use hidden from their children, there is considerable evidence to suggest that the combination of parental substance use and DVA causes greater detriment to children than just parental substance use.

## **DVA and young people in teenage relationships**

DVA in teenage relationships is very common and has generated great concern. Data from 20 specialist services in England and Wales supporting teenage victims of DVA over a two year period (2012-12) showed that: they experience the same level of violence as adult victims, and the majority are at risk of serious harm or death; many experience additional problems which increase their risk, including mental health issues and self-harm; and one in five victims is pregnant. Of the 183 teenage victims of DVA: two-thirds were classified as high risk; 78% were experiencing controlling behaviour such as threats to kill, threats to expose sexual activity, isolation from family and friends, and being put down in public; 76% were experiencing physical abuse such as broken bones, internal injury, slapping and pushing; 53% were experiencing harassment and stalking such as obsessive texts, constant phone calls and threats; and 22% were experiencing sexual abuse such as rape, sexual abuse, unwanted touching or sexual insults. Most of the abuse against teenage victims was perpetrated by a current or ex-partner who was not living with them; they were more likely (than adult victims) to be abused by more than one perpetrator; and some were at risk of forced marriage or HBV. It was also found that teenage victims experienced additional health-related and economic impacts: 27% had previously self-harmed; 25% had experienced mental health issues; 21% had previously threatened or attempted suicide; 20% were pregnant; 18% had financial problems; 8% misused alcohol and 5% misused drugs. Many of those in DVA relationships had sought help from other agencies in the year prior to accessing specialist DVA services: 70% had reported the abuse to the police, with an average of 2 reports each; 27% had attended A&E as a result of the abuse, attending twice on average; 42% had visited their GP, and had made an average of 5 visits. Teenage victims were more commonly referred to DVA services by children and young people's services and health agencies, and less commonly by the police than for adult victims.

An online poll of 16-18 year olds conducted in 2006 also found that 40% of girls had been coerced or pressured into sex; 42% of girls had been hit by their boyfriend; and 59% of young people felt they did not have enough information to advise their friends if they were experiencing abuse. The first UK research conducted on teenage partner violence by the NSPCC<sup>8</sup> found that girls reported greater incidence of relationship abuse, experienced more severe abuse more frequently, and suffered more negative impacts than boys. In particular, it found: of 88% of young people in an intimate relationship, 25% of girls and 18% of boys experienced physical abuse; 75% of girls and 14% of boys experienced emotional abuse, and 33% of girls and 16% of boys experienced sexual abuse. Whilst girls reported high detrimental impacts of the violence on their welfare, boys reported little impact and negative consequences. Moreover, boys minimised the use of violence as 'messaging around' and reported the violence as mutual though they often used disproportionate force.

Self-blame was more prominent for girls, especially in relation to sexual coercion. 'Giving in' to pressure from partners was the aspect of sexual violence, rather than the act itself, which affected them in the long term. Worryingly high levels of coercive control were reported in some young people's relationships, with this affecting girls most, through high levels of control over where they could go, whom they could see or what they

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<sup>8</sup> 1,353 young people, between 13 and 17 years old from England, Scotland and Wales took part in the research survey and 91 young people took part in in-depth interviews.

could do, resulting in isolation from peer networks. Constant surveillance through the use of online technologies, mobile telephones and text messaging was particularly prominent. Confused about whether controlling behaviour was caring concern or coercive control, many girls were often too scared to challenge their partner's behaviour. Girls with older partners were more likely to experience more severe physical and sexual violence. Girls reported greater fear than boys and tended to remain in the relationship compared to boys; when girls left abusive relationships, this resulted in an escalation in violence. The research found that the majority of young people told a friend about their experiences. Although in many cases peers provided a valuable source of support, in some instances they held inappropriate views about the acceptability of violence. School learning mentors were the main professionals approached by young people for help, from whom they generally received positive responses.

Research on young people's attitudes to sex, violence and relationships highlights the importance of boys learning about respect for women and the unacceptability of violence against women and the damage it inflicts. A study explored the understanding and attitudes to DVA of over 1,300 children aged 8 to 16, and revealed disturbing trends that suggest work in schools to address this issue must start at a very early age. Over 75% of 11-12 year old boys thought that women get hit if they make men angry, and more boys than girls of all ages, believed that some women deserve to be hit. Boys aged 13-14 were even less clear that men should take responsibility for their violence. Boys of all ages, particularly teenagers, had less understanding than girls of who is at fault, and are more likely to excuse the perpetrator.

Young people are reported to believe that their views are not taken seriously or acted on by professionals, suggesting that professional practice may not be responding to young people's concerns, fears and wishes regarding the impact of peer violence. A number of explanations have been offered to explain this, including viewing young people's behaviour as experimental, that peer abuse is less harmful than adult abuse, a lack of awareness of adolescent abuse, and low reporting levels. Following the NSPCC research which increased concern about the high levels of violence in young people's relationships, the definition of DVA now includes those aged between 16 and 17; the Home Office also launched a campaign on teenage violence aimed at young people which has been positively viewed. In general, the importance of developing prevention and protection measures for young people has been underlined.

The NSPCC research made a range of recommendations, which emphasised: the importance of developing prevention work which recognises specific forms of violence (physical, sexual, emotional) and the greater prevalence and impact on girls; intervention programmes that focus on girls and challenge minimisation by boys of their own use of violence; the role of new communication technologies in extending control and exploitation in young people's lives; child welfare professionals who work with young people need to include this area routinely into their overall assessments; agencies consider any girl with a much older partner as a risk factor and as a child in need; acknowledgement in school-based interventions and peer support that young people's help-seeking strategies favour peers; and counselling schemes need to be developed/ extended to include sexual bullying and peer violence in teenage relationships; adult learning mentors are trusted by young people and have an important role in offering support; personal, social and health education (PSHE) classes should focus on physical, sexual and emotional forms of partner violence and on coercive control; parents need better advice on supporting their children in their intimate relationships.

## **DVA and disabled people**



Research in North America, UK and Australia indicates that disabled women are more likely to experience a wide range of severe and frequent DVA from greater numbers of people, including intimate partners, family members, paid carers and health professionals, over longer periods than non-disabled women. In England, disabled people experience twice the rate of sexual assault, DVA and stalking than non-disabled people; and over 1 in 10 disabled women and just under 1 in 10 disabled men experienced DVA. However, disabled women are significantly more likely to experience DVA and experience more frequent and more severe DVA than disabled men, whereas disabled men experience a similar rate of DVA as non-disabled women. Disabled women are also subjected to DVA in additional ways, where disability specific abuse leads to increased power and control, which multiplies the vulnerability and isolation that they are likely to experience. All this creates more and complex barriers to escape. Thus, how gender and disability are structured in society affect the risk of DVA and how it is experienced. A German survey of 1,561 disabled women aged 16 to 65 years living in households and in institutions and interviews with 31 abused DW showed that: disabled women had experienced psychological, physical and sexual violence 2-3 times more frequently than women in the average population; and IPV was experienced 2-5 times more frequently than in the average female population. Canadian research has also reported that disabled women had a 40% greater likelihood of DVA and were at risk of severe violence. A study in the USA found that disabled women had more than four times the odds of experiencing sexual assault in the past year compared to non-disabled women. In the UK, research has highlighted the barriers faced by disabled women in getting away from DVA, including a lack of accessible services, low take up of DVA provision, tiny numbers disclosing to disability and DVA organisations, and the absence of awareness campaigns.

Disabled women experience multiple forms of violence across the life course from multiple perpetrators - leading many to argue that dominant definitions of DVA, as intimate partner violence, are unable to capture and represent its complexity in relation to disabled women's experiences. In a study conducted in the UK with women who had physical and sensory impairments, women recounted physical abuse, sometimes extreme, as well as the accompanying emotional degradation and humiliation linked to their disability to which they were subjected. They also spoke about being isolated from other people, being prevented from leaving the house, threats to take the children away or turning children against them, and control over everything they did and intrusion into every aspect of their lives. Being disabled significantly affects and worsens the abuse that disabled women are subjected to and abuse can be especially acute where the abusive partner is also the carer. Abusers commonly used women's impairments to perpetuate particular kinds of abuse, including ridicule and insults about the woman's condition and to perpetrate high levels of extreme sexual violence. Research also shows that those with learning disabilities are less likely to be aware of abuse or to report it. The marginal position of disabled women in society, situational vulnerability, and dependence on care givers increases power and control over women. Deliberate neglect by abusive partner-carers and other family members, being denied access to vital medicines or sanitary protection, and enforced isolation often multiplies neglect. Sexual violence also appears to be proportionately more common for disabled than for non-disabled women.

Myths around asexuality and their low body esteem contribute to greater risk of DVA for disabled women and where the abuse is presented as 'caring' this is used to exert greater power and control, a situation which often makes it difficult for women to 'name' abuse. Women with learning difficulties who may have experienced a lack of loving relationships in the early part of their lives often seek love and warmth in their intimate relationships but are targeted by men through similar processes to 'mate crime', such as being pressurised into cementing relationships too quickly which turn into coercive control and violence. Financial abuse, where partners take control over women's benefits and finances or deny them money for essential needs related to their impairment, is reported to be common, with many women being left in debt. Abuse from paid carers is

considered to be widespread in disabled women's lives, though professional understanding of the nature of the abuse perpetrated tends to be limited.

Disabled women have a greater need for services, based on the nature and extent of the abuse they experience, but this is accompanied by far less provision than is generally available for non-disabled women; therefore the barriers and difficulties encountered by disabled women in trying to escape from abuse and find appropriate services are immense. Responses to disabled women experiencing DVA by both disability organisations and by DVA services have been found to be limited, though there is some good practice amongst some. However, any positive interventions tend to short lived because of the way in which they are funded. Being disabled not only affects the nature, extent and impact of abuse but severely limits a victim-survivor's capacity to escape or take other preventative measures. Barriers to seeking help for disabled women include women not recognising their experience as abuse, blaming themselves, being unaware of any other options, fear of losing their independence or of being institutionalised, fear that their children will be taken away, and not trusting agencies to respond effectively. Professionals rarely ask disabled women about DVA and women are reluctant to disclose if not asked, and internalise negative beliefs about their worthiness to have a non-abusive relationship if this is not reinforced by others. Lack of accessible service provision is a significant barrier for women in seeking help: disabled women are often reluctant to leave their own housing if it has been adapted for them; accessible refuge provision is relatively scarce; and many women believe they cannot be accommodated according to their needs. In addition, disabled women who are unable to take their care packages and personal assistance with them when moving areas find their options severely limited.

## **DVA and LGBT people**

DVA is a feature in 1 in 4 lesbian, gay, bisexual and transgender (LGBT) adult relationships, and LGBT victim-survivors' experience of DVA is often compounded by their sexuality or gender identity, abuse from past and present sexual partners, type of relationship, extended family members, as well as abuse from entire communities and wider society. Data on sexuality has been included in the self-completion module of the CSEW since 2007 though data about the prevalence of DVA by sexuality has to be treated with caution due to small sample sizes. Nonetheless, findings show that LGBT people were more likely to have experienced any DVA in the past year compared with heterosexual people.

## **Impact on physical and mental health**

The extensive impact of DVA on women's physical, mental and sexual health is widely recognised. Gender inequality is considered to further exacerbate the harmful effects that violence has on women's health. DVA is associated with a range of physical health impacts and consequences; it causes extensive physical damage, including cuts and bruises, fractures, broken bones, facial and eye injuries, grievous bodily harm, miscarriages, permanent disability and at worse death. Physical injuries following choking and strangulation are common as are internal injuries following assault. A number of chronic health problems are also associated with DVA, including chronic headaches and back pain, gastrointestinal disorders and abdominal pain. Gynaecological problems – vaginal bleeding and infection, chronic pelvic pain, urinary tract infections, sexually transmitted infections and HIV – are the longer lasting and largest physical health difference between abused and non-abused women. According to the World Health Organisation (2013), women who have been physically or sexually abused by their partners are 16% more likely to have a low-birth-weight baby, twice as likely to have an abortion, almost twice as likely to experience depression, and are 1.5 times more likely to acquire HIV.



Women who have experienced sexual violence are 2.3 times more likely to have alcohol use disorders and 2.6 times more likely to experience depression or anxiety. DVA can start or get worse during pregnancy, and there is an increased risk of miscarriage, still or premature birth, foetal brain injury and fractures. DVA is also associated with women's irregular or late attendance for ante-natal care; poor attendance may be the result of low self-esteem and depression or due to an abusive partner controlling and restricting women's use of medical services. Health effects such as obesity and dental neglect are less well recognised. Homicide is the most serious health consequence, with around 47% of female homicides and 5% of male homicides being perpetrated by a current or former partner.

The methods of establishing control over another person are based on the systematic, repetitive infliction of psychological control designed to instil terror and helplessness and to destroy the victim's sense of self in relation to others. Whilst all forms of violence and abuse can cause lasting psychological harm - through isolation from family and friends, a loss of income or work, homelessness, and a general erosion of self - it is now well accepted that DVA has a significant effect on the mental health and wellbeing of victim-survivors and is associated with multiple conditions, such as depression, anxiety, post-traumatic stress disorder, substance use, eating disorders and psychosis. It can result in sleep disturbances, self-harm, suicide and attempted suicide. The severity of violence leads to a rise in psychiatric symptoms and a decrease in violence lessens these symptoms. Between 50 and 60% of women using mental health services have experienced DVA, and up to 20% will be experiencing current abuse.

Abused women experience depression or anxiety disorders at a rate that is at least three times higher than the general population. Women subjected to DVA show rates of depression that range from 38% to 83%. An overview of 42 studies also found high rates of PTSD associated with DVA, with rates of PTSD varying from 31% to 84% across 11 studies, which is greater than that for women who are victims of other crime. DVA commonly results in self-harm and attempted suicide: one-third of women attending emergency departments for self-harm were DVA victim-survivors; abused women are five times more likely to attempt suicide; one third of all female suicide attempts can be attributed to current or past experience of DVA; and a rate of 44% for women in refuges. Studies show elevated rates of self-harm and suicide attempts amongst Asian women: half of Asian women who attempted suicide or self-harm were DVA victim-survivors; Asian women are two and a half to three times more likely than the national average to commit suicide; DVA was a feature in 49% of suicide attempts among black women in the US. That many women recover their mental health and wellbeing when they are no longer living with DVA is shown by research. Being diagnosed with a mental health problem leads to negative stereotyping, stigmatisation, and discrimination, and can result in social isolation and exclusion and women experiencing DVA are particularly vulnerable to the additional negative effects of being labelled as 'mentally ill'. They may find it even harder than other women to report or even to name their experience as DVA.

Since those experiencing DVA incur a range of acute and chronic health conditions, they are more likely to use health services. Women who experience DVA have twice the level of usage of general medical services and between three to eight times the levels of usage of mental health services. The NHS spends more resources dealing with the impact of violence against women and children than any other agency, which makes action to tackle the causes and consequences of such violence not only cost-effective but something that contributes to the health and well-being of the whole population. Addressing DVA in a range of health settings is increasingly emphasised and recent research indicates that it is a form of early intervention, as many of those who present to health settings are younger, experiencing high levels of abuse and unlikely to have sought help from elsewhere. Other estimates suggest that around two in every five people in contact with a GP, one in every five

people in contact with A&E and six in every 10 psychiatric inpatients have experienced DVA. Women experiencing DVA have a 50% increased risk of hospitalisation and over three times the risk of psychiatric hospitalisation. Thus, the medical and mental health costs are considerable, estimated at over £1.73 billion in the UK every year.

Even though victim-survivors have increased contact with health services and report a willingness to disclose abuse, health services have been criticised for failing to adequately respond to DVA. A Department of Health report into the health impacts of violence against women and children acknowledged that if this was a single disease with the known health consequences, the NHS would be far more focused on it than is currently the case. There is an argument to be made that the health impacts of DVA, incidences of which exceed that of diabetes and strokes, need to be taken just as seriously. However, despite these consequences for the physical and mental wellbeing of victim-survivors, many health professionals tend to underestimate the proportion of their clients who experience DVA and to have only limited contact with DVA services.

## **DVA and substance use**

The overlap between DVA and substance use (SU) is well established for both victim-survivors and perpetrators.

Research highlights that DVA victim-survivors are 15 times more likely to use alcohol and nine times more likely to use drugs. The extent of the overlap varies: women using substance treatment agencies in the US reported rates of DVA between 47% (violence was current) and 70%; women using crack cocaine or other opiates show particularly high rates of DVA, with up to 75% reporting current or past victimisation and 40% regular physical assault from current partner. Research in the UK which asked women accessing DVA services a question about a history of SU either for them or their partner reported that between 33% and 86% experienced problematic SU. In substance use agencies also, there was a significant proportion of service users experiencing DVA problems. The extent of the overlap varied from 40% to 67% depending on the service and whether the primary service users were men or women. High rates of SU and DVA (63%) were also reported for men attending perpetrator programmes. In another study, 40% of Asian women who sought treatment for alcohol use were experiencing DVA. A history of alcohol abuse was found in 49% of perpetrators.

A study showed different patterns of drinking between men and women: men drank nearly twice as much as women during an incident, but women's drinking was twice as common following the abusive attack. Other studies indicate that although the perpetrator may have alcohol problems, that incidents of abuse were often unconnected to the drinking. While women report their partners drinking at the time of the incident, most women also report being beaten when they were sober. Thus, though there are increased vulnerabilities where there is SU, this does not mean that drugs or alcohol cause DV. Perpetrators may be drunk because they want to be violent and their drinking becomes part of their repertoire for establishing a regime of fear and control, leading some to argue that the disinhibiting effects of alcohol do not on their own account for men's violence or negate men's responsibility for their behaviour. These patterns of SU need to be understood as they affect assessment issues, the priority on safety and the focus of intervention.

Much of the DVA perpetrated in the context of SU is at the severe end, with 50% of women requiring hospitalisation for injuries in the past 12 months, and is a factor identified as increasing the risk of DVA fatalities, suggesting that perpetrators who use both drugs and alcohol are the most dangerous. Both victim-survivors and perpetrators with SU issues report either perpetrating or being subjected to chronic DVA at the

severe end of the continuum; alcohol appears to be particularly important in escalating existing conflict. Of 38 women using DVA services, 50% reported being raped 63% were pressured to have sex; 71% had been threatened with being killed and 74% had been held or grabbed by the throat. The patterns of violence reported by men and women using SU agencies are similarly serious with reports of beatings, rape, sexual pressure, and strangulation. The use of substances as a 'disinhibitor' can give perpetrators the belief that they will not be held accountable or responsible for their violent behaviour. There is also evidence that alcohol is invoked as a post-offence excuse. A multi-site evaluation of perpetrator programmes showed that the man's drunkenness after programme intake made him three times more likely to re-assault his partner and if the man was drunk nearly every day, he was 16 times more likely to re-assault than those who seldom or never drank. Significantly, in terms of service intervention, reducing SU may reduce levels of physical injury but does not stop the DVA – physical assaults may still occur but they are usually less severe, but non- physical abuse such as psychological, sexual and financial abuse is likely to still continue without specific intervention to reduce and prevent the DVA.

A significant majority of victim-survivors also experienced mental health issues, with the most commonly reported being depression, anxiety and suicide attempts. The frequency and severity of DVA experienced and perpetrated by those with SU issues has major implications for children living in families where there is both SU and DVA. Research indicates that many women use alcohol and drugs to cope with the attacks to which they are subjected as a form of self-medication and as a coping strategy. Almost two-thirds of victim-survivors from DVA services reported that they began their problematic SU following their experiences of DVA; all saw a link between their SU and DVA; and the most commonly reported reason was to dull both the physical and emotional pain. However, around a third was using substances prior to their experiences of DVA. In contrast, 93% of perpetrators reported that they had SU issues before they became domestically violent. In the majority of cases, SU began before they perpetrated an incident of violence and for half their use increased during incidents of violence. Most women reported that they had also been abused when their partner/ex-partner was sober. Thus, despite the co-existence there is no evidence to suggest a direct causal link between SU and DVA: women's SU should never be used to justify or 'explain' their experiences of violence, nor should drug or alcohol use by either partner be accepted as an excuse for violent and abusive behaviour.

Although many women who access drug and alcohol services will have current or past experience of DVA, the primary presenting issue often masks additional needs: if a client presents with SU problems, any DVA issues usually remain hidden and vice versa. Studies show that SU professionals tend to underestimate the proportion of their clients who experience DVA, and to have only limited contact with DVA services. Women with problematic SU who also experience DVA may find it even harder than other women to report or even to name their experience as DVA. This is partly due to the secrecy and shame that surrounds both issues, as well as fear of being misunderstood or excluded from services, which, along with social isolation, can produce further dependence on a partner. Some women are introduced to substances by their abusive partners as a way of increasing control over them; when a woman's partner is also her supplier, it becomes particularly difficult for her to end the relationship. When a woman seeks support, information or treatment for her SU, her partner may become even more abusive, or may actively prevent or discourage her attendance at a SU service. Women whose partners misuse substances may minimise or excuse their violence on those grounds even though if SU ceases, the DVA usually continues. The probability that a woman will engage with treatment decreases if doing so will anger her perpetrator.

Similarly, women who are problematic substance users can be excluded from DVA services, as they find it difficult to support women because they lack confidence and/or are insufficiently resourced to support women

with high or more complex needs. As a result, women with problematic SU who also experience DVA are particularly likely to feel isolated and be negatively labelled, and they are particularly vulnerable to long-term DVA and possibly homelessness and thus have reduced options for help, support and safety. They also receive poorer responses from professionals. If a victim-survivor is drinking or using drugs then their ability to assess risk may also deteriorate, increasing the risk to their safety. Even though drug, alcohol and domestic violence agencies often serve the same client base, and while numerous services deal specifically with DVA or SU, few organisations in the UK are currently equipped to provide the range of services needed by victim-survivors or perpetrators of domestic violence who also experience problematic substance use. Differing models of working, time restraints and philosophies mean that drug, alcohol and domestic violence services often do not work together as effectively as they could. The need for mental health services and community drug and alcohol rehabilitation services to respond more effectively to women with issues of mental health, SU and DVA has been highlighted. Training in identifying and responding to DVA alongside any drug, alcohol or mental health intervention has also been underlined. Evidence about the link between SU and DVA (and mental health) needs to inform joint commissioning groups, to ensure a more intelligent approach to commissioning.

## **DVA and homelessness**

Re-housing victims of DVA is the responsibility of a local authority housing service and homelessness caused by DVA is regarded as a priority especially when there are children involved. It constitutes the second largest category for causing homelessness though the range of need and priority will vary between localities. Changes in housing benefit and demand on already limited housing stock have created greater challenges for many local authorities. Single men and women face additional barriers to accessing housing as they do not have the same rights to assistance from local authority under the homelessness legislation and may also have low priority for social or other housing tenures. While homeless people, regardless of gender, will share many common experiences, a failure to adequately understand the unique situations of homeless women can ultimately result in a failure to develop appropriate responses, and a failure to effectively tackle and prevent homelessness amongst women.

DVA is one of the leading causes of homelessness for women and many studies demonstrate the link between DVA and homelessness, particularly among families with children. The majority of homeless families are headed by women, due to the links between DVA, relationship breakdown and homelessness. Many homeless women are also 'hidden' from statistics because they spend time living with friends or relatives and do not appear to access homeless services. This may either be due to a lack of awareness of the services available to them or due to a lack of suitable or available provision. Victim-survivors of DVA require housing related support either to make it possible for them to remain safely in their own homes, or to support them if they are forced to move to alternative accommodation. Some women who escape DVA are forced to remain in temporary accommodation for long periods while they wait to be re-housed. Many homeless women have complex needs: mental ill-health, drug and alcohol dependencies, childhood spent in the care of the local authority, experiences of physical and sexual abuse and other traumatic life experiences are commonplace.

It is likely that homeless women are facing increased issues in getting access to housing and the support they need. Research indicates that homeless women's situations are not adequately taken into account by local authorities, and services are failing to reach those most in need. It has been found that over 20% of women became homeless to escape violence from someone they knew; very vulnerable women were those most likely to be excluded from social services and to stay in the most insecure and difficult situations – care leavers,

women with mental ill health and dependencies were all more likely to have slept rough, squatted, and stayed in emergency accommodation. A large number of homeless women had engaged in unwanted sexual experiences (paid and unpaid) in order to secure accommodation and basic necessities such as food and clothing. Thus, a lack of access to safe affordable housing and support, to alleviate homelessness after DVA, are significant issues for women and need to be addressed at a local level in a joined up way.

## **DVA economic exclusion and child poverty**

Economic abuse within a context of DVA is considerable, affecting between 43% and 89% of women irrespective of their class or economic status. It results in poverty, debt and financial exclusion. As a means to gain complete control, economic abuse can take many forms: preventing victim-survivors from having access to their own money; making them account for every penny spent; not allowing them to spend the household income on themselves or their children; controlling bank accounts or benefits received; and stealing, taking or demanding money for their own use. DVA can undermine women's autonomy and the self-confidence needed to seek or maintain paid work and abusive men often sabotage their partners' attempts to become self-sufficient through education, job training or employment. A lack of access to money makes it harder to leave an abusive partner. Research shows that one in three abused women at the point of accessing DVA services do not have a bank account.

Leaving DVA results in (increased) poverty, irrespective of the victim-survivor's background, as women and children go into temporary accommodation and become dependent on income support and housing benefit. The barriers faced by many women after leaving DVA are not simply access to housing, money, work or education, but the ways in which both their aspirations and sense of self become undermined through abuse. The connections between DVA and women and children's poverty are well recognised - a high proportion of children in poverty live in lone parent families, 92% of single parents are women and one in six lone mothers have experienced DVA. Since one in five children and young people in England live in poverty and outcomes for children raised in poverty are significantly worse than for those who are not, addressing child poverty is a national and local priority. Women are at greater risk of poverty than men, are more likely to suffer recurrent and longer spells in poverty, and are the main managers of family poverty. Women face continued barriers and disadvantage in the labour market and where mothers are struggling with current/past experiences of DVA, their capacity to parent, to sustain and succeed in employment are also compromised.

Moreover, poverty and financial dependence are factors associated with increased risk of DVA (this does not mean that DVA is not found in better-off households). Families with a disabled adult are at increased risk of poverty and DVA. Similarly, teenage parents are more likely to live in poverty and there is a significant correlation between teenage pregnancy and DVA. The impact on children of living with poverty and DVA is significant. DVA impacts on parenting capacity and resources, and has a serious impact on children's life-chances, most importantly around safety and well-being. There are multiple pathways, therefore, through which DVA can reinforce and reproduce disadvantage.

## **DVA women offenders and youth violence**

The Corston Report (2007) found that women with histories of domestic and sexual violence are significantly over represented in the criminal justice system as offenders or are at risk of offending and have complex needs. Compared with male offenders, proportionately more women than men are remanded in custody; relationship

problems feature strongly in women's pathways into crime; and coercion by men can form a route into criminal activity for some women. Substance abuse also plays a large part in all offending and is disproportionately the case with women. Self-harm and mental health problems are far more prevalent among women offenders than male offenders or those in the general population.

The Corston Report called for improved community alternatives to custody for women and investment in supporting and diverting women away from offending as imprisonment is both costly and brings its own set of problems for both women offenders and their children. It found that projects in the community have a better chance of supporting women offenders or those at risk of offending and in keeping them out of prison. Research has also identified the links between domestic and sexual violence, and the impact of gang violence and serious youth violence on women and girls. Whilst boys and young men are more likely to be involved in gangs and/or carry (or be threatened with) weapons, the role of girls and young women in gangs has been insufficiently recognised though there are some initiatives to address this gap.

There are many ways in which women and girls' experiences relate to serious youth violence. As well as participating in gangs, minding weapons, and acting as alibis for male gang members, young women are frequently the targets of violence. Association with a gang member places them at risk of rape and sexual assault, as retaliation by others, since sexual violence is used as a weapon against females associated with gangs. Mothers, sisters, girlfriends and friends of male gang members, as well as females directly involved in gang offending, have described the use of domestic and sexual violence, coercion and exploitation as well as girls' attitudes towards the role of sex in relationships as being problems for them. Rape, often in the context of DVA, has become a weapon of choice, and used against girlfriends, sisters and on occasion mothers. This use of sexual violence takes place against a backdrop where girls have little peer support, where girls and boys are extremely confused about consent and their own motivations for engaging in sex, and where young people have little to no understanding of coercion.

Gang-associated women and girls rarely disclose their victimisation because of fears about reprisal and the belief that their criminal association means that they are not privy to state protection. Research has found that girls struggle to identify services that are independent of the state and have little or no confidence in claims of confidentiality by any service. Given the lack of intelligence on these issues, statutory services are not clear how they should respond to gang-related sexual violence, and cannot guarantee the safety of girls associated once they have disclosed exploitation or assault when using standard safeguarding models. Girls who carry firearms and drugs for their boyfriends often live in areas that are not perceived to have a 'gang-problem'; may attend grammar or private all-girls schools; will rarely be under any form of surveillance or be known to services such as children's or youth offending services and have their own bank account where their boyfriends can store their money. These girls rarely receive interventions and struggle to identify routes of support.

Women and girls affected by gang related violence have largely been ignored in both policy and practice which has been aimed at young men or adult women. This has a severe impact on their ability to address their offending behaviour and reduce their victimisation.

## **Impact on employers and employees**

DVA has a detrimental impact on businesses and employers. It can affect the productivity of employees, result in absenteeism and turnover, lost productivity, stress, and workplace violence that threaten the safety of all



employees. In 2009, DVA cost UK businesses £1.9 billion in lost economic output caused by physical injuries sustained as a result of DVA and there are additional losses to productivity as a result of stress and reduced performance. Research shows that one in ten people who had experienced DVA had been forced to take time off work because of its effects, and 20% of these had been absent for more than a month. Research in the USA has suggested that up to half of women have at some stage in their lives had to give up a job because of DVA. Moreover, an individual's concentration and ability to focus on their workplace duties is adversely affected by DVA and workplace harassment. Since more than one in ten victims of DVA chooses to confide in a manager or colleague, workplaces require clear and effective employer responses.

Perpetrators may use workplace resources such as time, phones, fax, e-mail or other means to threaten, harass or abuse their current or former partner. Any employee may also intentionally misuse their job-related authority – or encourage colleagues to do so – to assist perpetrators to locate their partners, assist in perpetrating acts of DVA or protecting an abuser. There are many benefits to employers addressing DVA: increase employee productivity and morale, reduce employee turnover thereby saving money, and reduce the risk of violence and save lives. Actions identified for employers and businesses include: creating workplace policies on DVA and reviewing existing policies to identify ways to promote and improve safety in the workplace; training and educating employees on DVA violence issues; providing access to workplace counselling, healthcare and other benefits; taking action against perpetrators convicted of DVA; making resources, posters and information available in the workplace; showing leadership in local communities by supporting DVA issues and fundraising for specialist support services.

Good practice on identifying and responding to DVA in the workplace can make a great deal of difference to victim-survivors seeking help and leading violence-free lives, thus significantly reducing the cost of DVA to the employer.

## Limitations of DVA data

The most reliable estimates of the extent of DVA are drawn from the CSEW and it is also established that only a minority of incidents of domestic and sexual violence go through the criminal justice system. For instance, DVA is both under-reported to and under-recorded by the police, with only around a quarter being reported and the proportion of incidents recorded as crimes is even less. Thus, information available on DVA within the criminal justice system provides an inadequate picture of the extent of the problem and relying on this as a primary source of local data has significant drawbacks. Crimes are reported in areas where services are responding to need and the presence of 'hot-spots' may reflect good practice, not the need for additional resources or services in those specific localities. Moreover, where offences take place in public places they may be incorrectly recorded because the relationship between the perpetrator and the victim is unclear or concealed. Reasons for not reporting DVA include a lack of information and awareness about sources of help, fear of retaliation from their abuser, a belief that the police will do anything about the incident, and a fear of the consequences such as their children being removed. DVA is less likely to be reported to the police by some BME groups, LGBT communities, and disabled victim-survivors.

Despite the acknowledged low level of reporting to the criminal justice system, DVA is still estimated to account for about 17% of all violent crime and is significantly implicated in femicide. Although there is no specific statutory offence of domestic violence, many forms of DVA are crimes – harassment, assault, criminal damage, stalking, attempted murder, false imprisonment, and forced marriage. Perpetrators can be prosecuted

for offences of rape, sexual assault, human trafficking, prostitution, sexual exploitation and child pornography and FGM. Other than the justice system, many more victim-survivors seek help, support or information from other services, such as housing, education, social care, health and the voluntary sector though some may be less likely than others to disclose DVA and to seek help. For instance, DVA victims of sexual violence committed by partners and ex-partners are less likely to tell anyone about their experience and those with no recourse to 'public funds' feel trapped and are less likely to seek help because of limited options. Victim-survivors seldom directly disclose the abuse unless seeking to leave. Even where responses to DVA are developed and specialist services exist, awareness of the availability of support services is low across all groups of victim-survivors, as is any knowledge of how to get help and information. In general, victim-survivors tend to first seek help, support and practical assistance from their informal networks, such as family members and friends before approaching other formal services. It is often only within the context of long term work such as prevention, awareness raising and empowerment carried out by specialist DVA services that many women are able to discuss their experiences and name it as DVA.

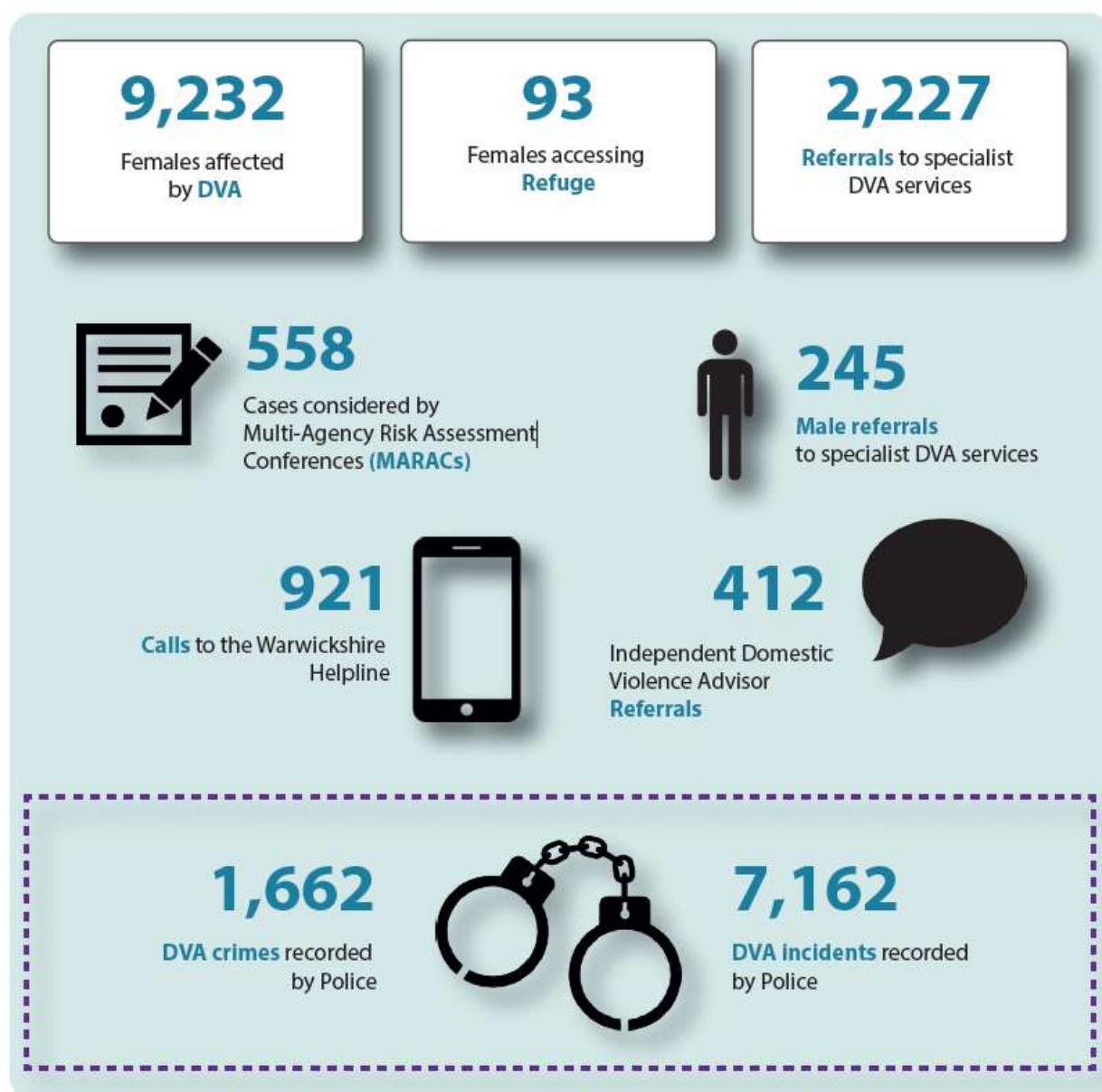
Issues around data collection and reporting can be further complicated if statutory and other services do not have systems in place to effectively identify, record, and respond to DVA. Victim-survivors have little trust or confidence in statutory services and consistently report that they are disbelieved or negatively judged and often not informed about support services. In particular, as part of 'mother-blaming' discourses, many women fear their children being taken off them. Research indicates that particular groups of women are labelled by services (disabled, sex worker, offender, traveller, drug-user, asylum-seeker), which exacerbates the poor response they receive and further hampers their help-seeking. Notably, victim-survivors often do not have high expectations of services but they repeatedly view their ideal service as one that listens and believes them without judgement; that treats them with dignity and respect; that helps them be safe; and that is accessible and available when they need support for as long as they need it. Research with victim-survivors reports that they want to be taken seriously, to be treated respectfully and to be believed; they are equally concerned with how a service is delivered as what is delivered.



# The Local Picture

## Summary of DVA in Warwickshire

The following illustration highlights the key DVA statistics identified by this needs assessment. The figures are per annum and are the average number based on the period analysed.



Source: Warwickshire Community Safety Team, Warwickshire Police, images: [www.flaticon.com](http://www.flaticon.com)

### Key findings:

- Police recorded DVA saw a gradual reduction over the period 2010 – 2015. However, new recording practices introduced in 2015/16 are changing this trend quite significantly.
- Nuneaton and Bedworth Borough recorded the highest rate of DVA incidents per 1,000 population with the lowest rate recorded in Stratford-on-Avon District.
- Violence with injury accounted for 51% of DVA crimes recorded; violence without injury accounted for 34%.
- 39% of the DVA crimes recorded were tagged with a drugs/alcohol interest marker.
- Between 2010 – 2015 the fiscal cost of DVA to agencies in Warwickshire is estimated to have been £99 million.
- There are an estimated 450 deaf women at risk of DVA in Warwickshire.
- There were 2,789 cases discussed at MARAC during 2010 – 2015 involving 3,574 children.
- Alcohol was a feature in 29% of the MARAC cases, drugs 21%, mental health 12%.
- The number of DVA cases heard by the courts in Warwickshire increased from 182 in 2012/13 to 259 in 2014/15. However, the percentage that resulted in a successful prosecution dropped from 77% to 64% in the same period.
- The number of DVA cases heard by the Specialist Domestic Violence Court increased from 312 in 2011/12 to 466 in 2014/15. The percentage that resulted in a successful prosecution has seen a gradual increase from 79% to 83% in the same period.
- Number of calls to the Warwickshire DVA helpline reduced over the period 2012 -2015 but referrals for specialist support increased from 1,500 in 2012/13 to 3,843 in 2014/15.
- Warwickshire has 23 units of refuge accommodation available to female DVA victim-victim-victim-survivors and their dependent children. This is a shortfall of 32 based on Council of Europe recommendations of 1 bedspace per 10,000 population.
- A high percentage of Victim Support referrals are DVA victim-victim-victim-survivors.
- Services in Warwickshire for perpetrators are limited with some work delivered by DACS and some through the Integrated Offender Management function.
- In 2014/15, details of 1,148 DVA offenders were recorded by Warwickshire Police. The vast majority of offenders were male (82%) and between the ages of 20-29.

## Estimated Local Prevalence

Estimated prevalence of adult DVA in Warwickshire is as follows:

District/Borough	Adult Female Population	Estimated DA cases	% of county	High risk at some point
North Warwickshire	26,402	1,056	11.4	105
Nuneaton & Bedworth	52,453	2,098	22.7	209
Rugby	41,643	1,666	18.0	166
Stratford	52,401	2,096	22.7	209
Warwick	57,905	2,316	25.1	231
<b>Total</b>	<b>230,804</b>	<b>9,232</b>	<b>100</b>	<b>920</b>

This estimate has been calculated by applying the Cardiff Model, developed by the Women's Safety Unit at Safer Wales<sup>9</sup>, to the most recent population statistics from the Office for National Statistics for 2014. The high risk element is calculated based on research by Safelives which estimates that 10% of cases will be high risk at some point.

There are currently no equivalent models of estimating need in relation to adult males. We can therefore expect these figures to be far higher when this is taken into account.

## Police Recorded DVA

### Data Integrity

It should be noted that Warwickshire Police has instigated a number of changes to how crime is recorded for the year 2015 – 2016. This followed recent inspections by Her Majesty's Inspectorate of Constabulary (HMIC) which revealed weaknesses in police crime recording, particularly the under-recording of crimes. This is a national issue and not just something affecting Warwickshire. As a consequence, we are currently experiencing an increase in levels of crime recording and as such 2015 – 2016 will establish a new baseline for this data.

### Recorded DVA Incidents

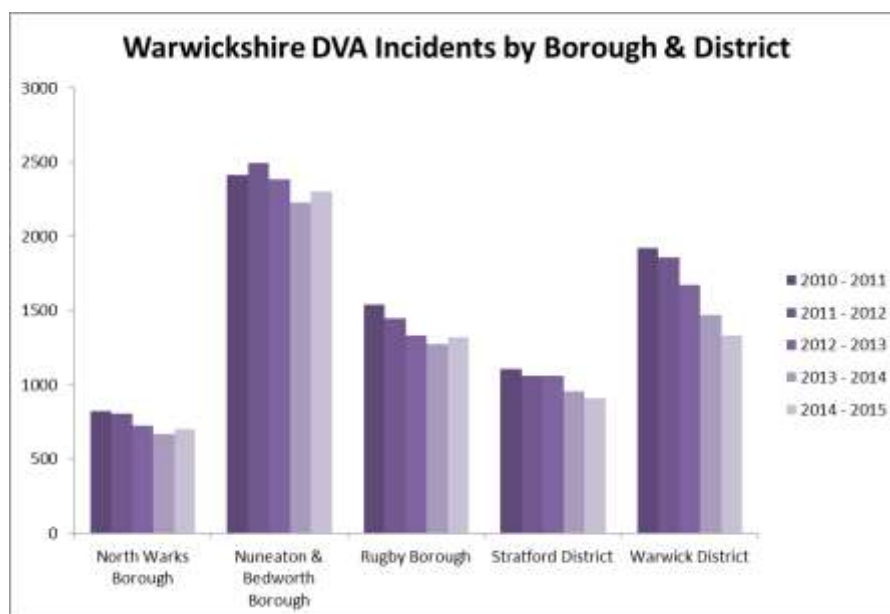
Data in respect of DVA incidents, crimes and offences in Warwickshire covers the five year period from April 2010 to March 2015. This has been supplied by Warwickshire and West Mercia Police from their Performance and Information Department based at Hindlip Hall, Worcester.

An incident in this context is a report of events received by the police, recorded on the electronic incident systems, which require police attention. Whether or not an incident report becomes a crime record is determined on the balance of probability that a notifiable offence has occurred as set out in the Home Office

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<sup>9</sup> The Cardiff Model estimates that there will be 400 cases of domestic abuse in every 10,000 of the adult female population. 'Cases' refers to individuals rather than the number of incidents, and there may be multiple incidents per case.

Counting Rules. If an incident does not turn out to be a crime, it must still be logged in an auditable form on the force's incident-recording system or some other accessible or auditable means.

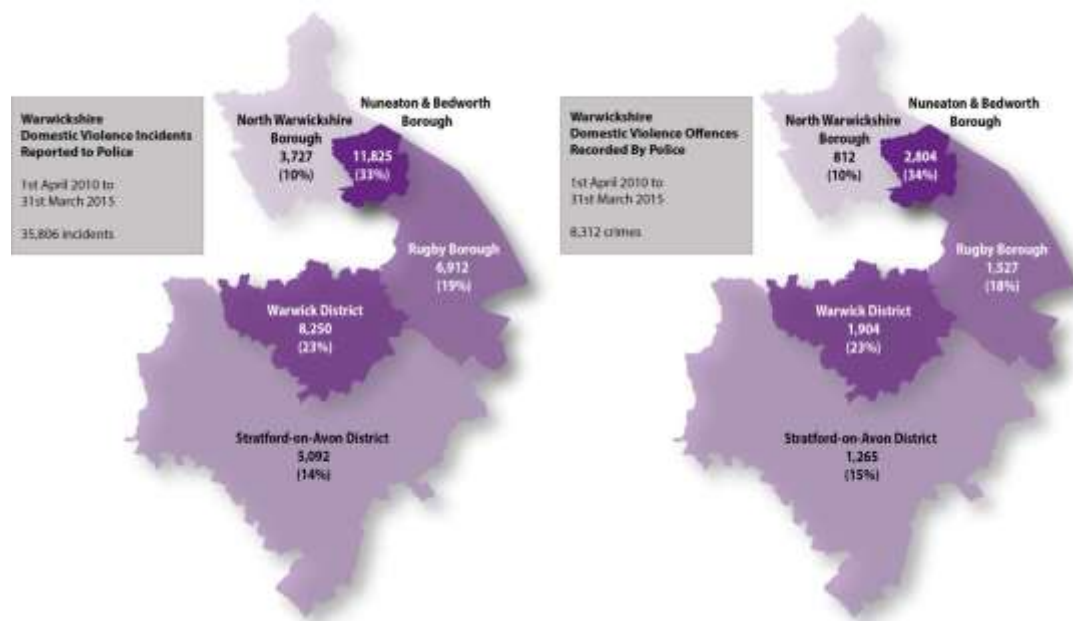


Source: Warwickshire & West Mercia Police

A total of 35,806 incidents with a DVA marker were recorded by the police during the period April 2010 to March 2015. Nuneaton and Bedworth Borough recorded a total of 11,825 (33%) followed by Warwick District 8,250 (23%), Rugby Borough 6,912 (19%), Stratford-on-Avon District 5,092 (14%) and North Warwickshire Borough 3,727 (10%). The figures show a gradual decrease over the 5 year period.

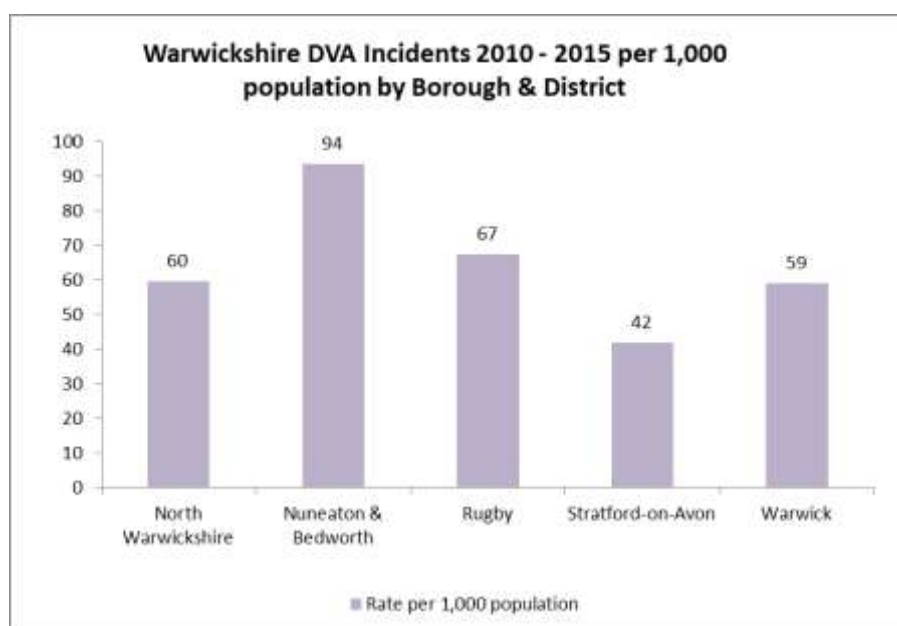
## Recorded DVA Crimes

The total number of DVA crimes recorded by the Police over the same period was 8,312. The vast majority involved violence to the victim. Violence with injury amounted to 4,213 of the DVA recorded crimes which was 51% of all DVA recorded crime. Violence without injury amounted to 2,811 (34%), criminal damage and arson 561 (7%), other crimes against society 356 (4%) with 153 recorded offences of rape (2%). These five categories of crime total 97% of all recorded DVA crime.



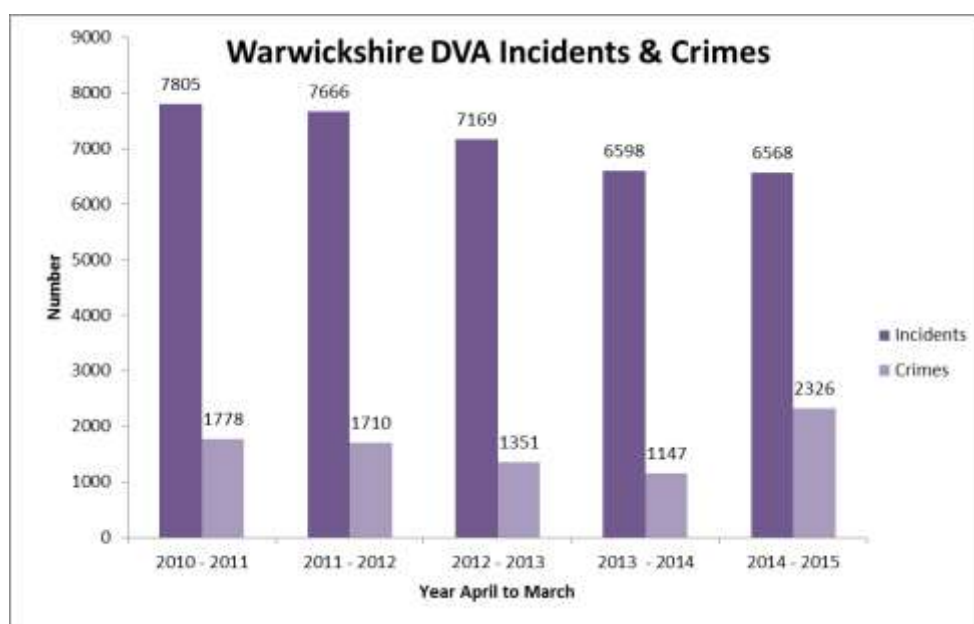
Source: Warwickshire & West Mercia Police

Incidents per thousand of the population within the county of Warwickshire broken down into boroughs and districts reveal that Nuneaton and Bedworth Borough has the highest rate of 94 with Stratford-on-Avon District the lowest at 42. North Warwickshire Borough, by comparison, despite having the least number of incidents has the third highest rate at 60 per thousand of population.



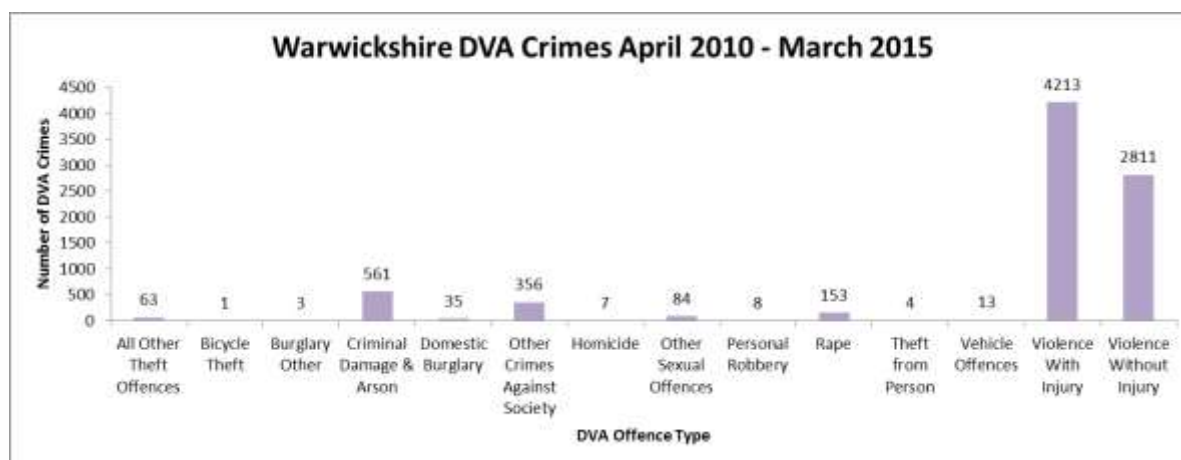
Source: Office for National Statistics (ONS) Mid 2014 Population (Estimates) and Warwickshire & West Mercia Police

Comparison of the number of DVA incidents against the number of recorded crimes illustrates a wide gulf between the two.



Source: Warwickshire & West Mercia Police

For the year April 2010 to March 2011, recorded DVA crime was 23% of the DVA incidents. In the period 2011/12 (22%), 2012/13 (19%), 2013/14 (17%) and in 2014/15 the figure more than doubled to 35%. This illustrates the distorting effect of the changed and tighter recording practices which have been introduced coupled with back record conversion into crimes of some incidents from the previous year.



Source Warwickshire & West Mercia Police

The most prevalent DVA crimes in Warwickshire during the period under review were those involving violence. Violence with injury accounted for 51% with violence without injury at 34% of the total. Criminal damage and arson were 7% of the total followed by other crimes against society 4%, rape 2%, other sexual offences 1% and all other theft offences 1%.

The offence category 'other crimes against society' is a group of offences recorded by the police which do not generally have a specific identifiable victim. Trends in such offences tend to reflect changes in police workload and activity rather than in levels of criminality. For example, in recent years the increases in recorded drug offences are thought to have been influenced by proactive policing in this area. Offences in other crimes against society fall into four main categories:-

- Drug offences
- Public order offences
- Possession of weapons offences
- Miscellaneous crimes against society which in the main comprises handling stolen goods, threat to commit criminal damage and perverting the course of justice.

Of the DVA crimes recorded by the police, a consistent 39% of them were tagged with a drugs – alcohol marker over the five year period analysed. Crimes of violence with injury accounted for 61% of these markers and crimes of violence without injury 29% which together accounted for 90% of the total.

Analysis of crimes with markers for Forced Marriage (FM), Honour Based Violence (HBV) and Female Genital Mutilation (FGM) revealed that only two crimes carried these markers in the five year period analysed. One crime in the Nuneaton and Bedworth Borough was tagged with a HBV marker in 2014 whilst in Stratford-on-Avon District; one crime was tagged with both a FM and HBV marker also in 2014.

## Recorded Crime April 2010 to March 2015

During this period, Warwickshire Police recorded a total of 149,990 crimes broken down as follows:

**Warwickshire Total Recorded Crime & DVA Crime April 2010 to March 2015**

Crime Category	All Crime	DVA Crime	DVA as % of Crime Category	Crime Category as % of Total Crime
Violence Without Injury	8,512	2,811	33%	6%
Violence With Injury	13,757	4,213	31%	9%
Homicide	23	7	30%	0%
Rape	802	153	19%	1%
Other Sexual Offences	1,779	84	5%	1%
Other Crimes Against Society	12,345	356	3%	8%
Criminal Damage & Arson	24,288	561	2%	16%
Personal Robbery	1,106	8	1%	1%
Domestic Burglary	9,254	35	0%	6%
Theft from Person	1,413	4	0%	1%
All Other Theft Offences	26,585	63	0%	18%
Vehicle Offences	20,713	13	0%	14%
Bicycle Theft	3,819	1	0%	3%
Burglary Other	13,763	3	0%	9%
Business Robbery	272	0	0%	0%
Shoplifting	11,559	0	0%	8%
<b>Total Crime</b>	<b>149,990</b>	<b>8,312</b>	<b>6%</b>	<b>100%</b>

*Source: Warwickshire & West Mercia Police*

The table has been sorted to display where DVA crime forms the largest percentage of the individual crime categories. The column alongside displays the volume each particular crime category forms of the total amount of crime committed. Violence without injury accounts for 6% of all the crime committed in Warwickshire during this period yet as a crime category, 33% of all these crimes are DVA related. The top four categories, despite totalling a relatively modest percentage of the total crime, are nevertheless, significant within each category for being DVA related.



Following their inspection and report<sup>10</sup> of Police Forces in England and Wales in 2014 on the police response to DVA, HMIC reported that 8% of all recorded crime was DVA related compared with the 6% total recorded in Warwickshire.

## The Cost of DVA

The cost of domestic violence to agencies is extremely high, particularly as this type of crime remains under reported and the true cost unknown. As part of the Troubled Families national programme, updated costs have been released which provide an update to the costs provided by Sylvia Walby's report 'The Cost of Domestic Violence 2009'. For this assessment the updated costs have been applied to the Warwickshire figures to reveal the cost of both domestic related incidents and offences.

The table below shows the fiscal cost for incidents reported in Warwickshire, by district and borough, for the Police, Local Authorities, Criminal Justice System and the NHS. The cost of each reported domestic incident to these agencies is £2,766.

There were 35,806 incidents reported in Warwickshire for the five year period 1<sup>st</sup> April 2010 to 31<sup>st</sup> March 2015 which is a cost of approximately £99 million over the five year period, costing £20 million per year. Nuneaton and Bedworth Borough reported the highest number of incidents and the total cost is almost £33 million.

District / Borough	Number of Domestic Related Incidents 1st April 2010 to 31st March 2015	Cost per Domestic Incident to the police, LAs, CJS and NHS (Per Incident)	Total Cost for Period 1st April 2010 to 31st March 2015
North Warwickshire	3,727	£2,766	£10,308,882
Nuneaton & Bedworth	11,825	£2,766	£32,707,950
Rugby	6,912	£2,766	£19,118,592
Stratford-on-Avon	5,092	£2,766	£14,084,472
Warwick	8,250	£2,766	£22,819,500
<b>Warwickshire</b>	<b>35,806</b>	<b>£2,766</b>	<b>£99,039,396</b>

Source: Warwickshire Police, Unit Cost Database (v.1.3) Manchester Cost Database - Troubled Families Programme

Focusing on domestic related offences, those recorded crimes with a domestic marker, these costs have been split down by crime type. Over the period of five year period 1<sup>st</sup> April 2010 to 31<sup>st</sup> March 2015 there have been 7 domestic related murders in Warwickshire which have cost agencies approximately £1.3 million.

Over the same period there have been 4,213 violence with injury offences in Warwickshire with a domestic marker, which cost agencies approximately £12.3 million, and violence without injury offences which cost approximately £1.3 million.

Nuneaton and Bedworth Borough recorded the highest number of domestic related rape and other sexual offences over the period, 82 in total, and cost agencies approximately £313,240.

<sup>10</sup> <http://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/2014/04/improving-the-police-response-to-domestic-abuse.pdf>



Criminal damage and arson offences have been reducing for a number of years but there were 561 offences which were domestic related over the five year period in Warwickshire and cost agencies £90,321. Nuneaton and Bedworth Borough recorded the highest number of offences, 209, costing agencies approximately £33,649.

Recorded Crime with a Domestic Marker	Cost Per Crime	North Warwickshire Total Cost of Crimes 1st April 2010 to 31st March 2015	Nuneaton & Bedworth Total Cost of Crimes 1st April 2010 to 31st March 2015	Rugby Total Cost of Crimes 1st April 2010 to 31st March 2015	Stratford-on-Avon Total Cost of Crimes 1st April 2010 to 31st March 2015	WARWICKSHIRE Total Cost 1st April 2010 to 31st March 2015
<b>Other Theft Offence</b>	£380	£4,560	£7,980	£5,320	£1,900	<b>£23,940</b>
<b>Burglary Other</b>	£1,696	£1,696	£1,696	£0	£0	<b>£5,088</b>
<b>Criminal Damage and Arson</b>	£161	£7,406	£33,649	£16,422	£11,109	<b>£90,321</b>
<b>Domestic Burglary</b>	£1,446	£2,892	£21,690	£11,568	£4,338	<b>£50,610</b>
<b>Homicide</b>	£185,195	£0	£370,390	£555,585	£185,195	<b>£1,296,365</b>
<b>Other Sexual Offences</b>	£3,820	£34,380	£106,960	£64,940	£38,200	<b>£320,880</b>
<b>Personal Robbery</b>	£3,902	£3,902	£7,804	£15,608	£3,902	<b>£31,216</b>
<b>Rape</b>	£3,820	£34,380	£206,280	£114,600	£126,060	<b>£584,460</b>
<b>Theft from Person</b>	£380	£380	£380	£0	£0	<b>£1,520</b>
<b>Vehicle Offences</b>	£158	£316	£1,264	£0	£158	<b>£2,054</b>
<b>Violence With Injury</b>	£2,937	£1,251,162	£4,358,508	£2,179,254	£1,885,554	<b>£12,373,581</b>
<b>Violence Without Injury</b>	£483	£129,927	£408,135	£262,752	£222,180	<b>£1,357,713</b>

Source: Warwickshire Police, Unit Cost Database (v.1.3) Manchester Cost Database - Troubled Families Programme

## Links to Health Data

### Accident and Emergency Department (A&E) Assault Database

An assault database was implemented in 2008 in the Hospital of St. Cross, Rugby with the aim of recording anonymous details of each assault victim that presented at the A&E department. The database was installed and is currently managed by Linxs Consultancy which continues to gather data. From April 2008 to June 2015, over 1,100 people were dealt with in the A&E department who were injured as a result of assaults.

Data that is recorded in the database includes various demographics such as age, gender and ethnicity. It also includes details that are pertinent to the assault such as the time and date of the assault, location details, whether weapons were used and also the relationship of the victim to the assailant. Patients are presented with a leaflet which explains the reasons for the data collection and are advised that the questions are not mandatory. The questions are asked as part of the usual attendance registration process.

Of the patients that were treated, 22% were aged between 18 and 21 years with 54% between the ages of 17 and 27 years. The vast majority were male (71%) and White British (81%). The relationship between the assailant and the victim where they were an acquaintance, partner or ex-partner, relative or known to the victim accounted for nearly half (47%) of those treated.

The police were aware of over half of the assaults (58%) as the victim had advised they had already reported the assault to Police or a Police Officer was in attendance at the hospital. A further 2% expressed their intention to report the matter to the police at a later stage which leaves 40% of these assaults excluded from any police statistics. A little over half (54%) admitted to having consumed alcohol when examined at the hospital.

## **DVA and Deaf Women**

Research by deaf charity Sign Health has estimated that there are 450 deaf women at risk of DVA in Warwickshire. This estimate is based on NHS data detailing the numbers of deaf people and deaf women living in Warwickshire and the statistic that one in two deaf women are at risk of abuse (twice the rate of hearing women). It also builds in a percentage for deaf women who come from BME groups, East European countries and migrant populations who may not be included in the NHS statistics.

According to Sign Health, Deaf women who are suffering DVA are extremely unlikely to access hearing services and therefore often not included in statistics. They remain a hidden group, unknown to providers, because they cannot access hearing services due to communication difficulties. Even if they were able to access them, they lack trust and confidence in current services and are very unlikely to come forward. In addition, deaf victims fear a backlash from the deaf community if they report abuse. In this respect they are very similar to BME communities who fear retribution from family and the wider community if they come forward.

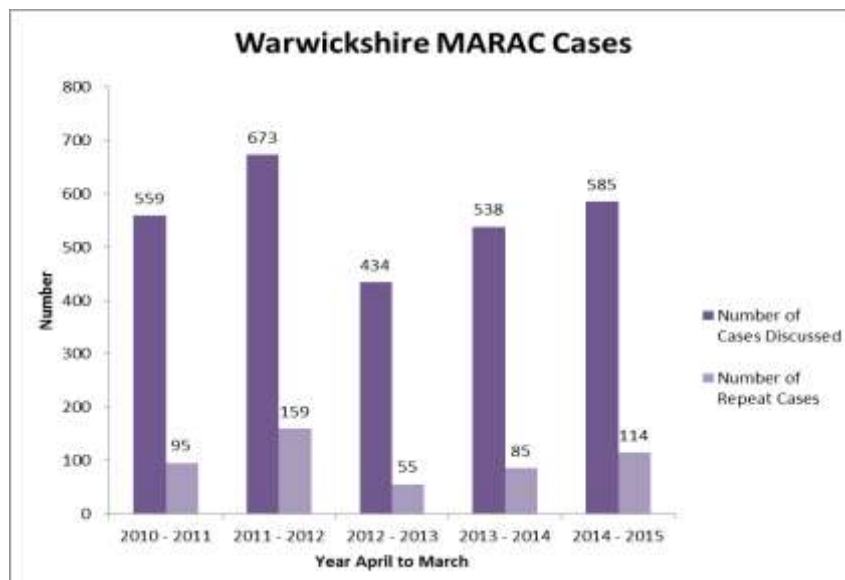
## **Multi-Agency Risk Assessment Conferences (MARAC)**

MARACs are held in Warwickshire on a monthly basis in North Warwickshire, Rugby and South Warwickshire. Cases heard at MARAC are typically classified as high risk. This means that a professional has completed a formal risk assessment and deemed that there is imminent risk of serious harm; the potential event is more likely than not to happen imminently and the impact could be serious. MARAC in Warwickshire works to an agreed operating protocol<sup>11</sup> the purpose of which is to establish accountability, responsibility and reporting structures for the MARAC and to clearly outline the process of the MARAC.

During the period April 2010 to March 2015, 2,789 cases were discussed by MARAC in Warwickshire of which 508 (18%) were repeat cases. A repeat MARAC case is one which has been previously referred to a MARAC and at some point in the twelve months from the date of the last referral a further incident is identified. Of the cases discussed by MARAC, a total of 3,574 children were in the households of those affected. This equates to an average of 1.3 children in the household of every case discussed by MARAC.

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<sup>11</sup> <http://www.talk2someone.org.uk/CHttpHandler.ashx?id=1569&p=0>



Source: Stonham (Home Group Ltd.) Domestic Abuse Support Service<sup>12</sup>

The overwhelming majority of referrals to MARAC come from the Police (92%) with the Probation Service (3%), Voluntary Sector (2%), Independent Domestic Violence Advisor (IDVA) (1%) and other sources 1%.

Of the total number of cases discussed by MARAC, 11.5% involved the Black and Minority Ethnic (BME) community. Cases where the victim has a disability accounted for 1.0% and cases involving the Lesbian, Bisexual, Gay and Transgender (LBGT) community accounted for 0.4%. Male victims account for 5.2% of the cases discussed. The cases where the harm affects people 17 years or younger accounts for 0.5% and the number of victims aged between 16 and 17 years is 0.4% of the total.

Data outlining the outcomes of MARAC together with identified factors involved in the cases discussed is not available before May 2014. Data, however, is available for the period May 2014 to June 2015 and some analysis of this provides an insight into the MARAC outcomes and some of the factors involved. During this limited period under review, a total of 696 cases were discussed of which 132 (19%) were repeat cases and the average number of children per household discussed by MARAC was 1.4. These are consistent with the period April 2010 to March 2015.

Analysis of the outcome of each MARAC case since May 2015 is sub-divided into four separate classifications of Removed, Avoided, Reduced and Accepted. These are used by MARAC to establish what sort of impact the MARAC has had on managing the risk to the victim of the abuse.

**Removed** – This is where MARAC feel the risk is removed. This may be where the victim has moved away and it is felt unlikely that the perpetrator would find them. Alternatively, when the perpetrator is sentenced to a significant term of imprisonment and it is felt the perpetrator doesn't have the ability to get someone else to commit the abuse on their behalf.

**Avoided** – Where the perpetrator is remanded in custody or the victim is staying at a temporary safe location.

<sup>12</sup> Domestic Abuse Support Service includes: Independent Domestic Violence Advisor (IDVA) Service, MARAC Co-ordinator, Sanctuary scheme, Freedom Programme, Floating Support, Black & Minority Ethnic (BME) Support and Male Victims Worker

**Reduced** – Where there are measures in place that reduce the impact of the risk, such as bail conditions that appear to be being complied with and or where the victim’s address has been target hardened. This effectively means any measure taken that has reduced the risk to the victim.

**Accepted** - This outcome is used where it is felt that MARAC hasn’t been particularly successful in reducing the risk to the victim. Reasons for this may include:

- The victim still in relationship with perpetrator.
- The perpetrator breaches bail or orders such as restraining orders.
- No controls in place.
- The status of the police investigation not known.

Nearly half of all outcomes with 392 (49%) fell into the accepted category followed by 252 (36%) reduced, 50 (7%) avoided and 35 (5%) removed.

Data relating to the factors in the MARAC cases being discussed is collated under the four fixed main headings of alcohol, drugs, mental health and pregnancy together with a free text opportunity to include others. Alcohol accounts for 203 (29%) of the factors collated, drugs 147 (21%), mental health 81 (12%) and pregnancy was cited as a factor on 5 occasions (1%).

Further analysis of the free text ‘other’ category revealed 190 factors which amounts to 27% of the total cases discussed. Within this section, lifestyle featured on 19 occasions (3%) followed by child contact 18 (3%), finance 13 (2%), housing 11 (2%) and isolation 11 (2%).

## The Criminal Justice System and DVA

### Crown Prosecution Service

The Crown Prosecution Service (CPS) is the principal prosecuting authority for England and Wales, acting independently in criminal cases investigated by the police and others. The CPS was established in 1986, under the Prosecution of Offences Act 1985, and the way in which it undertakes its role is governed by two key documents, the Code for Crown Prosecutors<sup>13</sup> and Casework Quality Standards (CQS)<sup>14</sup>.

CPS data for Warwickshire covers the period April 2012 to March 2015 and DVA cases are identified by a monitoring code on their system. They do not collect data on the type of the offences involved or the sentences, but they are able to show the results and outcomes from April 2012 onwards, together with some defendant demographic information as far as this is captured.

The figure shown as ‘finalised’ is the number of defendants for whom prosecution has been completed. This means they have been charged and have been through the criminal justice system to the point of either conviction or acquittal. A single case can be heard in multiple court centres, but for this purpose, the figure only counts against the last court in which the case was heard. The five courts within Warwickshire are

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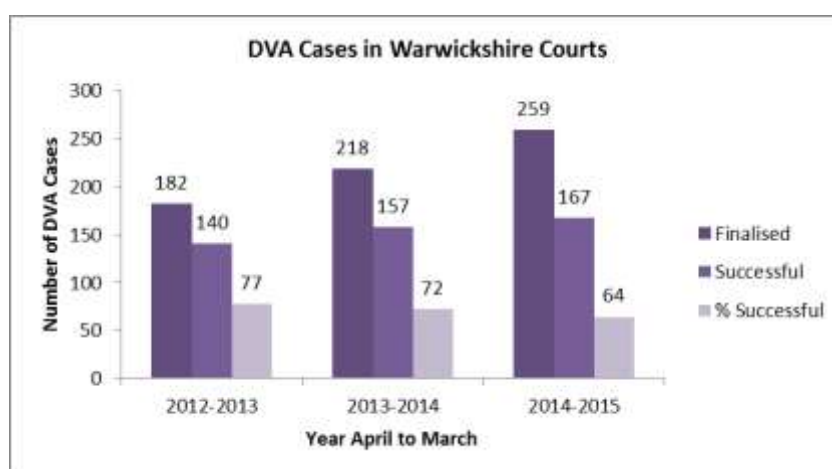
<sup>13</sup> [http://www.cps.gov.uk/publications/docs/code\\_2013\\_accessible\\_english.pdf](http://www.cps.gov.uk/publications/docs/code_2013_accessible_english.pdf)

<sup>14</sup> [http://www.cps.gov.uk/publications/docs/cqs\\_oct\\_2014.pdf](http://www.cps.gov.uk/publications/docs/cqs_oct_2014.pdf)

Leamington Spa and Nuneaton Magistrates', Leamington Spa and Nuneaton Youth Courts and Warwick Crown Court.

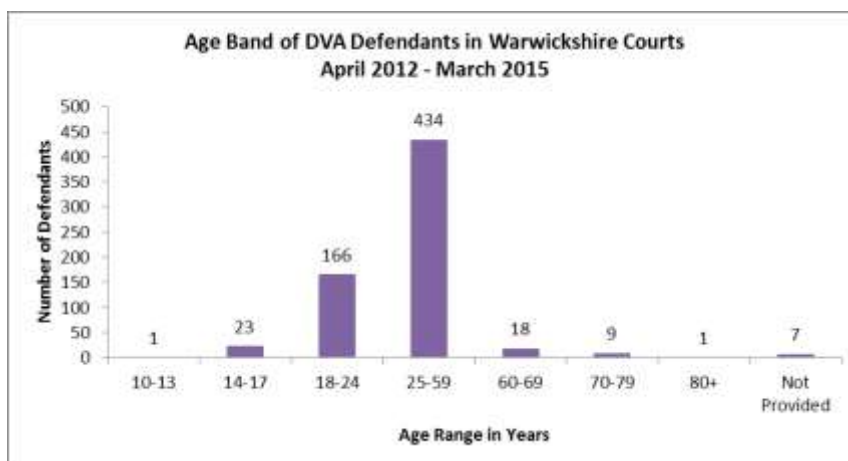
During this period, the number of cases finalised across the courts in Warwickshire amounted to 659 of which 471 (71%) were dealt with at the two Magistrates' Courts, 178 (27%) at the Crown Court and 10 (2%) at the Youth Courts. Of all these cases, 464 (70%) were successfully prosecuted at court, with 394 (60%) being the result of a guilty plea. CPS offered no evidence in a total of 93 (14%) cases.

The following chart shows the number of cases by year and the trend clearly shows an increasing number of cases at the courts over the three year period. There was a 42% increase in cases that were finalised when comparing 2014/15 to 2012/13. The chart also shows that there has been a reduction in the proportion of cases that have been successful at court with a 13 percentage point reduction over the three year period. This increase in the number of cases at court and the reduction in proportion that were successful is a worrying trend.



Source: CPS West Midlands

Of the defendants in these courts, 434 were in the age range of 25 to 59 years (66%) followed by 166 aged 18 to 24 years (25%) and 92% were male. Where ethnicity was recorded, White British accounted for 406 (62%), Other White background 40 (6%), Indian 26 (4%), White and Black Caribbean 18 (3%) and Caribbean 17 (3%). There is no obligation to record some data fields such as ethnicity and the data includes 91 (14%) 'not stated or not provided' values.



Source: CPS West Midlands

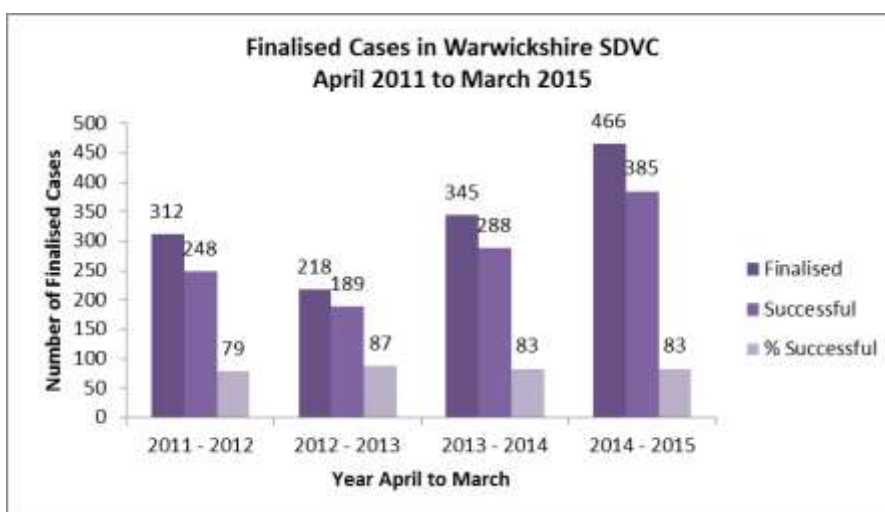
## Specialist Domestic Violence Court (SDVC)

The Specialist Domestic Violence Court (SDVC) is sometimes referred to as a Specialist Domestic Abuse Court (SDAC). It is a programme which has been running since 2005. It represents a partnership approach to domestic violence by the police, prosecutors, court staff, the probation service and specialist support services for victims. Magistrates sitting in these courts are fully aware of the approach and have received additional training. These court systems provide a specialised way of dealing with domestic violence cases in magistrates' courts. They refer to the approach of a whole system, rather than simply a court building or jurisdiction. Agencies work together to identify, track and risk assess domestic violence cases, support victims of domestic violence and share information better so that more offenders are brought to justice. Amongst the features of an SDVC are:

- Specially trained magistrates in dealing with domestic violence.
- Separate entrances, exits and waiting areas so that victims don't come into contact with their attackers.
- Cases clustered on a particular day or fast-tracked through the system, limiting the likelihood of further incidents.
- Tailored support and advice from Independent Domestic Violence Advisors (IDVAs).

Data in respect of the SDVC has been supplied by the Crown Prosecution Service (CPS) and covers the four year period from April 2011 to March 2015. DVA cases are identified by a monitoring code on their system. The figure shown as 'finalised' is the number of defendants for whom prosecution has been completed. This means they have been charged and have been through the criminal justice system to the point of either conviction or acquittal. A single case can be heard in multiple court centres, but for this purpose, the figure only counts against the last court in which the case was heard. The Magistrates' Courts at Nuneaton and Leamington Spa are the locations for SDVC in Warwickshire.

The CPS and Warwickshire Police have also established Witness Care Units (WCU) in the county who work very closely with the volunteer sector, Independent Domestic Violence Advisors (IDVA) and the SDVC. This is designed to ensure that all victims of domestic violence automatically access greater care to minimise the stress of attending court. During the four year period under review, The WCU in Warwickshire dealt with a total of 798 victims or witnesses who were required to attend court, of which 664 (83%) attended.



Source: CPS West Midlands

The number of cases finalised in the Magistrates' Courts between April 2011 to March 2015 was 1,272 (95%) with the remaining 69 (5%) in the Crown Court. Of these cases, the CPS had a success rate of 1,054 (83%) in the Magistrates' and 56 (81%) in the Crown Court. Final outcomes of these 1,341 cases may be summarised as follows:

Warwickshire SDVC Outcomes April 2011 to March 2015				
Outcome Type	Successful	Unsuccessful	Grand Total	Percentage
Guilty plea	1035	0	1035	77%
Offered no evidence	0	102	102	8%
Discontinued	0	55	55	4%
Conviction after trial	54	0	54	4%
Dismissed after full trial	0	40	40	3%
Withdrawn	0	26	26	2%
GP + Conviction after Trial	16	0	16	1%
Admin finalised	0	5	5	0%
GP + Dismissed after full trial	3	0	3	0%
Proved in absence	2	0	2	0%
Lie on file	0	1	1	0%
No case to answer	0	1	1	0%
Prosecution Stayed	0	1	1	0%
<b>Total</b>	<b>1110</b>	<b>231</b>	<b>1341</b>	<b>100%</b>

Source: CPS West Midlands

## Local DVA Services Data

There are a range of commissioned and non-commissioned specialist services currently available to DVA victims and perpetrators in Warwickshire. They include:

- Warwickshire Domestic Abuse Support Service (currently provided by Stonham – part of Homegroup)
- Warwickshire Domestic Abuse Refuge Service (currently provided by Refuge)
- DACS (Domestic Abuse Counselling Service)
- Victim Support
- Warwickshire Local Welfare Scheme

The following sections highlight activity data from these services with a view to giving an indication of service need and outcomes.

## Warwickshire Domestic Abuse Support Service

Stonham (part of Home Group) is commissioned by Warwickshire County Council to provide the Warwickshire Domestic Abuse Support Service. The contract for this service commenced in April 2012 and is due to end in March 2017. The service provides:

- The Warwickshire DVA helpline
- Outreach support, including drop-in sessions

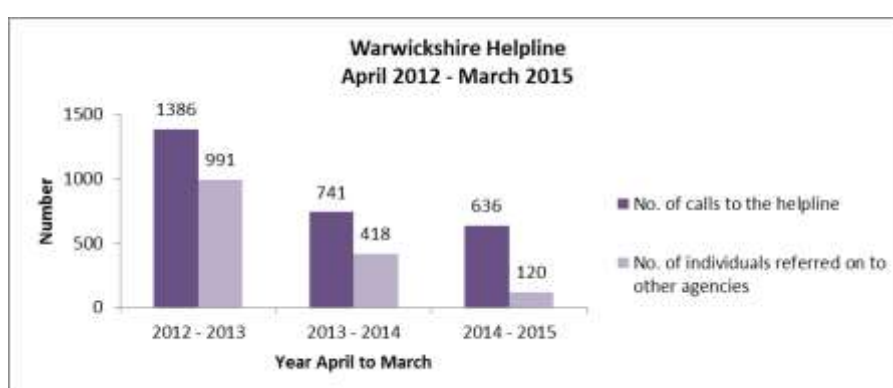


- Specialist support for male, LGBT and BME, including Eastern European, victims
- Sanctuary Scheme
- Independent Domestic Violence Advisors (IDVAs)
- Multi-Agency Risk Assessment Conference (MARAC) coordination
- Freedom Programme
- Identification & Referral to Improve Safety (IRIS) GP liaison programme (since April 2015)

## Warwickshire DVA helpline

There were 2,763 calls to the Warwickshire DVA helpline over the three year period April 2012 to March 2015. The data shows a reducing trend in the number of helpline calls over the period and the number of onward referrals from this service to other agencies.

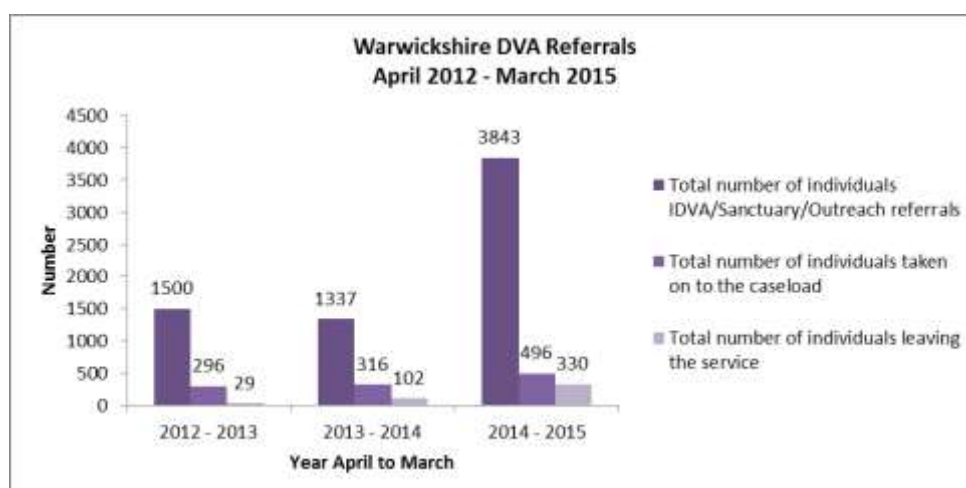
The number of females calling the helpline averaged 96% of all callers over this period.



Source: Stonham (Home Group Ltd.) Domestic Abuse Support Service

## Referrals and case management

During the period April 2012 to March 2015, there were a total of 6,680 referrals to an Independent Domestic Violence Advisor (IDVA), the Sanctuary Scheme or Outreach Support. The number of people referred has increased over this three year period with a significant increase in the year April 2014 to March 2015.

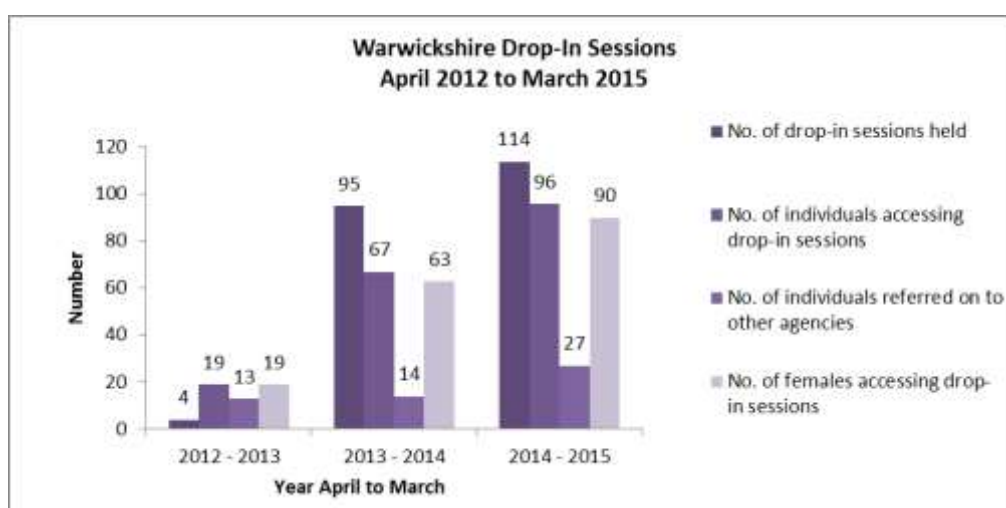


Source: Stonham (Home Group Ltd.) Domestic Abuse Support Service

Analysis of the referrals by source reveals that the vast majority, 6,009 (90%), were made by the police over this three year period. The number referred by them in 2012/13 was 1,241 which amounted to 83% of the annual total. In 2013/14 they referred 1,101 cases (84%) followed by a significant increase in 2014/15 of 3,667 cases or 95% of all referrals that year.

The majority of referrals in Warwickshire came from Nuneaton and Bedworth Borough with 2288 (34%) over the three year period examined and they maintained this dominance for every year. They were followed by Rugby Borough 1310 (20%), Warwick District 1080 (16%), Stratford-on-Avon District 912 (14%) and North Warwickshire Borough 801 (12%). There were a further 267 (4%) referrals where the county area was not known.

The number of drop-in sessions within the county increased significantly after the first year to a total of 213 over the three year period with only four being held in the first year. There was a similar increase in the number of individuals accessing the drop-in sessions and the number of individuals being referred to other agencies.



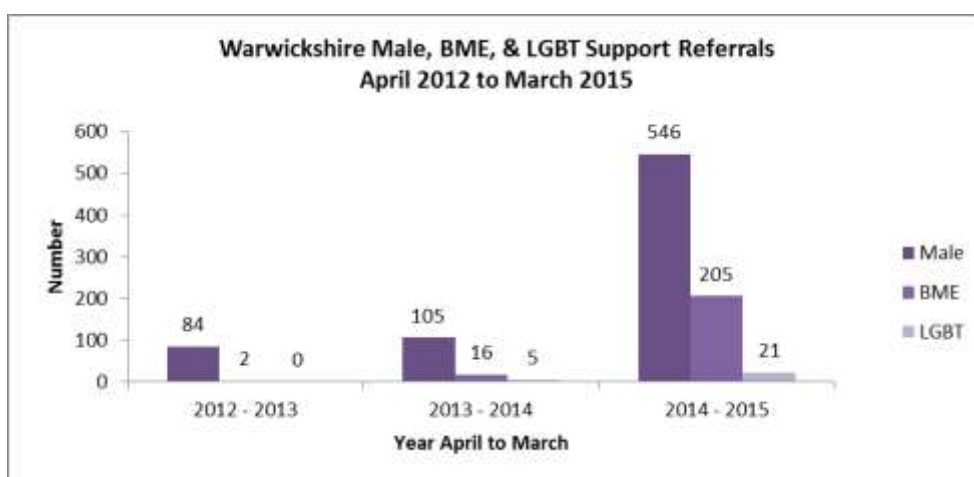
Source: Stonham (Home Group Ltd.) Domestic Abuse Support Service

The number of females accessing drop-in sessions totalled 172 forming 95% of the total during the period examined.

## Male, BME and LGBT support

The volume of Male, BME and LGBT Support has increased significantly since April 2012 with a total of 984 referrals over this three year period. In 2012/13 there were 86 referrals or 8% of three year total. This was followed by 126 (13%) in 2013/14 and 772 (78%) in 2014/15.

Over the three year period of April 2012 to March 2015, 735 Male referrals accounted for 75% of the total. This was followed by BME 223 (23%) referrals and 26 (3%) LGBT referrals. The number of individuals assessed were 293 or 3% of the total and of these, 168 (17%) were taken on to the caseload. During this three year period, a total of 636 cases were open to the service and 11 cases were closed.

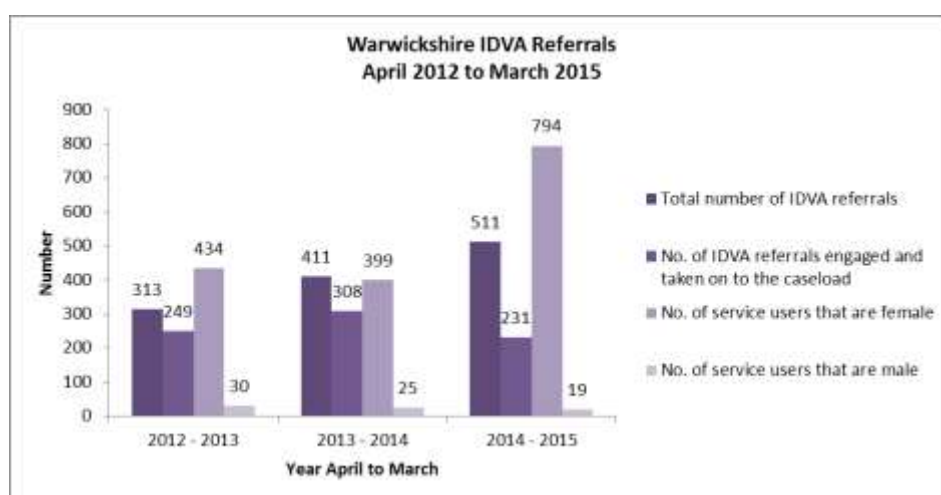


Source: Stonham (Home Group Ltd.) Domestic Abuse Support Service

## Independent Domestic Violence Advisors (IDVA)

IDVAs provide support to high risk victims of domestic violence and abuse. They work with the victim to develop an intensive risk management plan and ensure they are receiving all the support required to keep themselves and their families safe. They also offer support to clients who are accessing the criminal justice system and need support during criminal or civil legal proceedings. IDVAs can provide support during court hearings, act as an advocate and refer victims to a range of other specialist agencies and support. IDVAs are available for all high risk female and male victims of domestic violence and abuse aged from 16. They accept both self-referrals and referrals from any agency.

During the period April 2012 to March 2015, there were a total of 1,235 referrals for IDVA support. Of these referrals, 788 (64%) were engaged and taken on the caseload. Over this same period, the number of cases open to the service was 1,858, 96% (1627) of all users were female and 5% (92) were BME.



Source: Stonham (Home Group Ltd.) Domestic Abuse Support Service

As the number of IDVA referrals has increased over the three year period, the percentage of referrals engaged and taken on to the caseload has nearly halved. In 2015 – 16, there was additional investment into the IDVA service by the Warwickshire Police and Crime Commissioner to address this issue.

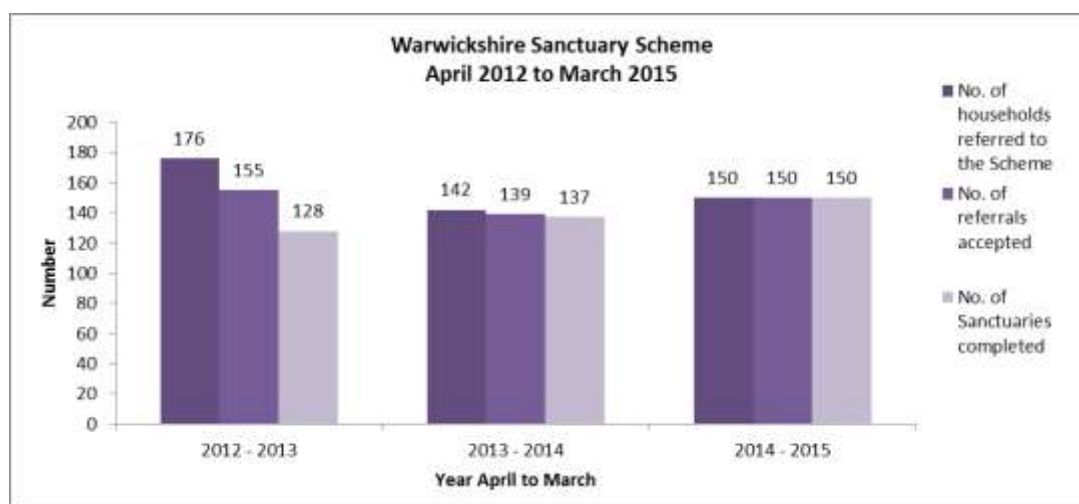
IDVA Service	April 2012 – March 2013	April 2013 – March 2014	April 2014 – March 2015	Total
Total number of IDVA referrals	313	411	511	1235
No. of IDVA referrals engaged and taken on to the caseload	249	308	231	788
<b>% IDVA referrals engaged and taken on to the caseload</b>	<b>80%</b>	<b>75%</b>	<b>45%</b>	<b>64%</b>

Source: Stonham (Home Group Ltd.) Domestic Abuse Support Service

## Sanctuary Scheme

The Sanctuary Scheme provides support to help victims to remain living safely in their own homes once they have ended their relationship, including the installation of home security measures. The project is for all female and male victims of DVA aged from 16 who are living in any type of property within Warwickshire. The project accepts both self-referrals and referrals from any agency.

A total of 468 households were referred to the Sanctuary scheme during the three year period of which a total of 444 (95%) were accepted. A total of 415 (89%) were completed during this period. Referrals may be broken down as follows:



Source: Stonham (Home Group Ltd.) Domestic Abuse Support Service

Of the five boroughs and districts within Warwickshire, Nuneaton and Bedworth referred 189 households (44%) followed by North Warwickshire Borough 96 (23%), Rugby Borough 82 (19%), Stratford-on-Avon District 37 (9%) and Warwick District 22 (5%).

## IRIS programme

The IRIS (Identification & Referral to Improve Safety) programme was a new addition to the Stonham contract in April 2015.

IRIS is a general practice-based domestic violence training, support and referral programme for primary care staff. It is a targeted intervention for female patients aged 16 and above experiencing current or former DVA from a partner, ex-partner or adult family member. IRIS provides care pathways for all patients living with abuse as well as information and signposting for perpetrators.

The Warwickshire IRIS service model rests on three full-time advocate educators working with 75 practices. The advocate educator is a specialist domestic violence and abuse worker who is linked to the practices and based in a local specialist domestic abuse service. The advocate educator provides training to the practice teams and acts as an ongoing consultant as well as the person to whom they directly refer patients for expert advocacy. The advocate educators work in partnership with a local clinical lead to deliver the service model.

Prevalence of DVA is substantially higher in a general practice population than that found in the wider population. 80% of women in a violent relationship seek help from health services, usually general practice, at least once, and this may be their first or only contact with professionals. There is extensive contact between women and primary care clinicians with 90% of all female patients consulting their GP over a five year period.

IRIS provides a unique opportunity for primary care clinicians and their patients to talk about domestic abuse. General practice can play an essential role in preventing and responding to domestic abuse by intervening early, providing treatment and information, and referring women on to specialist services.

In the 10 month period April 2015 – January 2016, focus has been placed on training Warwickshire's general practice workforce starting with South Warwickshire, North Warwickshire and then Rugby. As of January 2016, all practices were trained in South Warwickshire, all but 4 practices were booked to receive the training in North Warwickshire and 4 of 12 practices were booked to receive the training in Rugby.

Since May 2015, there have been 44 referrals for specialist DVA support from across 18 GP practices. All but 5 of these individuals decided to take up the offer of support.

Warwickshire's approach to IRIS has been nationally recognised as having outstanding results both in the number of practices trained and the most referrals in a short space of time.

## **Outcomes monitoring and Insights**

In 2015 – 16, Stonham began using the Insights system which is an outcomes measurement programme, specifically designed by Safelives for specialist DVA services. Insights enables services to:

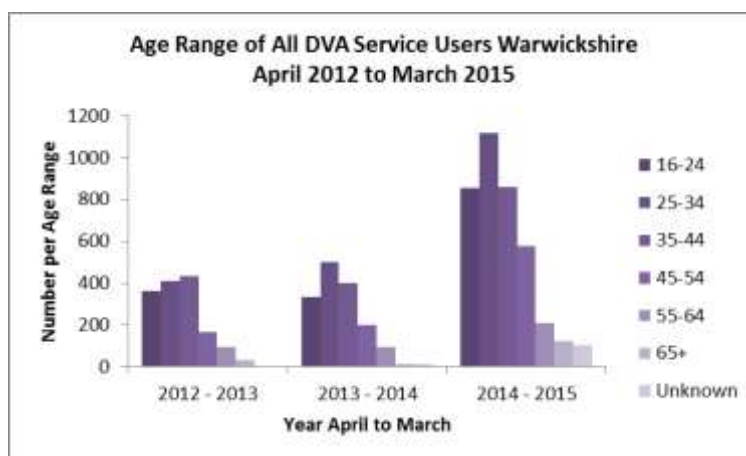
- understand who is accessing their service and identify gaps
- tailor interventions and support to meet the needs of their clients
- evidence the impact of their work on improving the safety and wellbeing

Frontline practitioners collect information about the people they support and submit it to SafeLives using online forms. There are more than 40 specialist DVA services across England and Wales using Insights enabling Safelives to provide benchmarking information against similar services.

The Warwickshire service and commissioners will begin to benefit from this in 2016/17.

## **Equality monitoring**

The age range of all service users falls predominantly between 25 to 34 years of age. Between April 2012 and March 2015, this age range accounted for 2,027 individuals or 29% of the total. This was followed by 35 – 44 years 1691 (25%), 16 – 24 years 1556 (23%), 45 – 54 years 400 (6%), 65+ years 168 (2%) and 114 (2%) unknown.



Source: Stonham (Home Group Ltd.) Domestic Abuse Support Service

## Ethnicity

Data in respect of ethnicity has been collected under five broad divisions which have been further sub-divided. These five divisions and sub-divisions are:

- White - British, Irish and any other White background.
- Mixed – White and Black Caribbean, White and Black African, White and Asian and any other mixed background.
- Asian or Asian British – Indian, Pakistani, Bangladeshi and any other Asian background.
- Black or Black British – Caribbean, African and any other Black background
- Other Ethnic Groups – Chinese, any other ethnic group, prefer not to say and Gypsy or Traveller.

From the data available, the largest ethnic group utilising the services of DASS were White. A total of 4071 White service users over this three year period accounted for 61.2% of the total. Other Ethnic Groups accounted for 2424 users (36.5%), Asian or Asian British 88 (1.3%), Mixed 39 (0.6%) and Black or Black British 25 (0.4%).

Of the Other Ethnic Groups division with 2,424 users, 2,415 (99.6%) stated that they would prefer not to say what their ethnicity was.

## Warwickshire Domestic Abuse Refuge Service

Women who become homeless because of abuse, violence or threats may be able to get a place in a refuge at a secret address. For those that don't feel safe in their own area, they may be able to go to a women's refuge in another part of the country. Hence the data for the Warwickshire Refuges will also include those who have come from another part of the country to seek refuge in the county. Many refuges are run by Women's Aid or Refuge, who jointly run the helpline.

Refuges are safe houses open to any woman who needs to get away from violence, threats, intimidation or bullying from a partner, ex-partner or a relative. There is no age limit and they don't need to have left the violent person permanently. They can usually bring their children with them however, not all refuges are able to accept boys over the age of 12 years of age. Many refuges have disabled access and some have provision for women with particular cultural backgrounds. A few refuges offer places for women who are using alcohol or drugs.

There are four refuges in Warwickshire accommodating women and children from the county together with others from other parts of the country. They are operated by the organisation Refuge and provide 23 units of accommodation. Warwickshire County Council commissions 18 units of this provision. The additional 5 are funded by local fundraising and grants. The existing contract with Refuge started in April 2012 and will end in March 2017.

Research undertaken by the Council of Europe recommends 1 family refuge space per 10,000 of the population. Based on Warwickshire's current population size of 551,594 (ONS 2014 mid-year estimates) this would equate to 55 refuge spaces, meaning that there is currently a shortfall of 32.

Based on the expected population increases this estimate increases to 57 refuge spaces by 2020.

## **Client profile - age**

Data from the Warwickshire refuges covers a two year period from April 2013 to March 2015. During this time, there were 589 referrals to the service of which there were 185 recorded intakes into the refuges split into the age ranges 21 to 30 years 85 (46%), 31 to 40 years 45 (24%), 41 to 50 years 19 (10%), 18 to 20 years 9 (5%), 51 to 60 years 5 (3%) with 1 (1%) younger than 18 years. The age of 21 (11%) of the intake was missing from the records.

## **Gender and gender identity**

All of the 185 intake into the refuges were female with one recorded as a transgender client.

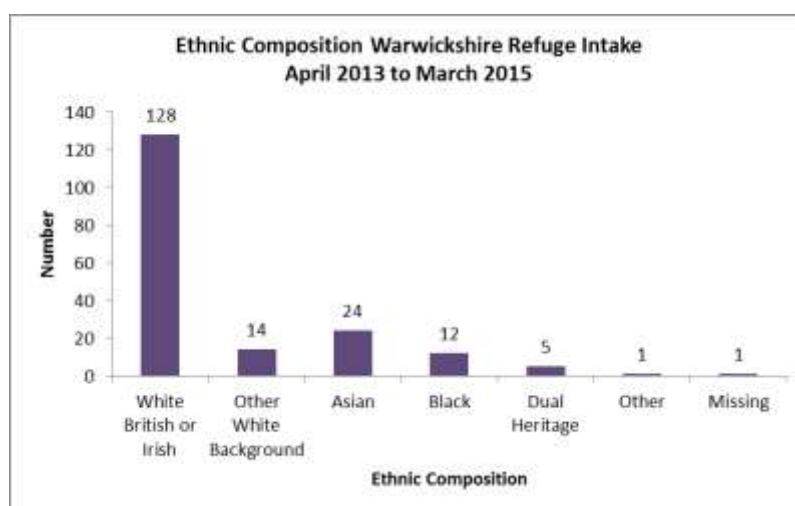
## **Sexual orientation**

So far as sexual orientation is concerned, 173 (94%) were Heterosexual, 4 (2%) were Lesbian, Bisexual, Gay and Transgender (LGBT) with 6 (4%) where they were not asked, it was not disclosed or the record was missing.

## **Ethnic composition**

White British or Irish formed the majority ethnic background forming 69% of the total. They were followed by Asian at 13%, Other White Background 8%, Black 6%, Dual Heritage 5% with Other 1% and Missing record 1%.





Source: Warwickshire Refuge's Services

## Immigration status

The immigration status of the intake to the refuges in Warwickshire is predominately those who are British, European Union (EU) or Permanent Residents with Indefinite Leave to Remain<sup>15</sup> (ILR) comprising 160 (86%). Temporary Residents including those from the European Economic Area<sup>16</sup> (EEA) amount to 5 (3%) and 28 (15%) records were found to be missing. There were 2 (1%) clients who needed an interpreter, 28 (15%) with no recourse to public funds and 1 (1%) client who needed to apply for ILR.

## Children

The majority of the women 129 (70%) entering the refuges were clients with children whilst 34 (18%) did not have any. Twelve (6%) of the clients were pregnant and the records for 22 (18%) missing. The total number of children amounted to 251 over this two year period with the average number of children per household with children at 1.9.

## Children and Young People's Services<sup>17</sup> (CYPS) involvement

Clients with CYPS involvement with the family amounted to 65 (23%) whereas those with no involvement were 99 (35%). There were 119 clients where it was not known if there was any such involvement.

## Where there is CYPS involvement

The Children Act 1989<sup>18</sup> is concerned with the provision of local authority support for children and families. In particular it describes how local authorities should carry out their responsibilities in relation to care planning,

<sup>15</sup> Indefinite leave to remain (ILR) or permanent residency (PR) is an immigration status granted to a person who does not hold the right of abode in the United Kingdom (UK), but who has been admitted to the UK without any time limit on his or her stay and who is free to take up employment or study, without restriction. When indefinite leave is granted to persons outside the United Kingdom it is known as indefinite leave to enter (ILE).

<sup>16</sup> The European Economic Area (EEA) provides for the free movement of persons, goods, services and capital within the internal market of the European Union (EU) between its member states.

<sup>17</sup> Children and Young People's Services concerns the provision of public services in Warwickshire relating to education and skills for children, young people and families. This includes schools, 16-19 years education, pre-school children, Connexions, child protection, family support and social care, children with specific needs and the Youth Service.

placement and case review for looked after children. In June 2015, the Government published revised Guidance and Regulations<sup>19</sup> setting out how local authorities should carry out their responsibilities.

Following an initial assessment of the child, if they are found to be disabled or that their health and development is likely to suffer without local authority intervention, the child will be classed as in need, as defined by Section 17 of the Children Act 1989. This means that the local authority is now legally obliged to provide the necessary services and support. There were a total of 3 children classed as in need under Section 17 during this period.

Section 31 of the Act sets out the legal basis or the threshold criteria on which a Family Court can make a Care or Supervision Order to a designated local authority in respect of a particular child. During the period April 2013 to March 2015, there were a total of 5 Care Orders made under Section 31 of the Act. Section 47 enquiries are conducted through a Core Assessment, carried out by an experienced child protection social worker. This builds on the information already received and may require specific examinations by other professionals (medical, psychological, emotional or developmental tests). The outcome of a Section 47 enquiry may range from no further action necessary through further monitoring needed to the convening of a Child Protection Conference. There were a total of 14 Child Protection Enquiries in Warwickshire during this period.

The Common Assessment Framework (CAF) and Lead Professional role are a key part of the strategy to improve outcomes for children and young people by ensuring that all of the agencies in local areas work together in an integrated way. The CAF supports timely and integrated responses to the needs of Children and Young People who may not meet traditional thresholds for statutory or specialist services but who, without help, are at risk of not achieving a positive outcome. There were 7 CAF's recorded relating to children in refuges during this period.

## Victims' vulnerability issues at intake

On intake to the refuges, the victims are asked whether they are vulnerable to any of the following nine issues:

- Alcohol misuse
- Community care payments
- Depression or suicidal thoughts<sup>20</sup>
- Drugs misuse
- Financial problems
- Mental health problems
- Need for benefit advice – if answered “yes” to financial problems
- Self-harm
- Threatened or attempted suicide

There were a total of 221 responses where the nine issues above were cited as factors in the vulnerability of the victims. Financial problems was the most common 52 (24%) followed by the need for benefit advice 46 (21%), drugs misuse 26 (12%), mental health problems 25 (11%), alcohol misuse 13 (6%), threatened or

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<sup>18</sup> <http://www.legislation.gov.uk/ukpga/1989/41/contents>

<sup>19</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/441643/Children\\_Act\\_Guidance\\_2015.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/441643/Children_Act_Guidance_2015.pdf)

<sup>20</sup> Data for this category is only available for April 2014 to March 2015

attempted suicide 13 (6%), self-harm 12 (5%) and community care payments 2 (1%). Despite the data only being available for one year, depression or suicidal thoughts was the third highest 32 (14% of the two year total). If the only year being examined was April 2014 to March 2015, then it would have been the highest category with 25% of the total.

## **Clients' circumstances at intake**

All clients entering the refuges are asked a series of questions relating to their particular circumstances including their relationship with the perpetrator and their living arrangements. During this two year period, the nature of the relationship with the perpetrator was recorded on 160 occasions. The most common relationship to the perpetrator was that of ex-intimate partner 88 (55%). Intimate partner accounted for 51 (32%), missing 14 (9%), adult family member 6 (4%) and a known person or associate 1 (1%). Multiple perpetrators were recorded on 12 (8%) occasions, 3 (2%) were at risk of forced marriage and 3 (2%) were at risk of honour based violence. So far as the living arrangements were concerned, 101 (63%) were not living with the perpetrator, whereas 42 (26%) were. Two clients (1%) were living with the perpetrator on an intermittent basis and details of 15 (9%) were missing.

Clients were also asked a series of questions concerning whether they had attempted to leave, made a report to the police, attended Accident and Emergency (A&E) or attended their General Practitioner's (GP) surgery. Of the 185 intakes during this two year period, 132 (71%) had attempted to leave, 28 (15%) had never attempted this and for 25 (13%), the response was not applicable, available or missing. Reports to the police were made by 103 (56%), 60 (32%) had never done this and for 22 (12%), the response was not applicable, available or missing. Attendance at A&E was made by 26 (14%), 111 (60%) had never done this and for 48 (26%), the response was not applicable, available or missing. A visit to the GP was made by 43 (23%), 61 (33%) had never done this and for 81 (44%), the response was not applicable, available or missing.

## **Type of abuse**

There were 384 instances of abuse recorded during this period. The most common form of abuse reported was that of jealous or controlling behaviour which was recorded on 127 (36%) occasions. Next came harassment or stalking 97 (28%), physical abuse 91 (26%) and sexual abuse 34 (10%).

## **Client outcomes**

For the cases dealt with by the refuges where exit data was gathered, a record was made comparing the type of abuse between intake and exit. The number of clients reporting an end to all types of abuse and controlling behaviours was 97.

## **Living arrangements at exit**

The majority of clients 119 (78%) were not living with the perpetrators upon their exit from the refuge whereas 10 (7%) were. Details of 23 (15%) were missing. Of the clients who reported they were not living with the perpetrator, 62 (53%) reported no ongoing contact whereas 29 (25%) reported ongoing contact. Details of 27 (23%) were not known or missing.

Of the reasons given for ongoing contact with the perpetrator, 24 (62%) cited children as the reason. Others include legal proceedings 8 (21%), family and social network 3 (8%), ongoing abuse by the perpetrator 2 (5%) and other reasons 2 (5%) were reasons given by the clients.

## Case worker perception of risk and safety at exit

A moderate/significant 85 (36%) risk reduction accounted for the majority of outcomes classified by the case workers. This was followed by a significant reduction 56 (24%), moderate 29 (12%), limited 25 (11%) and an increased risk 2 (1%). Those that were classed as don't know or missing totalled 40 (17%).

Sustainability of any reduction in risk were classified by the case workers as long-term being greater than two years 25 (16%), the risk permanently eliminated 24 (6%), the medium term of six months to two years 17 (11%), the short term of one to six months 10 (7%) and the very short term in terms of days and weeks 4 (3%). The majority 72 (48%) were classed as don't know, unpredictable or missing.

Client reported outcomes at exit were recorded regarding feeling of safety, quality of life, feelings of fear and their confidence in accessing support. So far as feeling of safety is concerned, 78 (34%) felt somewhat / much safer. This was followed by much safer 56 (24%), somewhat safer 22 (10%) and no change 5 (2%). No client stated they felt less safe. Those that were not asked, not contactable or missing amounted to 69 (30%). When questioned as to their quality of life, 70 (32%) responded that it had changed much / a little improved. This was followed by improved a lot 48 (22%), improved a little 22 (10%), no change 6 (3%) and only one person felt it had become worse. The majority 75 (34%) were those that were not asked, not contactable or missing.

Feelings of fear prompted 152 responses. 42 (28%) said that they were not at all frightened, 38 (25%) were a little frightened with 1 (1%) feeling quite frightened and 1 (1%) feeling very frightened. Those that were not asked, not contactable or missing amounted to 70 (46%).

Those feeling confident to access support amounted to 42 (28%) of those responding. They were followed by very confident 38 (25%) with those that not confident 2 (1%). Those that were not asked, not contactable or missing amounted to 70 (46%).

## Safety outcomes requested and achieved

A record was collated of what safety outcomes the women requested together with what outcomes were actually achieved. Over the two period examined, a total of 871 safety outcomes were requested covering a comprehensive range of issues with 714 (82%) being achieved. The top ten safety outcomes requested together with their achievement rate are detailed below in order of most requested:

Women's Requested Safety Outcomes Requested and Achieved	Requested	Achieved	% Achieved	% of Total Requested
1.1 To develop and implement an individual support and safety plan for myself and my child/ren	141	124	88%	16%
1.10i Woman is enabled to live as safely as possible in Refuge accommodation	136	118	87%	16%
1.10 Help finding new safe accommodation	115	93	81%	13%

1.2 To discuss possible actions which could help protect me and my children	92	77	84%	11%
1.9 Support to protect my children and myself around issues of contact and residence	44	35	80%	5%
1.7 To find out about obtaining civil orders that provide protection	33	27	82%	4%
1.10iv Help finding new safe accommodation out of my local area	30	24	80%	3%
1.3 To find out about reporting the domestic violence to the police and seek protection	29	25	86%	3%
1.10iii Help finding new safe accommodation in my local area	27	23	85%	3%
1.3ii Police statement made	25	21	84%	3%

Source: Warwickshire Refuge's Services

This top ten of requested safety outcomes amounts to 672 (77%) of the total and has an average achievement rate of 84%.

## Health outcomes requested and achieved

A total of 573 health outcomes were requested by the women during this period and a total of 484 (84%) outcomes were actually achieved. This top ten of requested health outcomes amounts to 549 (96%) of the total and has an average achievement rate of 85%. The top ten health outcomes requested together with their achievement rate are detailed in the table below in order of most requested.

Women's Requested Health Outcomes Requested and Achieved	Requested	Achieved	% Achieved	% of Total Requested
2.4 Information about registering with local health services e.g. GP, health visitor, antenatal care	130	109	84%	23%
2.6 An opportunity to discuss the emotional effects of the domestic violence on me and my children	89	78	88%	16%
2.1 Support with any immediate urgent health needs	66	56	85%	12%
2.6i To talk about the myths and realities surrounding domestic violence	62	50	81%	11%
2.4i To register with a health visitor (child/ren under 5)	61	54	89%	11%
2.7 Information about specialist support services in the community e.g. for depression	46	36	78%	8%
2.3 Support around addressing the children's and my physical health	43	37	86%	8%
2.5 Information about specialist health care services e.g. disability services, substance abuse agencies	19	15	79%	3%
2.5vii Woman accesses support from specialist domestic violence services other than a refuge	17	14	82%	3%
2.5vi Woman accesses specialist provider in relation to mental health	16	15	94%	3%

Source: Warwickshire Refuge's Services

## Economic outcomes requested and achieved

A total of 604 economic outcomes were requested by the women during this period and a total of 509 (84%) outcomes went on to be achieved. This top ten of requested economic outcomes amounts to 586 (97%) of the total and has an average achievement rate of 84%. The top ten economic outcomes requested together with their achievement rate are detailed in the table below in order of most requested.

Women's Requested Economic Outcomes Requested and Achieved	Requested	Achieved	% Achieved	% of Total Requested
3.5i Worker assists woman in making a housing benefit application within 48 hours of arrival in a refuge	136	116	85%	23%
3.2 Help to obtain, clarify or change my financial documentation	112	95	85%	19%
3.5 Help in claiming benefits for myself and my children, including housing benefit	105	90	86%	17%
3.1 Support to review my financial situation following domestic violence	82	67	82%	14%
3.4 Support to deal with any rent arrears	59	52	88%	10%
3.3 Support to deal with any debts	38	32	84%	6%
3.7 Help with my personal budgeting	24	20	83%	4%
3.8iii Woman is supported to pursue further education or training	12	6	50%	2%
3.8v Woman is supported to obtain new employment	11	7	64%	2%
3.1i Support with perpetrator being financially abusive	7	7	100%	1%

Source: Warwickshire Refuge's Services

## Social well-being outcomes requested and achieved

A total of 157 social well-being outcomes were requested by the women during this period and a total of 133 (85%) outcomes were actually achieved. The six economic outcomes requested together with their achievement rate are detailed below in order of most requested:

Women's Requested Social Well Being Outcomes Requested and Achieved	Requested	Achieved	% Achieved	% of Total Requested
4.5 Information about local schools and nurseries for my children	45	41	91%	29%
4.3 Information about play activities for my children	40	37	93%	25%
4.4 Information about local leisure and social activities	31	23	74%	20%
4.1 Help to think about friends or family whom I can safely talk to and reconnect with for support	18	15	83%	11%
4.2 Information about contact with others from my culture or faith	12	7	58%	8%
4.6 Support to access additional services for my children	11	10	91%	7%

Source: Warwickshire Refuge's Services

## Civil justice outcomes

During this two year period, there were 22 clients supported by a caseworker with any civil orders, including those made under the provisions of The Children Act 1989<sup>21</sup>. Of these 22 clients, 15 (68%) qualified for Legal Aid and 18 (82%) were provided with legal support by a solicitor. Details of 8 (36%) of those receiving legal were not known or missing. There was no client that did not qualify for Legal Aid.

A total of 11 civil orders were applied for during this period of which 7 (64%) were non-molestation orders, 2 (18%) orders were applied for under the Protection from Harassment Act 1997<sup>22</sup>, 1 (9%) contact order 1 (9%) and 1 other order under The Children Act. So far as the application for the non-molestation order were concerned, 5 (71%) were granted and both of the applications for orders under The Protection from Harassment Act were also granted. Neither of the remaining two applications was granted. Of the successful applications, none were breached during this period.

## Details of all referrals

A summary of the types of referrals reveals the following main groups:-

- Source – Other DV or SV Service 20%
- Ethnicity – White British 55%
- Disability – Mental Health 8%
- Sexual Orientation – Heterosexual 44%
- Age – 20 to 29 years 44%
- Number of children – No children 41%

Of the 185 referrals, 28 (15%) were deemed to be repeats. Cases are deemed repeats if the client returns after their case was previously closed or made inactive.

The main types of abuse experienced at referral when they answered yes were that they have separated or were trying to separate 149 (7%) and where the perpetrator controls everything or excessive jealousy 142 (7%).

## Domestic Abuse Counselling Service (DACS)<sup>23</sup>

The Domestic Abuse Counselling Service is a non-profitable charity organisation that came into being in January 2006 due to a gap in service provision for victims of abuse. In Warwickshire, the service has offices in Nuneaton and Stratford-upon-Avon together with other outreach counselling rooms throughout the county. On average, DACS provides a counselling service for about 100 people every week utilising a team of professional counsellors that specialise in providing therapeutic services for families affected by domestic abuse.

DACS works within a multi-agency framework as one of the service providers to reduce domestic abuse in the community and they are an active member of the Warwickshire Multi-Agency Risk Assessment Conference (MARAC).

DACS delivers three main services:-

<sup>21</sup> <http://www.legislation.gov.uk/ukpga/1989/41/contents>

<sup>22</sup> [http://www.legislation.gov.uk/ukpga/1997/40/pdfs/ukpga\\_19970040\\_en.pdf](http://www.legislation.gov.uk/ukpga/1997/40/pdfs/ukpga_19970040_en.pdf)

<sup>23</sup> <http://www.dacs-service.org.uk/home.htm>



- Victim's Services - for female and male victims of domestic abuse.
- Perpetrator Intervention Service - for male and female perpetrators of domestic abuse.
- Partner Support Service - for victims who have a partner engaging with the perpetrator intervention service.

They receive referrals from Police, Social Services, Refuge, Housing, Health and all other statutory and voluntary organisation working with domestic abuse. They are members of RESPECT<sup>24</sup>, a nationally recognised umbrella organisation for domestic violence services in the UK and also members of the British Association of Counselling & Psychotherapy<sup>25</sup> (BACP).

Between April 2014 and March 2015, DACS Victim's Services received 1,144 referrals and this represents the majority of the type of work they undertake. More than 50% of their Victim's Services clients have been repeat victims in more than one relationship and approximately 70% of their workload is involved in the child protection court process. The Perpetrator Intervention Service received 157 referrals during this period.

They also run a Partner Support Service for victims of abuse who have a partner engaging with the DACS Perpetrator Intervention service. The aim of this service is to:-

- Increase the safety of the victim and their children
- Improve the mental and emotional well-being of the victim
- Promote realistic expectations of the Perpetrator Intervention Service

Their clients range in age between 16 and 100 years old and they recently received a referral for a 91 year old woman. All types of abuse are encountered including, physical, emotional, sexual and financial.

Their aim is to reduce domestic abuse in our community and reduce the risk of repeat victimisation. They work from a preventative perspective with models of therapeutic intervention from an educational perspective that teaches skills for example of 'self-evaluation of risk'.

They have an evaluation system in place for their work and encourage feedback from their service users. An initial assessment procedure is carried out to identify the risk and safety needs of the service user. This is followed by a mid-therapy review and an end of therapy report which provides the service user with feedback of the service provided. This evaluation system is used to improve the training programmes for the volunteer base and the programmes offered to the service users.

## Victim Support

Victim Support is contracted by the Warwickshire Police and Crime Commissioner (PCC) to provide Warwickshire victims of crime with emotional support to help them cope and recover from their experience. It should be noted that emotional support is a general form of emotional support and not specialist therapeutic counselling as provided by some agencies working within the specialist area of supporting victims and victim-survivors such as such as domestic abuse, sexual violence and homicide.

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<sup>24</sup> <http://respect.uk.net/>

<sup>25</sup> <http://www.bacp.co.uk/>

Victim Support utilise local volunteers and caseworkers working principally from Nuneaton and Leamington. The contract became live on the 1<sup>st</sup> April 2015 following the completion of a commissioning and procurement process by the PCC. The contract has been let for 3 years with an option to extend a further two years should contract performance be acceptable to the PCC. The Warwickshire PCC has let this contract in recognition of obligations placed on PCCs by the Ministry of Justice to support victims of crime. In accepting this responsibility the OPCC is fully cognisant of a statutory duty to support victims of crime as defined by the Code of Practice for Victims 2015 and EU Directive 2012/29 - 'establishing minimum standards on the rights, support and protection of victims of crime'.

By the end of the financial year 2015/16 it is expected that Victim Support will have offered support to approximately 12,000 victims of crime in Warwickshire. It would seem so far that most victims taking up support have experienced some form of personal physical violence. The subsequent support they request typically comprises of emotional support, information and equipment relating to personal safety and security. The support offered to victims of violent crime reflects the biggest growth area of recorded crime by Warwickshire Police which is crimes of violence irrespective of whether injury has occurred.

As the first year of the contract comes to an end the OPCC is looking forward to working closely with other partners, statutory and non-statutory to further develop understanding of the victims and victim-survivors landscape to ensure support is placed where it is most needed especially where victims and victim-survivors are vulnerable.

The following statistics from the period October 2015 – December 2015 provide a snapshot of the level of usage for this service:

- There were 3,392 referrals to Warwickshire Victim Support
- 55% of the referrals were for victims of a violent crime
- 627 of these went on to receive extended support from the service
- 66% of those supported were female
- 85% of those that were identified as being vulnerable received extended support and were identified as being a victim of DVA

Clearly, the service is supporting a high number of individuals affected by DVA. Work is ongoing to understand the nature and level of support being offered, and to ensure the referral pathways between the Police, Victim Support and Stonham are working as they should to deliver an efficient and effective service to the victim.

## Warwickshire Local Welfare Scheme

The Warwickshire Local Welfare Scheme (WLWS) distributes help to the most vulnerable residents at times of unavoidable crisis. The scheme has two strands; immediate need and planned need. It supports eligible Warwickshire residents when they have no other means of help and are in a situation that poses a serious risk to the health and safety of them or their immediate family.

It is not a cash benefit. It provides the most basic and essential help – food and energy. This is provided either in emergency food parcels with three days supplies or with credit for energy.

Applicants need to be legally resident in the UK and satisfy Warwickshire County Council that:

- They are aged 16 or over
- Have no other access to funds or sufficient resources to pay for food or heat
- Their situation poses a serious health or safety risk to themselves or their immediate family
- They have been a resident of Warwickshire for the last six months, or three of the last five years
- In the case of members of the armed forces, if they do not meet residency criteria, they should demonstrate a strong connection to Warwickshire

Those not eligible include:

- Someone in hospital or a care home unless their discharge is imminent
- Someone subject to immigration control by virtue of the Immigration and Asylum Acts
- Applicants or their immediate family who have received three awards for food, or two awards for energy, household goods or clothing, within a 12 month period
- Prisoners and people lawfully detained
- Someone from abroad who fails or would fail the habitual residence test for the purpose of welfare benefits

During the year August 2014 to July 2015, there were 26 applications for immediate need assistance which were granted. These were broken down as follows:

Aug 2014 - Jul 2015 WLWS Immediate Need Applications	Number	Per cent
Food	10	38%
Bed / Cots	8	31%
Microwave	3	12%
Fuel	3	12%
Bedding (including all items)	2	8%
Total	26	100%

*Source: Warwickshire County Council*

The scheme also provides help to those whose needs are more long term and who are vulnerable through an ongoing set of circumstances rather than an immediate crisis. This is known as planned need. Typically, this includes care leavers, victims of domestic abuse, former armed forces personnel or those resettling in a community after a custodial term.

Planned help might take the form of help in furnishing accommodation with basic furniture and appliances. Preventative measures look to address problems at source and tackle them before they happen. One-off grants are available for organisations to offer training in life skills such as cooking, finance or ICT, for example, to vulnerable people.

During the year August 2014 to July 2015, there were 1061 applications for planned need which were granted. These were broken down as follows:

Aug 2014 - Jul 2015 WLWS Planned Need Applications	Number	Per cent
Bedding (includes all items)	471	44%
Other Kitchen Items (including tea towels, cutlery, utensils etc.)	156	15%
Beds / Cots	123	12%
Storage	96	9%
Fridge	51	5%
Other Electrical Kitchen Appliances	51	5%
Washing Machine	31	3%
Any Other Items (including towels, bath mats)	31	3%
Combination Microwave	23	2%
Mini Oven	23	2%
Table and Chairs	3	0%
Sofa	2	0%
Total	1061	100%

Source: Warwickshire County Council

The Local Welfare Scheme will also point customers in the direction of other agencies and organisations who can offer help and support.

## Local Services for DVA Perpetrators

In order to reduce harm from DVA we need to tackle the cause of the problem (perpetrators) as well as support those affected to cope and recover. Warwickshire does not currently have an accredited perpetrator programme. Grant funding allows for small scale, individual interventions, in some parts of the county – for example, the Perpetrator Intervention Service delivered by DACS. However, this creates a postcode lottery and waiting lists are extensive.

Warwickshire Police are piloting a small scale DA Integrated Offender Management project. This requires intensive input so can only engage in a very small number of cases each year. The following provides a summary of this work.

## Integrated Offender Management - Domestic Abuse Coordinator

Integrated Offender Management (IOM) is a significant element of the Home Office and Ministry of Justice strategy to prevent crime and reduce reoffending. It provides a unique opportunity to maintain oversight and a degree of control over offenders who are at a high risk of reoffending, even when they are not subject to statutory supervision. The key principles of the approach were set out in a joint Home Office and Ministry of Justice revised publication<sup>26</sup> in February 2015. Integrated Offender Management involves criminal justice and other agencies working together to deliver a local response to crime, targeting those offenders most at risk of reoffending or committing offences that might cause serious harm to others. Further detail about IOM is contained in the joint Home Office and Ministry of Justice IOM supplementary information document<sup>27</sup> published in 2015.

<sup>26</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/406865/HO\\_IOM\\_Key\\_Principles\\_document\\_Final.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/406865/HO_IOM_Key_Principles_document_Final.pdf)

<sup>27</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/406868/IOM\\_Key\\_Principles\\_refresh\\_supplement\\_final.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/406868/IOM_Key_Principles_refresh_supplement_final.pdf)

In 2015, the Police and Crime Commissioner for Warwickshire provided funding for a 12 month pilot project to introduce Domestic and Violent Abuse (DVA) into IOM within the county. The aim being to provide end-to-end offender management of those identified as DVA offenders. The scheme in Warwickshire will focus on the most high risk DVA offenders and work to reduce their offending behaviour.

These individuals will be subject to intensive supervision, enhanced enforcement and provided with a premium service by agencies. For those who want to address their offending behaviour, there will be opportunities to work towards the seven pathways to reducing reoffending. These include:-

- Entering into a perpetrator programme,
- Gaining support with education, training and employment
- Accessing healthcare support
- Entering into drugs and alcohol treatment
- Pro-social modelling, attitudes and behaviour
- Ensuring accommodation is suitable
- Increasing access to legitimate finance
- Working to protect and safeguard children and vulnerable

Currently the scheme has the capacity to provide a premium approach to those posing the highest risk of domestic abuse. It is a county-wide programme that will utilise and develop links with statutory and voluntary agencies working in the field of domestic abuse.

The IOM co-ordinator responsible for this programme will work within the IOM Unit and work closely with the Warwickshire Police Protecting Vulnerable People<sup>28</sup> (PVP) unit. They will not only actively case manage the offenders in their cohort, but coordinate a suitable risk management plan. This will include ensuring that all enforcement opportunities are maximised, information sharing between agencies is consistent and the risk to the victim is minimised through all related activities. The scheme will manage all aspects related to the offender and work in partnership with the Domestic Abuse Risk Officers from within PVP who manage the victims.

The scheme will utilise the six main principles of IOM:-

- All Partners Manage Offenders Together
- Delivering a local response to local problems
- All offenders potentially in scope
- Offenders face up to their responsibility or face the consequences
- Making best use of existing programmes and governance
- Supporting desistance from crime

In Warwickshire there are 20 males, all white, who are being managed under this scheme primarily for violence towards their partner or ex-partner all of which are female. There are also a number of associated offences such as harassment and breach of restraining orders. Of the offenders, 7 are from the Rugby area of the

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<sup>28</sup> PVP includes child protection, child exploitation enquiries, concerns for mental health, domestic abuse, sexual offences, vulnerable adults and the management of offenders.

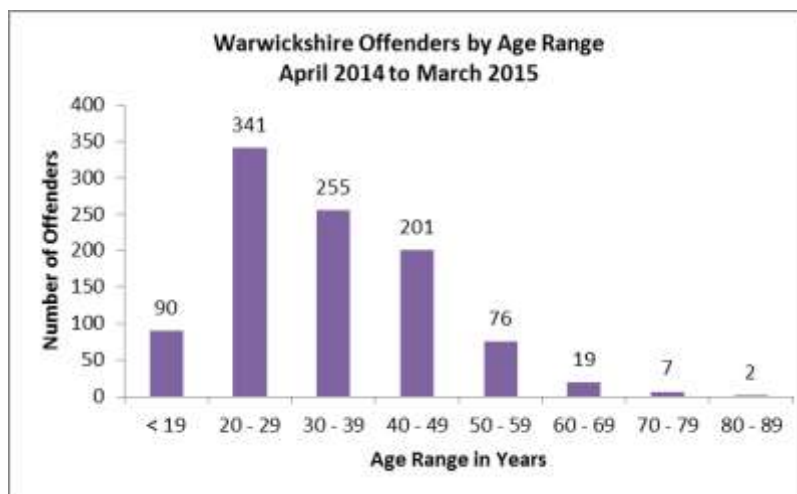
county, 6 from Nuneaton and Bedworth, 4 from North Warwickshire and the remaining 3 from South Warwickshire.

## Warwickshire Offender Profile

### Recorded Crime with a Domestic Marker

During the period April 2014 to March 2015, Warwickshire Police recorded 1,176 crimes with a domestic marker of which the profiles of the offenders are available for 1,148. Examination of the 1,148 profiles reveals that there are 991 individual offenders with 120 being repeat offenders. One offender was recorded on 6 occasions during this period, and another on 5. Of the remainder, 5 were repeat offenders for 4 occasions, 20 were repeat offenders for 3 occasions and 93 were repeat offenders on 2 occasions.

The age of the offenders ranges from 12 years to 86 years. The highest number of offenders with the same age of 22 years accounted for 45 (5%) of the total. Offenders aged between the ages of 22 and 29 years account for 207 (21%) of the total.



Source: Warwickshire & West Mercia Police

The vast majority of the offenders were male 815 (82%) and British 792 (80%). Under the Home Office crime classification scheme, malicious wounding accounted for 504 (51%) of the offences committed by the offenders. The top five offences accounted for 888 (90%) of the total and are:

Home Office Crime Classification	Number	Per cent
Malicious Wounding	504	51%
Common Assault	208	21%
Other Criminal Damage	88	9%
Other Summary Offences	61	6%
Other Public Order Offences	27	3%

Source: Warwickshire & West Mercia Police

The police use a series of markers against recorded crime which gives further explanation about the type of offence and some the circumstances. They use as many that apply to each crime. During April 2014 to March 2015, of the 1176 crimes recorded, a total of 5455 markers were applied to these crimes. Analysis of these

markers reveals the most common used was Domestic Violence (DV) – Partner on Partner 869 (16%). The top ten markers used are highlighted in the below table. In total they account for 4348 (80%) of the markers used.

Marker	Description	Number	Per cent
DP	DV - Partner on Partner	869	16%
DRS	DV Risk - Separation or child contact dispute	486	9%
DVB	Domestic Abuse - SOCAP <sup>29</sup> condition to arrest, arrest made	447	8%
AI	Alcohol involved	438	8%
DRN	DV Risk - Substance misuse, mental ill health of the suspect	422	8%
DRE	DV Risk - Escalation and severity of violence	379	7%
DVC	Domestic Abuse - SOCAP condition to arrest, no arrest made	372	7%
DRB	DV Risk - Controlling behaviour, stalking and harassment	353	6%
DRT	DV Risk - Afraid of suspect	306	6%
IV	Violence intoxicating substance involved	276	5%
	Total	4348	80%

*Source: Warwickshire & West Mercia Police*

<sup>29</sup> Serious Organised Crime and Police Act 2005. The term arrestable offence ceased to have effect as, bar a few preserved exemptions, one power of arrest now applies to all offences when the arrest is made by a constable.



## 6. Views of the Public and of Practitioners

### Key findings:

- Access to safe accommodation, emotional support to cope and recover from DVA, and support for children affected by DVA were identified as the top 3 forms of support required by victim-survivors.
- Overall views of the commissioned service provision were positive. However, provision was not felt to be sufficient enough to meet the need.
- Better communication and coordination of support where other agencies are involved were key areas for improvement.
- Increasing the visibility (publicity) of services and access to services (e.g. out of hours, rural areas) were common themes as well as more peer support/victim-survivor befriending provision and support for the wider family.
- Support for children and young people affected by parental DVA was felt to be particularly lacking, and more education provision in schools was regularly identified.
- Practitioners are concerned about the rise in online abuse.
- Training for universal services consistently appears throughout the feedback from practitioners to help improve their understanding of DVA and the support and empathy they give to victim-survivors.
- More services for perpetrators are needed to address the cause of the problem.
- An improved and more consistent response to DVA victim-survivors and their families is required in relation to access to housing and move-on accommodation.

There were two methods deployed to get the views of both the general public and practitioners on what DVA support they feel is needed in Warwickshire: online surveys and focus groups. This section highlights the findings from that work.

### Online Surveys

Two surveys were open between September and December 2015. These were electronic surveys available via the Ask Warwickshire consultation website. The surveys were promoted using a variety of means including circulation to the WADA distribution list, regular promotion internally within Warwickshire County Council and on Safe in Warwickshire social media, promotion by partner agencies including the Police and OPCC. The first survey was aimed at the general public and the second was aimed at practitioners working with individuals and families affected by DVA.

### Public Survey

There was a low response to the public survey: only 45 individuals. Key findings were as follows:

- The majority of respondents were White British, female and aged between 30 and 59 years.

- 10 respondents identified as having used the current commissioned services within the last 3 years with the majority reporting an excellent or good experience.
- Access to safe accommodation, emotional support to cope and recover from DVA, and support for children affected by DVA, were identified as the top 3 forms of support required.
- Confidentiality, out of hours access and services delivered by a specialist DVA organisation, were identified as the top 3 characteristics of an effective DVA service.
- In terms of accessing services, respondents gave equal weighting to online, telephone and face-to-face mechanisms.
- Other comments noted related to feeling let down by the criminal justice system, a lack of provision for young people, a lack of information about services for men, and a lack of understanding around violence, mental health and disability.
- Peer mentoring was suggested as an additional useful support option.

## Practitioner Survey

A good response was received to the practitioner survey with 198 individuals having responded from a good geographic spread and a wide range of service areas including health, local authority, education, police and third sector. Key findings were as follows:

- 74% of respondents reported feeling confident in talking about DVA with their clients.
- 78% knew how to refer to the appropriate specialist services.
- When asked about use of the DASH risk indicator checklist, the largest proportion of respondents was not aware of this tool.
- The majority of respondents who had used the commissioned DVA services were satisfied with the current process and also the support their clients received.
- Common themes in terms of areas for improvement were:
  - Better communication and feedback in respect of the referral process
  - More partnership working and greater engagement between services
  - More support for children and young people
  - Improved access to translation services
- Most respondents felt that services were accessible enough but suggested improvements around increasing service promotion, more face-to-face access in more locations and more use of technology and online services.
- With regards to diversity, most felt that the services were meeting the needs of women well but all other categories were only considered as fair.
- Awareness raising in a variety of communities and locations was suggested as well as more education and information for young people.
- The majority of respondents felt that the current arrangement of having separate refuge and community-based support services worked well and offered choice.

- The majority of respondents did not feel that the current commissioned service provision was sufficient to meet the demand they were experiencing - respondents commented along the lines of there being a general lack of resources resulting in staff being too busy and carrying high caseloads.
- When asked about emerging issues, respondents identified a lack of support for children and young people and an increase in abuse involving social media as areas of concern.
- In terms of training, the majority of respondents has received specific DVA training or had covered DVA within another training course.
- A common theme throughout the survey was a desire for more training and awareness.

## Focus Groups

Focus groups were run by Dr Ravi Thiara, Research Fellow and Director at the Centre for the Study of Safety and Well-being at Warwick University. The following presents a summary of the information gathered and suggestions for consideration by statutory agencies, providers and commissioners.

### Victim-survivor feedback

#### Profile of victim-survivors consulted:

A total of 13 women were consulted in four focus groups across Warwickshire, drawn from DVA service providers and Children's Centres. The focus groups each lasted two hours.

Details were available for 12 of the women. All except two were White British; 11 of the 12 women had children; six women were unemployed, two were in full-time and two in part-time employment. Women's housing arrangements included three women living in refuge, one living with her family and eight in rented accommodation.

All of the women were separated at the time of the focus group. In relation to experiences of DVA, three women had been in the abusive relationship for six years, four for 10 years, three for 3, 4, and 5 years respectively, one woman for 8 years and one woman had lived with abuse for 18 years. Two women had not had support for DVA.

Questions were asked around the following areas:

- Journey to DVA services and expectations
- Contact with statutory services
- Experience of DVA services
- What makes an effective DVA service
- Gendered services
- Work with perpetrators
- Children

The following presents a summary of the key themes and suggestions from the sessions. A separate report with more detail is available on request.

### **Journey to DVA services:**

- The majority of women knew little about DVA services before accessing them for help, through either being referred or making contact themselves after being given information by another agency.
- Taking an initial step to contact a DVA service was described as momentous, with women being uncertain about what would happen thereafter. Those who had fears about contacting a DVA service or who lacked confidence to do so valued a professional, such as a health visitor, making an appointment for them.
- The fear of Social Services and having their children taken off them was the biggest concern for women during this period.
- For some, the fear of repercussions if their partners found out was also of considerable concern. Feeling safe was very important to women when accessing DVA services since contacting services can be a risk and create huge worry for women.
- The initial reception women received from a service was vital in determining women's engagement and important for the process of building up trust.
- Having a prompt response from professionals who had an understanding and believing attitude was highly valued by women during the initial stages of contact with services and agencies.
- Transport was identified as a gap by a number of women with children. While some support services helped women with transport, generally it was a barrier in women being able to access support.
- For disabled women in abusive relationships it was especially hard to identify avenues of help, both formal and informal. In relation to the latter, a woman commented that *'my family thought he was amazing taking me on'*. In relation to the former, disabled women spoke about the difficulties in getting services/professionals to recognise the support they needed to separate from their partners.

### **Suggestions for improvements were:**

- The importance of giving greater visibility to DVA and sending a message that it is unacceptable to ensure that women do not view it as a normal part of relationships was emphasised.
- Being given information about sources of help in discreet ways, such as the lip balm with the Helpline number, was viewed extremely positively.
- Given the persisting secrecy around DVA, women said *'a lot of advertising'* should be done to bring it out in the open. Further suggestions included information in workplaces, in schools, at bus stops, hairdressers, nail bars and supermarkets.
- The role of health professionals in responding to DVA and in providing information to women was underlined. In particular, health visitors and GPs were identified as key to referring women to DVA services. It was suggested that posters and leaflets should be placed in doctors' surgeries and in hospitals.
- Having information in Children's Centres and support workers at Children's Centres that can make women aware of their options was suggested.

- The importance of all professionals being adequately trained in every form of DVA was also highlighted.
- The availability of information for family members was considered important.
- Women suggested that a brochure should be produced which lists all the support services available for DVA in Warwickshire, viewing paper copies to be better than online information.

### **Contact with statutory services:**

- The women underlined the importance of being given information and being linked into specialist DVA services from an early stage.
- Although some felt out of control when information was shared between agencies, many women spoke about the importance of information sharing and co-ordination among agencies to provide a better service to DVA victims.
- Since most of the women had issues with housing, help with 'sorting out housing' and issues such as getting their partner's name off the tenancy were highlighted as a key area of support.

### **Experience with DVA services:**

- The women had been supported by the range of DVA services in Warwickshire and sometimes elsewhere – Refuge, Stonham, DACS, and Families First. None of the women had accessed the Warwickshire Helpline.
- Their overall experience of the services was highly positive from both a practical and an emotional support perspective.
- Being listened to and being understood were the main things that women appreciated about the support from specialist services.
- Those women who had not gone into a refuge believed that the support available to women who were continuing to live at home was limited. This was made worse if women had children. In such cases, women said a support worker should meet them in the Children's Centre, as childcare was a big gap for women who could not access any support without child care or crèche facilities.
- Women valued being able to access a single service and have face to face contact rather than being in contact with many professionals from different agencies. Women found the current arrangements confusing and having to repeat their story as traumatic. The women suggested there should be 'one door and one number to call' when accessing support from a DVA service. They also wanted to talk to 'a living person' and not 'just do tick boxes'.
- Being helped to understand coercive control and that DVA is not just physical violence was an important role of DVA services in helping those women who did not realise they were experiencing DVA – *'I felt like a fraud'*.
- All participants emphasised the importance of outreach, open door and drop-in facilities. Having someone to check-in with even after intense support had ended was seen as valuable for women, who often felt alone or who needed advice if something occurred in their lives.
- It was suggested that evening sessions were required for those women who were at work during the day.

## Effective DVA services:

- A consistent theme across all the focus groups was the importance of a service with expert knowledge and expertise which understands and believes women's experiences of DVA.
- The importance of services being co-ordinated, well organised and consistent was also emphasised, as women can be easily put off if they experience any negativity. This is especially important when women are making the first contact.
- Women emphasised the importance of feeling secure and safe, having someone to talk to and a support network so '*you're not your own*' as key to being effectively supported.
- Ideally, women wanted 24 hour support, especially those who had felt suicidal and not told anyone about this.
- Some women had been supported through contact proceedings by DVA services – '*help you fight your corner*' – and thought this was crucial, especially in the face of their fear of facing perpetrators in court and/or waiting with perpetrators in the same building. Women wanted separate safe areas for victims in the family courts.
- Having an immediate response to their issues from a DVA service (and others) was valued by women.
- Advocacy with other agencies/professionals was very important for women, who thought professionals listened to other professionals more than to women. The support from a DVA service often elicited positive responses more quickly.
- 'Courtesy' calls/keeping in touch after women have left a support service was greatly valued by women, not least because it made them feel they were not alone.
- Women stated that support through both one-to-one work and group work was needed. One-to-one support was highly valued by women who thought this should be the main mechanism of support at the start. Once women had learnt to trust and opened up, then talking to other women in a group context was considered an important next step.
- The women were generally positive about the Freedom Programme but some felt that one-to-one sessions would have prepared them for being in a group. Better assessment needs to happen before women are accepted on to the Freedom Programme to ensure only women who are more settled start the group.
- Being in touch with other women who had had the same experiences was highly valued.
- Group work was experienced as an important opportunity to reflect on the process of being abused and how this had affected them. It also allowed women to build friendships – '*the mix of women is amazing*'.
- Those women who had completed the 'Triple P' (parenting course) said this had helped their self-esteem and self-confidence, and suggested it should be offered to all those who need it.

## Suggestions for service improvements were:

- There should be a fully trained DVA support worker at every Children's Centre.
- Health visitors, GPs and teachers should routinely give information about DVA and support services to women.

- More training for police officers.
- Helpline number should be given to women in discreet ways, such as the lip balm, and on sanitary products.
- Barriers faced by some groups, such as disabled women, should be better recognised – harder for disabled women to disclose because partners are always present and this is made worse when there are no children as disabled women tend not to be in contact with any services.
- GPs should have more training and be proactive in their responses – such as documenting injuries.
- More information about DVA through posters and TV advertisements, including key messages about where to go for help.
- Posters in toilets in key places.

### **Gendered services:**

- All participants made a strong case for women-only services. Women said they felt safer in a women-only service, something that was crucial in helping women to regain their confidence, which had been broken by abusive partners.
- Some thought that services should also be available for male victims but these should be separate from those for women.
- A minority of women wanted positive role models for themselves and for their children.

### **Barriers and challenges to recovery:**

- When speaking about the challenges in re-establishing their lives, women spoke about the injustice of having to leave everything behind:

*It's your whole life, you're leaving your life behind...instead of moving women out of the area, women have to move the kids, instead they should arrest men and move them out. Need stronger action on men. They get to move on with their lives and we get nothing.*

- Some women continued to be fearful, saying they 'always look over your shoulder'. Others said they needed to learn to 'break old habits' and be able to trust men again.
- For some, a lack of childcare was a big barrier to accessing any services, such as counselling or support groups.
- When asked about the barriers to their recovery, women spoke of their fears about letting their children down. Child contact is a significant issue in preventing women and children from recovering from DVA. Having support through child contact issues, which can be protracted, was regarded as crucial for women in dealing with ex/partners.
- Housing and being re-housed was a particular anxiety for women who felt uncertain about where they would be placed.
- Women wanted to move forward and not be reminded of their past – '*I want to close the door, otherwise they're winning*'. The availability of long term emotional support in this process was emphasised.



- For those in a refuge, being able to help each other out and the support of other women was a factor in women becoming stronger and more independent. This was something that women said should be available to all women who needed it. It was suggested that Children's Centres, for example, could run groups for parents with similar age children for peer support, as a regular drop-in for an unlimited time.
- A victim-survivor befriending programme to link in with similar age women to support each other was also suggested.
- Women suggested that self-confidence and self-esteem courses were needed for women after being supported by DVA services.
- Triple P parenting courses were also seen to be a good thing for women coming out of domestic violence by some who had completed such courses.
- Information, support and counselling for the wider family network, as a way for all to recover from the impact of DVA, was seen by some to be of great value and something that was believed not to happen currently.

### Work with perpetrators:

- Women were of the view that abusive men '*will never change*'. However, it was also thought that '*there is help out there for them if they want to take it up*'. Some women thought that men should be made to go on the Freedom programme.
- A minority of women wanted their partners to go on a perpetrator programme and wanted them to do this for themselves, not to reconcile.

### Children:

- Work with children and young people was identified as a gap by women, who said '*children need services as well*' and '*there needs to be work with teenagers*'. Waiting lists for CAMHS were reported to be too long; some women were scared of accessing this service for fear of labelling children.
- Instead, women suggested that DVA services should offer support to children, including with the transition of moving to keep things as normal as possible after leaving their homes – '*I'm telling my son that we're waiting to have our house built*'. This was especially the case for those who were living in a refuge.

## Practitioner Feedback

Three focus groups were conducted with 18 Warwickshire professionals. This included staff from Refuge (5), Stonham (7) and 6 health professionals (4 health visitors and 2 family nurses).

The participants were asked for their views on the following areas:

- The role of DVA services
- The support needs of women
- Children/schools, benefits and housing
- Available specialist support
- Response from statutory agencies

- Training

The following presents a summary of the key themes and suggestions from the sessions. Again, a separate report with more detail is available on request.

### **Role of DVA services:**

- In providing emotional and practical support, the aim of DVA services was considered to be that of strengthening women (and children) in a context that believed them and gave them opportunity and space.
- DVA services provide a crucial link between women and statutory services, providing an important advocacy role; for example, DVA services support women to challenge unrealistic actions expected of them in the plans produced by Children's Services.

### **Support needs of women:**

- Women accessing DVA services were reported to require a wide range of support, which included:
  - Emotional support
  - Advice and information about options, including civil routes to protection
  - Support with benefits and housing
  - Advocacy and support, including at court
  - Support with children's issues, including Children's Services
- This range of support was aimed at empowering women to make their own decisions. Building a relationship of trust to enable them to feel safe was a key aspect of the work done.
- Women were considered to have more and more complex needs, including issues of mental health and problematic substance use, for which women were connected to relevant support services.
- The use of social media/technology in the perpetration of abuse was considerable and women were sometimes unaware of this.
- Young women in refuge were reported to not know how to cook, have limited parenting skills and to need support with budgeting and financial skills.
- Relationship building between mothers and children was thought to be frustrated by limited interaction because of time being spent watching television or the use of iPads and computers.
- Financially, women tended to be disadvantaged as men were often the main breadwinners.
- Women's fears about losing their children were widespread and they were reported to be 'petrified of Social Services' with some withdrawing from support or being too afraid to give evidence in court.
- A number of issues for BME women were identified - no recourse to public funds; importance of not using 'culture' to excuse DVA; moving women could lead to social isolation as the numbers of BME communities is low across Warwickshire; Polish women tend to be highly financially reliant on partners; rehousing is a challenge.
- Disabled women were generally dealt with through Adult Safeguarding but concerns were raised around professionals not knowing what to do if victims did not want to pursue legal action or to separate.

## Children/schools, benefits and housing:

- For refugees, one of the most important aspects of support offered to women is to settle the children into school soon after them coming into the refuge. However, a number of issues with availability and access to schools were highlighted.
- More generally, children were reported to be a '*big concern*' for women but meeting children's needs was a challenge for all given the lack of available intervention and support services; CAMHS were considered to be '*not enough*'.
- In supporting women in refuge, issues are also encountered with an increasingly complex and rigid housing and benefits system.
- Every district in Warwickshire was reported to be different with regard to housing and responses from officers varied.
- A high level of misunderstanding about DVA among Housing officers was reported.
- With regard to furnishing and equipping properties, women have access to a local Welfare Fund across Warwickshire but this is limited.
- Legal aid was also reported to be a 'massive issue' and a challenge in supporting women around immigration, child contact and divorce. Proving DVA is key and many women are unable to get the required evidence.

## Views about available specialist support:

- The support provided by DVA services was regarded as vital by other professionals. However, a number of issues were raised about the current support available and overall they perceived a lack of capacity to meet need.
- The Freedom Programme is over-subscribed and there is a lack of capacity.
- The lack of work with children was highly concerning to respondents and it was suggested this was a multi-agency responsibility and all should contribute to the development and sustainability of support interventions for children.
- Further gaps were identified in relation to work with perpetrators and in counselling provision for women.
- Issues were raised about referrals to refuge – Coventry services only take women from Coventry but Warwickshire refuges are open to all therefore there is a perception of Warwickshire refuges being an 'overspill' for Coventry.
- The short term nature of funding was considered counter to good practice in DVA support work, where longer intervention periods are necessary to build trust and to see real impact.
- Drop-ins needed to be better advertised and more accessible.
- Timeliness, accessibility, consistency, and knowledge and experience were considered crucial for any specialist DVA service. Relationships with women need to be sustained with cases of all levels of risk; the current focus on high risk was considered problematic
- Women were thought to require a safe supportive space where they could make decisions without pressure or judgement.

- Parallel group work for women and children was also thought to be required.
- It was said to be hard to know where to send young men – their issues were all seen as ‘anger’, a label which was seen to be misused.
- Support for child contact issues was reported to be ‘*non-existent*’.
- Better support for women, whose parenting was often poor because of DVA, to equip them to help their children to recover from DVA was a key issue raised by many respondents.
- The importance of early intervention was underlined.

## Response from statutory agencies:

- Women experiencing DVA who are in contact with Children’s Services are typically given a plan which includes going to a refuge, a Freedom Programme and Parenting programme. Concern was expressed about what is expected of women in such situations.
- More generally, the attitude and lack of understanding of social workers towards women raised much consternation
- ‘*Why doesn’t she leave*’ is still a very common question among professionals.
- Responses to women from the police were reported to be ‘good’, and DVA services were generally considered to have good relationships with the police. In general, that women are more willing to report to the police and know that something will be done was seen to reflect many women’s trust and confidence in the police.
- Improvements were suggested around feedback from the police regarding cases and the flow of referrals from the Police Harm Assessment Unit for standard and medium risk cases.
- A lack of knowledge about DVA was reported among magistrates, who were said to order child contact but place the responsibility on women to arrange contact. A lack of clarity was also reported to exist about what happens once contact is ordered by the court. A shortage of supervised contact centres was further highlighted. That women had to take many buses to contact centres or that elderly grandparents are often third parties in contact arrangements were also identified as concerns.

## Views of health professionals:

A focus group was conducted with six health professionals, four of whom were health visitors and two family nurses, to ask them about how present DVA was in their work, how they responded and what support needs women had. Presented here are the issues that were specific to this group:

- DVA is one among a number of issues for which support is provided. Health visitors and family nurses ask women about DVA if there is no one present.
- Information through leaflets is given to women through an information pack and DVA is ‘*slipped into the conversation*’ to send a message to women.
- Training on DVA is accessed through the Warwickshire Local Safeguarding Board and cascaded to others. The difficulty in accessing training was highlighted.
- The importance of multi-agency training was reinforced as was the need to develop knowledge and skills beyond basic training but this was said to be unavailable.

- Getting women to disclose was considered a challenge as women did not often recognise what they were going through as DVA. Even those who did disclose, unless there was a police report, only did so after a relationship had been established with the health professional and many women tended to view health visitors *'as an arm of social services and are fearful'*.
- The under 20 age group was reported to be a *'big issue'* – tended to be *'volatile'* as a group which is learning to manage their own relationships in healthy ways but with many having little experience of healthy family relationships.

## Training for professionals:

The need for and importance of training for all professionals, especially for judges, social workers and housing officers, on DVA and other forms of VAWG was identified by the majority of respondents. In general, the need for a rolling programme of multi-agency training was underlined.

## Issues for the next commissioning process:

All professionals in the focus groups were asked to identify 3 issues they wanted to feed into the commissioning process for DVA services. The following provides an overview of the areas that were identified.

- Children's workers to be based in refuges.
- More refuge spaces are needed as there is currently a deficit of 31 places (instead of 55 there are only 24).
- Refuges need to have 'looked after children' status.
- Tiered training for all professionals, especially police, housing and social services – currently a tick box approach to DASH and do not always understand the dynamics and complexity of issues.
- Develop services to reach 'hard to reach women' in rural areas – community based regular services.
- Multi-agency responses need to be strengthened – address lack of legal involvement in MARAC or in DVA services.
- Develop better perpetrator services – *'we are not going to resolve the issue until the focus is on offender's behaviour'*.
- Education programmes in schools.
- A focus on issues for BME women and children to increase knowledge, awareness and support.
- Increased provision for children who have been exposed to DVA.
- Longer funding for DVA services to establish themselves in the multi-agency context.
- Better partnership working and links between services to reflect a truly multi-agency approach to DVA where all agencies (statutory/generalist and voluntary/specialist) take responsibility – provide better referral pathways; smoother transition and seamless progression; better communication.
- Improved move-on for families – currently battle to move families on; little recognition that women move from temporary accommodation into poverty.
- Increased capacity to manage realistic and safe caseloads.

## 7. Best Practice to Inform Commissioning

### Key findings:

Best practice is identified across 3 main areas:

#### 1. **Primary prevention**, covering:

- Measures designed to raise awareness among local communities and enhance the capacity of community, family and friends of victim-survivors and perpetrators
- ‘Whole school’ approaches to gender equality and VAWG education work, using nationally evaluated, evidence-based interventions
- Targeted and universal awareness raising campaigns
- Self defence programmes for women and girls
- Workplace awareness campaigns
- Minimum standards for all agencies to publicise DVA and to encourage early identification and disclosure
- Programme for involving and training victim-survivors in development and review of service interventions

#### 2. **Early intervention**, covering:

- Training for professionals and frontline staff to spot early signs and risk factors of DVA
- Fully accessible universal/mainstream services so that victim-survivors, children and young people and perpetrators face minimal barriers in seeking help and accessing support
- Routine and selective (safe) enquiry and improved initial response to disclosure across public services for adult victims and children
- Targeted early intervention work with groups who possess certain risk factors including FGM, forced marriage, pregnancy, young people, substance misuse, mental health
- Early identification and response to perpetrators across all agencies, especially NHS, children’s and adult services

#### 3. **Provision of ongoing support**, covering:

- Accessible universal services for victim-survivors, children and perpetrators delivered by trained, skilled staff equipped to identify and respond effectively to DVA, based on the principles of safety, accountability, and undoing the harm caused
- Provision of independent, accessible specialist DVA services for victim-survivors and perpetrators – adults and children
- Specialist individual support service for children and young people including supervised child contact centres
- Programmes for perpetrators and related women’s safety services
- Supporting families with complex needs
- Multi-agency risk management systems (MARAC)
- Specialist Domestic Violence Courts

Research undertaken by Warwick University has identified the following best practice for partners and commissioners to consider when developing their response to DVA in Warwickshire. This divided into three areas: primary prevention; early intervention; and provision of ongoing support:

## Primary Prevention

Primary prevention involves education to change attitudes and behaviours to reduce the incidence of a problem among a population before it occurs. It is targeted universally, at broad population groups, such as school-age children or members of a particular community.

### **Measures designed to raise awareness among local communities and enhance the capacity of community, family and friends of victim-survivors and perpetrators:**

Communities need to recognise DVA, work together to address it, and provide information and support to victim-survivors whilst challenging and holding perpetrators to account for their behaviour. This is critical since much support to victims and challenge to perpetrators comes from these sources, not from service providers. A positive and knowledgeable response from the immediate network – bystanders - surrounding victims and their children is critical to increasing the likelihood of early intervention. Community action may include:

- Increasing the knowledge of community members, family and friends of victim-survivors and perpetrators through targeted leaflets and online resources; through workshops, meetings and events; and through community engagement and community outreach programmes.
- Supporting the development of women's discussion groups amongst different BME communities whose needs are less likely to be met through mainstream agencies.
- Community-led awareness raising of forced marriage and HBV through professional and community engagement and outreach programmes, including amongst disabled and LGBT groups. This should take place both in the communities it may affect and with the practitioners and agencies that potential/victims may use or go to for information or help.
- Community-led outreach work on FGM with young people and women from the communities at risk to increase awareness that the practice harms the women and girls concerned and degrades the men and women that advocate the need for FGM.
- Services that work with children, young people and families promote healthy relationships as part of their mainstream service delivery (including health visitors, youth services, Children's Centres, services for looked after children, colleges, schools and nurseries).
- Government advocates community based initiatives which can foster collective support and which also have the benefit of raising awareness of violence against women and girls more widely in that community.

### **'Whole school' approaches to gender equality and VAWG education work, using nationally evaluated, evidence-based interventions:**



Evidence shows that a whole school approach is crucial to conducting effective prevention work in schools as this tackles gender inequality, sexual and sexist bullying, DVA, and other forms of VAWG. The importance of schools ensuring that all incidents of DVA and sexual and sexist bullying are recorded and reported separately to other forms of bullying has also been emphasised. A whole school approach to prevention includes:

- Every school should make it clear that all forms of DVA and all forms of VAWG are a safeguarding issue and ensure that all staff know how to deal with children they identify as being affected, including when to refer to the school's designated senior person for child protection.
- Key messages about DVA and VAWG and what schools can do to tackle it should be included in a range of existing and planned guidance to help mainstream it into school policies and roles, and incorporate this into initial and ongoing teacher training.
- Material is available for schools, children and young people to raise awareness of both the issue and provide information about available help. That young people's help-seeking strategies favour peers needs to be acknowledged in school-based interventions aimed at supporting children living with DVA and at reducing teenage partner violence.
- Peer support and counselling schemes in schools should be developed/ extended to include DVA, sexual bullying and peer violence in teenage relationships.
- Better advice for parents is needed about supporting their children in their intimate relationships, including on how to protect them from associated harm. Schools should also offer parents and carers information about where they can get help about DVA.
- Direct referrals should be made by schools (nurse, counsellor, teacher) to specialist external services.
- Extended school services should develop and maintain partnerships to support DVA education in schools; ensure school interventions on DVA are integrated with community activities; find ways to consult with families about initiatives to reduce DVA; monitor and evaluate partnership working and incorporate good practice into planning.
- School inspections and monitoring should include how schools engage with students and staff on DVA issues, how a school undertakes its equality duties, and works to prevent violence and supports children who are experiencing violence.
- Gender equality, DVA and VAWG should be included in the school curriculum for Personal Social and Health Education (PSHE) and Sex and Relationship Education (SRE). The voluntary sector has a role to play in supporting schools to provide information and to facilitate discussions with young people and must be supported to do this. Schools should also be supported to comply with the Forced Marriage statutory guidance and the Gender/ Single Equality Duties. PSHE classes should focus on physical, sexual and emotional forms of partner violence and particularly address teenage partner violence and the role of coercive control, including in isolating victims from support networks.
- Incorporate domestic, sexual violence and sexual consent into sex and relationships education lessons. Raising awareness of the continuum of sexual violence and its gendered dimensions as a core aspect of SRE lessons, with young people and teachers encouraged to work towards a whole school approach. Consent, coercion and pressure must be explored explicitly, including how notions of sexual reputation influence expectations and reinforce notions of masculinity that normalise sexually coercive behaviours.

- Media literacy should be introduced into SRE to enable young people to critically analyse media messages that sexualise girls and young women and present narrow and exploitative models of masculinity.

The recent PEACH review of evidence about different approaches to preventing DVA for children and young people, found there was a range of innovative work being done to help children and young people avoid and/or deal with DVA in their own and in their parents' relationships across the UK. Much of the work takes place in secondary schools, though work undertaken in primary schools is increasing and media campaigns are increasingly used to deliver key messages. However, overall provision was found to be patchy and poorly sustained, reflecting a lack of policy direction and a reliance on unstable funding sources. It was also asserted that emphasis should also be placed on home grown initiatives which include features that young people find engaging, such as drama/narrative. Many interventions targeted at young people show a change in knowledge and attitudes rather than behavioural change though greater knowledge and awareness among young people can result in behaviour change within the peer group. A school's 'readiness' to introduce preventive interventions across the school and at different levels, has been underlined by much of the research in this area. Placing young people at the centre of the design and delivery of programmes is seen to be a key ingredient in achieving impact and effectiveness, as are longer interventions delivered by appropriately trained and confident staff. Whilst teachers are well placed to embed interventions in schools, they require training and support from those with specialist knowledge and skills in working with DVA. Boys are identified as a key target for change; there is also a need for interventions to be targeted at disabled and BME children and young people and for materials and programmes to be designed for LGBT young people. The importance of schools building close links to services that can respond to children's disclosures of abuse in their own or their parents' relationships has been underlined.

### **Targeted and universal awareness raising campaigns:**

Careful consideration should be given to the design of education and awareness-raising campaigns and programmes on DVA, rape and sexual assault so they spread understanding of the current law; do not perpetuate false understandings of how victims respond; and take full advantage of the diverse range of new media outlets so that they are as targeted and effective as possible. For example, how being drunk or incapacitated becomes a conducive context for sexual coercion needs to be addressed but rather than promoting the message that young women should not get drunk, an alternative promoting sexual ethics for young men in such situations should be developed.

DVA and other forms of VAWG is a significant public health concern and the NHS should lead a culture change amongst professionals to play a key role in educating professionals, communities and individuals to raise awareness that these forms of violence are significant public health issues that require public health interventions.

To ensure victim-blaming messages are not inadvertently reinforced by local campaigns, any local campaigns need to be developed in accordance with the Government Equalities Office Violence Against Women Awareness Toolkit, developed from public research and evidence from experts, together with the learning from many evaluations of annual campaigns to raise awareness about and prevent VAWG. For example, police messages in response to newspaper reporting of DVA, rape and sexual violence, should focus on targeting perpetrators and on holding them responsible for their behaviour, and not on perpetuating victim-blaming

messages<sup>30</sup>. Campaigns that associate rape, sexual violence and alcohol should not target women who drink or display images of women who are drunk on posters, thereby implying they are to blame for the violence. This leads to women being urged to modify their behaviour by drinking less, or abstaining completely. Campaigns also need to be accessible for different communities, and also targeted at different aspects of DVA. That local agencies distribute and display national materials on DVA, partner violence in teenage relationships, forced marriage, FGM, rape and sexual violence should be ensured. Adverts in newspapers and on the radio for services are a useful way to highlight DVA behaviour by perpetrators and direct them to services.

## **Self defence programmes for women and girls:**

Women's self defence programmes are a specific form of training that take an integrated approach to violence prevention by combining cognitive, behavioural, psychological, social and physical dimensions to empowering women and girls. There is a compelling body of evidence demonstrating that such programmes lead to an increase in women's confidence and a marked reduction in fear of violence. The ability to participate fully in local communities should not be under-estimated; women's lives are impacted on a daily basis by their lack of (actual and perceived) safety at home, at night, on transport, and at the workplace. In contrast, women who feel confident and empowered are more likely to work, to engage in the community they live in, to be more equipped to recover from experiences of abuse and be less susceptible to becoming repeat victims of violence in the future.

## **Workplace awareness campaigns:**

DVA is a workplace issue that requires effective workplace policies and procedures. It affects both men and women either as victims or perpetrators in the workplace, and has far reaching effects, as already noted. However, employers lack awareness and the skills and knowledge required to deal effectively with victims of DVA. Employers need to work with unions to develop and implement workplace agreements on addressing DVA and raising awareness of it as a workplace issue. These agreements need to include provisions on how to deal with employees who are perpetrators as well as victims. National charities, Refuge and Respect, have developed a workplace toolkit for employers. A case study outlining the potential for improved practice and the associated cost savings by the Equality and Human Rights Commission shows that if an organisation fails to address DVA effectively, the costs associated with an individual employee can be in the region of £155,000 per employee, compared with just over £700 per employee if the workplace has a whole-workforce approach to identifying and responding to DVA, the development of which is estimated to cost around £17,000 in the first year.

## **Minimum standards for all agencies to publicise DVA and to encourage early identification and disclosure:**

It has been suggested that all local public services should:

- Display DVA posters in all public areas.

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<sup>30</sup> For example, a recent Scottish Police rape awareness campaign distributed postcards that depict women enjoying themselves with the direct message that "Drinking is not a crime — rape is." The police message was clear and unambiguous: 'Sex without consent is rape and responsibility for rape will always lie with the rapist, and the Police will robustly investigate every report of rape'.

- Provide DVA information in accessible formats (posters, leaflets, crisis cards) in easily accessible areas (receptions, interview rooms, toilets).
- Include DVA information of relevance to victim-survivors, children and perpetrators on their agency website.
- Agencies should ensure that staff at all levels receive basic training and that staff with specialist functions receive specialist training which equips them for early identification, risk assessment and response.
- Develop a specific personnel policy on DVA for staff experiencing or perpetrating DVA.
- Develop DVA policies and guidance for all staff delivering services, outlining their specific role and responsibilities.
- Have a specific named individual within the agency who has lead responsibility for DVA work and for this role to be explicitly included within their job description. In the case of local authorities, there should be a specific individual in the commissioning unit and in each service area.
- Mechanisms to monitor the agency's response to DVA and to collate meaningful and accurate data for sharing with other agencies.
- Systems to communicate DVA developments to all staff.

## **Programme for involving and training victim-survivors in development and review of service interventions:**

Victim-survivors of DVA are best placed to identify what constitutes an effective response to those experiencing DVA. The challenge for public services and commissioners is to create mechanisms for them to be supported to have a voice which informs local developments and responses. Annual processes need to be developed to ensure ongoing consultation and involvement with adult and child victim-survivors of DVA so that the development, delivery and review of services are victim-survivor informed<sup>31</sup>. Holding a victim-survivor conference is also regarded as an effective way of meeting victim-survivors, identifying key issues and establishing the key issues to be addressed. Another approach is to set up victim-survivors' panels which meet quarterly, are independently facilitated and made up of a broad group of victim-survivors who are paid for their time. Different agencies attend and meet the panel to talk through their views and experiences of services. Ideally, members of panels should receive training (such as listening skills, group work, boundaries, and presentations).

## **Early Intervention**

Secondary prevention refers to the early identification of those who are particularly likely to experience DVA (such as pregnant women) to provide support and information with the aim of reducing risk.

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<sup>31</sup> An established model of good practice in involving women victim-survivors in the development and review of policies and services exists in the South West region where there is a network of Victim-survivors Empowering and Educating Domestic Violence Services (SEEDS) groups. SEEDS members are involved in training, raising awareness, giving presentations, participating in consultation events and conducting research amongst victim-survivors. Examples of SEEDS achievements include: walking the Specialist Domestic Violence Courts to advise on lay out and on safety issues; meeting with CAFCASS to raise concerns about mothers' experiences of the family justice system; contribution to a DVA housing policy.

## **Training for professionals and frontline staff to spot early signs and risk factors of DVA:**

In order to identify those affected by DVA so that they can be offered information and support, front-line staff need to be more aware of DVA, how it may present, what signs to look out for and what action to take. Staff also need to elicit disclosure through sensitive and safe enquiry. Increased awareness will also enable staff to work proactively with service users and the general public, to help raise awareness about DVA, to spread the message that it is not acceptable, and to help people come forward to access support. Good practice includes:

- Mandatory training which includes domestic violence and sexual violence awareness, risk assessment and safety planning equips staff with a clear framework for response when a disclosure is made. Within this the risk to children as well as to adult victim-survivors should be assessed, both as part of the same process and separately, to ensure that the needs of both are fully met.
- Provision of e-learning courses for GPs on violence against women and children.
- Training for health professionals in NHS Walk-In Centres to identify, respond and refer to local specialist DVA services.
- Police officers, NHS and other frontline staff to be aware that DVA and other forms of VAWG can be an underlying issue in other crimes or health problems, particularly substance abuse. They also need to be aware of how to respond effectively.

## **Fully accessible universal/mainstream services so that victim-survivors, children and young people and perpetrators face minimal barriers in seeking help and accessing support:**

In a national consultation, victim-survivors spoke about being denied access to universal healthcare services – GP receptionists acting like ‘gatekeepers’ by preventing them from registering with GPs; not giving them appointments; not providing access to independent interpreters; and requiring women to explain why they needed the appointment in public waiting areas. In particular, women from BME communities and women asylum seekers mentioned being refused access to healthcare. This is of concern as GP or other healthcare settings are highly used by victim-survivors. Good practice suggests that:

- Health services should be accessible for the most vulnerable groups of women, and GP surgeries should introduce drop-in appointments to enable women to access their GP on the same day that they need help.
- Services should deliver culturally sensitive services to women in their own language or through professionally trained interpreters that are not from their local community. All statutory agencies should have a clear policy on the use of interpreting services that ensure victim-survivors and children are able to disclose violence and abuse confidently and confidentially.
- NHS and local authorities should publicise that direct treatment needs should be met by the NHS for women and children experiencing DVA irrespective of their immigration status.

## **Routine and selective (safe) enquiry and improved initial response to disclosure across public services for adult victims and children:**

Speaking out about DVA is difficult for victim-survivors. Research shows that victim-survivors want to be asked about DVA but most professionals very rarely ask them or if they do ask, this is often done in an environment that is unsafe to disclose. Even when victim-survivors disclose to professionals in public services, they often receive unhelpful responses, which includes being disbelieved, judged, and blamed or their experiences being minimised. Professionals often lack the information to refer women to specialist support services or do not know how to respond once a disclosure is made; such responses can create increased risk.

There is a key role for early intervention (secondary prevention) in universal and targeted service settings where every intervention given to a victim-survivor may prevent further violence. Early identification and effective intervention by the NHS, for example, should not only protect victims from immediate harm but also have longer term health benefits, including reducing the number of women requiring treatment for mental health problems, problematic alcohol and drug use, gynaecological and sexual health problems, and reduce the incidence of teenage pregnancy, self-harm and suicide attempts. Those with responsibility for safeguarding adults and children need to be aware of the 'one chance' rule and ensure all professionals are aware of their responsibilities and obligations when they come across forced marriage cases.

Research shows that victim-survivors value a response where professionals listen and believe them, treat them with dignity and respect, and help them be safe. They also value a response from health services that focuses on their emotional wellbeing as well as medical treatment; and from all mainstream services, information about specialist services that can provide emergency and ongoing support and advocacy, and referral to these support services where appropriate. However, a lack of knowledge, skills and understanding of DVA are common among professionals, which impacts on their ability to provide effective intervention. A reluctance to engage with DVA in some agencies and amongst some staff may also exist and there may also be a lack of clear referral and care pathways to refer victim-survivors, perpetrators and children.

- Safe, selective enquiry should be required in healthcare settings, children's services and adult services. Safe enquiry, linked to referral to appropriate services, can be effective in early identification. Safe enquiry should be part of an overall approach encompassing training for frontline staff to raise their awareness of DVA, support for them from co-located specialist DVA practitioners, and an expansion of the screening role of alcohol, mental health and other specialist workers to enable them to ask about DVA safely. This should be accompanied by robust monitoring so that health professionals are held to account for failing to identify DVA.
- Services should give women victim-survivors the choice of being seen by female professionals to encourage disclosure and to receive support following disclosure.
- Maternity services should hold separate, confidential, professional notes to record information about abuse; this should not be recorded on hand-held maternity notes without the woman's consent.
- All professionals should have protocols for safe information sharing within their own organisation, with the victim-survivors' consent, and for consensual information sharing with external agencies, if violence is disclosed.
- Front-line police officers should be provided with an appropriately designed information

- leaflet or card to distribute to women and to children and young people at the scene of a DVA incident and should be aware of safety issues.
- Schools should ensure staff are aware of how violence may affect a child's behaviour and what action they should take if they suspect that it is related to DVA or teenage partner violence.
- GP practices should be linked to independent DVA advocacy workers who provide support and advocacy on disclosure of DVA at a GP service. The adoption of the Identification and Referral to Improve Safety (IRIS) scheme by CCGs has been encouraged at a local level.
- An evaluation of IRIS showed how the education of clinicians, coupled with a partnership approach with local community groups can greatly improve the quality of care provided to DVA victims. It shows that for PCTs, commissioning consortia and GPs this is a straightforward and cost effective approach which can transform the care received by some of the most vulnerable people in society.

### **Targeted early intervention work with groups who possess certain risk factors:**

Those at particular risk of repetitive and escalating violence include women refugees and asylum seekers; women involved in prostitution; young women not in education, employment or training; women offenders and in prison; women from BAMER communities, including Gypsy and Traveller communities; lesbians, bisexual and transgender women, and disabled women. Targeted, selective and safe enquiry should be routinely undertaken within services that work with these groups. Targeted intervention should be undertaken with victim-survivors where it is known that DVA starts or escalates depending on their identity or life experience, for example, in pregnancy, where there are service users with substance misuse or mental health problems, where there are groups at risk of FGM, HBV and forced marriage (BAMER communities, disabled and LGBT groups) and those at risk of sexual violence within intimate relationships, such as young people experiencing teenage partner violence (up to 70% of teenage mothers are in a violent relationship).

#### **FGM:**

- Midwives and health professionals should be trained to provide information to mothers from communities which practise FGM. Ideally this should take place during the antenatal assessment. The use of targeted questioning in those communities where FGM is practised should be employed as part of an integrated local pathway of care for FGM.

#### **Forced marriage:**

- All services that have a safeguarding function for the welfare of children and vulnerable adults should comply with the national statutory guidance on forced marriage.

#### **Pregnancy, including teenage pregnancy:**

- Midwives and health visitors who are in contact with pregnant women need to be appropriately skilled to recognise DVA, conduct routine enquiry and respond to the issue when raised, provide support and to signpost them to other services.
- Genito-urinary and contraception services are not routinely asking young pregnant women about non-consensual sex, especially if they are over 16. There is strong evidence pointing to the need for routine screening protocols to be implemented for all young women attending sexual health services,



particularly those who are pregnant, regardless of whether or not they wish to continue with a pregnancy.

- Sexual and DVA to be mainstreamed into teenage pregnancy policy and practice.
- Training on the extent and consequences of non-consensual sex should be developed for all professionals, in order that they can provide sensitive and non-judgemental support to young women, and practitioners should develop referral routes to specialised sexual violence services.

#### **Young people:**

- Services working with young people should ensure they understand the importance of healthy relationships and respect, and should promote the government published materials on teenage relationship abuse to support young people, teachers and schools to tackle this issue.

#### **Substance misuse:**

- Substance misuse agencies and DVA services should routinely ask questions about DVA and substance use, and conduct appropriate initial risk assessments, including questions about children's safety.
- Services should have posters and leaflets visible in waiting rooms and toilets to let service users know that DVA is not a hidden issue and that these issues commonly overlap.
- Safe separate provision should be available for victim-survivors and perpetrators; if both partners are accessing the substance misuse service, workers must always see them separately when discussing violence and abuse.
- Although victim-survivors may continue to use substances, working to maximise their safety should remain a priority for both DVA and substance misuse agencies. Safety planning involves more than assessing future risk; it can create psychological safety, the space needed to recover and freedom from fear.
- Drug and alcohol workers should consider including safety planning as part of standard care plans for victim-survivors. Sample safety plans are available in the Stella Project Toolkit.
- Ensure that DVA information is provided to alcohol and drugs workers located in custody suites.
- Develop holistic responses to victim-survivors with substance misuse problems by enabling skills transfer between professionals in DVA and drugs and alcohol services.
- Develop clear information sharing protocols between agencies to improve partnership working.

#### **Mental health:**

- Evidence indicates that in order to provide better acute and long-term mental healthcare for victim-survivors of violence, NHS services need to raise awareness about domestic and sexual violence, improve identification of victim-survivors, provide an initial supportive response, refer to services that can support them, and develop better collaboration with other agencies in the statutory and voluntary sectors.
- All mental health services should provide or commission specialist targeted psychological support in the context of current or past DVA; there is a need for integration of psychological support and treatment for victim-survivors and their children into mainstream health services in primary and

secondary care and specialist agencies, with DVA issues included within improving Access to Psychological Therapies training and competencies.

- Specialist targeted psychological interventions that explicitly focus on early intervention and addresses DVA with victim-survivors and their children are effective in improving mental health and behavioural outcomes respectively.

## **Early identification and response to perpetrators across all agencies, especially NHS, children's and adult services:**

Research shows that when perpetrators seek help they most frequently access GPs, and are likely to be in contact with Relate, Social Services, Samaritans, alcohol or drugs services, hospitals, solicitors, welfare services at work, and to use websites. Evidence also indicates that where perpetrators went to their GP, they presented themselves as depressed or in need of psychological/psychiatric care, without any acknowledgement of their abusive behaviour. Alcohol, drugs, depression and 'jealousy' rather than violence were often presented as the issues requiring 'treatment'. Male perpetrators are also more likely to seek help at a 'crisis' moment, usually when their partner gives them an ultimatum or actually leaves, or where there are child contact issues. This is also when they are likely to be especially dangerous and/or homicidal, and safety for women and children has to be a priority for any agency intervening with men at this time. Reducing a perpetrator's substance use may reduce levels of physical injury but has not been shown to reduce the actual occurrence of DVA. Even if treatment is able to reduce the severity of the violence it does not address the complex dynamics of power and control; hence work which specifically addresses such dynamics should always accompany a treatment plan. Drug and alcohol agencies should also exclude families where DVA is an issue from network therapies, because of the risk of this to such families.

Couple-counselling or other therapy is also not appropriate if DVA is a current feature of the relationship. Couple or family-based interventions which work with partners together often locate the problem of DVA within the family. Seeking to intervene with the whole family perpetuates the myth that DVA occurs in 'problem' families rather than it being rooted in the fundamental inequality that exists between men and women. There are significant dangers of colluding with abuse by reinforcing that the perpetration of abuse stems from communication problems between couples or lack of anger management. This sends a message that the victim is to blame for the DVA rather than holding the perpetrator responsible for his behaviour. In any services that deliver couple-based or family-work it is important to routinely and safely screen for DVA at the point of initial assessment in one-to-one sessions, and include follow-up enquiry at later stages of any service intervention. Professionals should also be aware of potential indicators of abuse and respond accordingly. For similar reasons, restorative justice is regarded as inappropriate in cases of DVA. The use of restorative justice has been particularly controversial due to fears of further re-victimisation that could arise. Further complications include the potential for restorative justice practitioners to miss subtle messages or threats that could be exchanged within a meeting. Working with both the victim and abuser together can be dangerous for the following reasons:

- Victim-survivors commonly minimise the abuse for fear of consequences of disclosure and the hope that the relationship can be saved. In this context, such interventions will potentially unwittingly undermine rather than increase their safety.
- The work is unlikely to be useful when one partner is fearful about how much they can disclose about the relationship. Regardless of the skill of the therapist they will be unlikely to gain the open and

honest thoughts and feelings of a victim while the abuser is in the same room. This can apply equally to children who may suffer the consequences of speaking openly.

- Evidence from mediation, couple counselling and court welfare work all indicates that neither women nor children fare well in any model where they have to negotiate their safety in the presence of their abuser. Out of fear for the consequences if they do not, women frequently reach 'agreements' which are not in their best interests.
- If the victim-victim-survivor is the one with the substance use problem it is not helpful for more information about the complexity of their problems to be passed onto the abuser. It provides the abuser with more ammunition with which to control his partner.
- It is beneficial to work with the children and the non-abusing parent. This could include the wider family if it is safe to do so and where family members are supportive of the non-abusing parent. Ideally, this should be done in partnership with a DVA agency. Perpetrators may not be engaged with specialist perpetrator services and there are steps practitioners can take to partially address the abuse safely and effectively, including perpetrator identification, giving safe messages to clients and referral to appropriate agencies.
- Agencies that come into contact with perpetrators need to ask about their abusive behaviour and respond appropriately. Service responses should not refer perpetrators to counselling or related approaches that may reinforce ideas of victimisation. Instead, GPs and other health service staff should direct perpetrators to services that aim to challenge and change abusive men's behaviour.
- Key agencies – criminal justice, health, social care, family courts – need to challenge men's abusive behaviour and hold them to account for their actions, while also ensuring safety for the victim-survivors and children. This should apply to the whole 'continuum' of DVA perpetrators, from early intervention to chronic and severe offenders. Children's services also require training, supervision and support aimed at increasing skills and confidence in working with perpetrators.
- Any discussions about DVA should emphasise that there is no excuse for abuse. Any other approach is in danger of colluding and condoning the abuse. It should be made clear that substance use is not an excuse and no one deserves to be abused. Where an organisation is working with both partners, there is a duty of care to ensure the safety and wellbeing of the victim-survivor of DVA. There is a responsibility to share information if a service user is deemed a risk to others.
- In drug and alcohol services perpetrators are more likely to blame their violence on their substance use. Alternatively, perpetrators may refer to their violence as an 'anger management' issue. Substance use services should include questions to ascertain whether the service user has ever been abusive towards a partner in their assessments though perpetrators are unlikely to disclose the level and extent of violence (particularly sexual violence) through direct questioning. Professionals should be alert to indicators which have been found to be risk factors for DVA victim-survivors.

## Provision of Ongoing Support

Provision of individual and group support and advocacy services for victims and perpetrators of DVA to address tertiary prevention which reduces the harm already caused through provision of support and advocacy to victims and children.

## **Accessible universal services for victim-survivors, children and perpetrators delivered by trained, skilled staff equipped to identify and respond effectively to DVA, based on the principles of safety, accountability, and undoing the harm caused:**

Whilst emphasis should be placed on early intervention, efforts need to prioritise responses from those agencies most likely to be approached by or already being used by victims, including GPs and other health staff, solicitors, housing services, children's services, adult services, schools and other education institutions, and voluntary sector services.

Some women enter the UK on a spousal visa or have temporary immigration status and find themselves in a situation where they have to escape an abusive relationship. There need to be local arrangements in place to ensure that such women and their children are supported to access safety while their case for indefinite leave to remain in the UK is developed and considered through the DDV.

Minimum standards for all agencies are needed to ensure that any agency working with DVA is safe and offering appropriate interventions. This includes ensuring services have trained and dedicated staff and that issues of diversity and equality are addressed. The following is set out in national evidence-based guidance for the NHS and for adult services:

- Every organisation should have a single designated person to advise on appropriate services, care pathways and referrals for all victims of DVA, providing urgent advice in cases of immediate and significant risk.
- Every organisation should ensure that in addition to having selective, safe enquiry and response procedures, victim-survivors and children who are experiencing DVA are provided with information that helps them to access services quickly and safely.
- All staff should have – and apply – a clear understanding of the risk factors for DVA, and its consequences for health and wellbeing when interacting with service users. This should include: appropriate basic education and training of all staff to meet the needs of women and children who have experienced DVA; more advanced education and training of 'first contact' staff and those working in specialties with an increased likelihood of caring for women and children who have experienced DVA; and staff awareness of the associations and presentations of DVA and how to broach the issue sensitively and confidently with patients.
- NHS organisations should ensure that information relating to DVA is treated confidentially and shared appropriately. This means that there should be consistency and clarity about information sharing and confidentiality and staff should be equipped, through training and support from local leads on violence against women and children and Caldicott Guardians, to share information appropriately and with confidence.
- Every organisation should nominate local strategic DVA leads, to drive change and improve outcomes.

## **Provision of independent, accessible specialist DVA services for victim-survivors and perpetrators – adults and children:**

Whilst the most effective mix of services required should be based on a robust assessment of need, overall levels of DVA are not sensitive to changes in demographics and place and every area will need to make the following provision, as a minimum:

- Access to information
- Safe accommodation and protection
- Financial, immigration and legal advice and advocacy
- Emotional and peer support
- Children's services
- Physical and mental health provision
- Drug and alcohol support
- Provision for perpetrators

Within this service mix, it is crucial that services that are safe are developed and delivered and there is separate service provision for women and for men (for example, where services are needed for male victims of DVA, these should be provided in a separate location by different professionals). There is significant evidence to show that female victim-survivors of violence prefer and receive more effective support from independent women's services. The women's sector has a long history in addressing VAWG and in providing practical solutions in support of those who most need them. Government has acknowledged that specialist women's services are expert in this field and should be put on a more sustainable funding basis. Evidence is emerging to indicate that it is good practice to co-locate and coordinate DVA services for victim-survivors and children in one venue, enabling cross-agency teams of expertise to provide a coordinated response to victim-survivors. Targeted support for victim-survivors from specific communities may also need to be developed as part of this specialist provision, such as BME, disabled, and LGBT victim-survivors.

To deliver the above provision, the following types of services are needed as a minimum, in every area, as part of the national evidence based Co-ordinated Community Response model for responding to DVA. These include:

***Domestic violence helpline service*** – For victim-survivors and professionals to access specialist information, help and support. It is important that local helpline services have good links with national domestic and sexual violence helplines for men and women, victim-survivors and perpetrators.

***Refuge based support and resettlement service, and safe housing options including Sanctuary Schemes*** – One refuge place per 10,000 is required as a minimum for emergency accommodation and support and to enable successful reintegration into a new home and community as well as to prevent repeat victimisation.

***Independent countywide DVA advocacy service*** – Countywide advocacy for all victims irrespective of risk, which includes targeted and intensive advocacy for high risk victim-survivors linked to MARACs and SDVCs; and targeted advocacy linked to acute, specialist and primary care services in the NHS (A&E, maternity, mental health services and GP practices). Individual advocacy helps victim-survivors to secure their rights and entitlements across many areas, including the justice system, welfare benefits, debt, asylum and immigration, mental health, community care, housing, and education. Whilst individual advocacy is extremely important and

forms the backbone of specialist DVA services' work, to be effective it must be delivered alongside more preventative and policy change work. There is compelling evidence that early access to independent advocacy interventions can decrease violence and increase quality of life for victim-survivors and their children, and improve mental health outcomes for women victim-survivors. It can support women and their children in escaping and recovering from a violent relationship. The work of independent domestic violence advisers (IDVAs) and independent sexual violence advisers (ISVAs) at local level is effective in protecting high risk victims and supporting victims to access the help and advice they need. Targeted advocacy that provides in-reach services at NHS premises and focuses on supporting health-based intervention has been positively evaluated.

***DVA individual and peer support services through community outreach provision*** – For victims needing a range of support within the community, in their own home or through drop-in centres. Evaluations of specialist DVA outreach services and multi-agency services found that they are effective in supporting women experiencing DVA and helping them escape abusive relationships. Many examples of effective peer-led support and befriending schemes for women who have been abused, raped or sexually assaulted exist; for example, the Amina Scheme in London involves pairing women service users with specially trained volunteers who have experienced sexual violence in the past. Volunteers meet with women once a week in a community setting to provide a listening ear, help women to talk about how they feel, and support them to access information about the effects of sexual violence. They also provide support during court proceedings and assist women in accessing other support services.

***Group support for victim-survivors and children*** – There is significant evidence to show that women and children benefit from group activities using a strengths-based model such as those devised and used by specialist DVA services, both refuge or community-based. Various models of good practice for setting up and running structured facilitated support group programmes for victim-survivors and for setting up peer-facilitated support groups or un-facilitated self-help groups exist. Separation of services for children and for women, with an emphasis on the former, can have an adverse effect on women victim-survivors, as the improved vigilance and protocols for child protection may result in the non-abusing parent's needs being overlooked. Similarly, those working exclusively with abused women may overlook the impact of DVA on children. Integrated services for women and their children, which recognise that both are 'at risk' or experiencing violence, deliver significantly improved outcomes.

## **Specialist individual support service for children and young people including supervised child contact centres**

More children than women are affected by DVA, even when they may not be the primary target of the violence. Services are required to meet their needs aside from, and in addition to, those of their non-abusive parent/carer. Local authorities and CCGs have a statutory duty to ensure that they safeguard and promote the welfare of all children, including child victims of DVA.

Outcomes for children affected by DVA will not be improved without support and empowerment of the non-abusive parent and thus support to the non-abusive parent and children needs to be provided through an integrated approach. Intervention aimed only at the child will not have a sustained impact. The most effective intervention for ensuring safe and positive outcomes for children living with DVA is support that incorporates risk assessment, specialist DVA support, advocacy and safety planning for the non-abusing parent in conjunction with protection and support for the child. Support services are also required for those children and families who do not reach the threshold for receiving intervention from children's social services but for whom

DVA is a persistent feature. These interventions could be delivered by specialist DVA services (in refuges and in the community), which can intervene early and offer timely responses to a wide range of needs presented by children and their mothers, such as risk, effects of DVA and trauma, and specialist assessments, reports and advocacy.

High quality supervised contact services that families can access offer intervention in circumstances where DVA often arises. Evidence of effective supervised contact centres, in ensuring safety and vigilance, has been demonstrated by research.

### **Programmes for perpetrators and related women's safety services:**

Whether perpetrator provision is court mandated through the Probation service and/or a voluntary programme that is accredited by Respect, these require a Women's Safety Service provided by, or in partnership with, the local specialist DVA service. The case for commissioning and delivering community-based perpetrator programmes has been set out by Respect.

Indicative findings from an overview of research into the effectiveness of perpetrator programmes, carried out by Respect, show:

- Most men who take part in a well-established programme situated in a coordinated community response model to domestic violence stop using violence.
- Women whose partners and ex-partners take part in programmes feel much safer and attribute this to the programme.
- Taking part in a perpetrator programme makes criminal sanctions more effective.
- Men find the use of experiential learning helpful for making sustained changes.
- Perpetrator programmes, through proactive contact with partners and ex-partners of programme participants, often make contact with and provide support to victims who do not otherwise contact or receive support from any other organisation.
- There are several forms of mandate which help to keep them participating in programmes.
- Social services can effectively operate a mandate for programme attendance, which brings more women into contact with people who can help them and provides men with ways of making changes.

However, more research is still needed on the ways in which men can be most effectively assisted to stop using violence and other contributions perpetrator programmes can make to victim safety as part of a coordinated community response model.

Greater availability of accredited perpetrator programmes which can be accessed on a voluntary basis is required at a local level. Such programmes should liaise closely with children's social services to ensure that their work feeds into parenting assessments.

### **Supporting families with complex needs:**

Many families have multiple and complex needs. Typically these problems include DVA, substance misuse, mental health problems, long-term unemployment, parenting Issues, child neglect, and behavioural problems



with children, including issues at school and involvement in offending. Intervention at such families, where DVA is a significant issue, has been targeted through Family Intervention Projects (FIPs). However, evidence of success in reducing DVA through FIPs has been contested, and concerns continue to be raised about the ways in which DVA is identified and assessed and the nature of the support offered, including referral to specialist DVA services. It has been argued that FIPs should not be viewed by policy makers as a front-line response to DVA and a continued need for community based perpetrator programmes and specialist DVA services, with clear referral pathways from FIPs to specialist DVA services, as well as DVA training for FIP workers.

### **Multi-agency risk management systems (MARAC):**

Multi-Agency Risk Assessment Conferences (MARACs), set up to prevent or reduce harm to high risk victims of DVA are an established part of the local response to victim-survivors. It is necessary for MARAC to be linked to local structures in place for MAPPA, safeguarding children and vulnerable adults. There is an increased national debate about the need to better understand the effectiveness of the MARAC process in protecting victims of DVA and to identify any areas in which the response to all victims can be improved. It is important that all local relevant organisations participate fully in local multi-agency fora.

### **Specialist Domestic Violence Courts (SDVC):**

SDVCs exist in many local areas and provide a prompt and informed response to victims of DVA. It is important to introduce measures to routinely measure and review victim satisfaction with the CJS. In order to monitor and review response, good practice in some areas involves CPS domestic violence, sexual violence or violence against women Scrutiny Panels bringing members of the voluntary and community sector into the CPS, together with CPS lawyers and independent legal advisors, to jointly scrutinise a random selection of completed cases (for example, including domestic violence, rape and sexual assault).

## 8. Other Evidence

### HMIC Inspection of the Police Response to Domestic Abuse

In September 2013, the Home Secretary commissioned HMIC to conduct a national inspection on the police response to domestic abuse. HMIC inspected all police forces in England and Wales, interviewing senior and operational leads, and held focus groups with frontline staff and partners. They carried out visits to police stations, which were unannounced, to test the reality of the forces' approaches with frontline officers.

The report<sup>32</sup> on this inspection entitled 'Everyone's business: Improving the police response to domestic abuse' was published in 2014. The overall conclusion was that the police response to victims of domestic abuse needed improvement with the following identified as key findings:

- A lack of visible leadership and clear direction set by senior officers
- Alarming and unacceptable weaknesses in some core policing activity, in particular the collection of evidence by officers at the scene of domestic abuse incidents
- Poor management and supervision that fails to reinforce the right behaviours, attitudes and actions of officers
- Failure to prioritise action that will tackle domestic abuse when setting the priorities for the day-to-day activity of frontline officers and assigning their work
- Officers lacking the skills and knowledge necessary to engage confidently and competently with victims of domestic abuse
- Extremely limited systematic feedback from victims about their experience of the police response

### HMIC Inspection of Warwickshire

As well as producing a national report, HMIC also published reports on each force inspection on their response to domestic abuse. The report<sup>33</sup> entitled 'Warwickshire Police's approach to tackling domestic abuse' was also published in 2014.

This report found the following situation in relation to domestic abuse during their period of inspection:

- Calls for assistance – DVA accounts for 5% of all calls to the police for assistance. The force was unable to provide the number of these calls that were from repeat victims.
- Crime - Domestic abuse accounts for 4% of all recorded crime.
- Assault with intent - Warwickshire recorded 191 assaults with intent to cause serious harm, of these 34 were domestic abuse related. This is 18% of all assaults with intent to cause serious harm recorded for the 12 months to end of August 2013.

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<sup>32</sup> <http://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/2014/04/improving-the-police-response-to-domestic-abuse.pdf>

<sup>33</sup> <http://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/2014/03/warwickshire-approach-to-tackling-domestic-abuse.pdf>

- Assault with injury - The force also recorded 2,377 assaults with injury, of these 702 were domestic abuse related. This is 30% of all assaults with injury recorded for the 12 months to end of August 2013.
- Harassment - The force recorded 380 harassment offences, of these 65 were domestic abuse related. This is 17% of all harassment offences recorded for the 12 months to end of August 2013.
- Sexual offences - The force also recorded 522 sexual offences, of these 27 were domestic abuse related. This is 5% of all sexual offences recorded for the 12 months to end of August 2013.
- Risk levels - On 22<sup>nd</sup> October 2013, Warwickshire had 249 active domestic abuse cases; 90% were high risk, 8% were medium risk, and 2% were standard risk.
- Arrests - For every 100 domestic abuse crimes recorded, there were 63 arrests in Warwickshire. For most forces the number is between 45 and 90.
- Outcomes - Warwickshire recorded 1,281 domestic abuse related crimes for the 12 months to the end of August 2013. Of these crimes, 19% resulted in a charge, 16% resulted in a caution and, 4% had an out of court disposal, for example, a fixed penalty notice for disorderly conduct.

The source of this data is HMIC and is based upon the forces' own definition of calls for assistance and domestic abuse, and forces' use of domestic abuse markers on IT systems. Crime figures are taken from police-recorded crime submitted to the Home Office.

## HMIC Summary of Findings

HMIC summarised its findings following its inspection of Warwickshire and its response to domestic abuse as follows:

- Warwickshire Police provides a good service to victims of domestic abuse
- The public in Warwickshire can have confidence that the force is working well with partners to tackle domestic abuse and keep victims safe
- Tackling domestic abuse is a priority for the force and the Police and Crime Commissioner (PCC)
- Staff demonstrate a high level of commitment and understanding throughout the organisation
- There is still some room for improvement and the report outlines areas where the force could further strengthen its response

## HMIC Recommendations for Warwickshire

The specific recommendations for Warwickshire were identified as follows. These should be considered in conjunction with recommendations to all forces set out in HMIC's national report on domestic abuse.

- The force should implement a robust quality assurance process that provides systematic audits of domestic abuse calls in the OCC
- The force should conduct a training needs analysis to establish what domestic abuse training is required across the force, and develops a timed implementation plan
- The force should consider options to provide officers with effective mobile equipment to capture early photographic evidence at domestic abuse incidents

- The force should consider increasing the access to the public protection CATS<sup>34</sup> database for staff who are likely to have contact with victims of domestic abuse
- The force should commission a comprehensive domestic abuse problem profile at a force level
- The force should develop a programme to identify and manage serial perpetrators of domestic abuse

## Formal Response to the Inspection by the Police and Crime Commissioner (PCC)

Following the publication by HMIC of the inspection of the force in respect of its response to domestic abuse, The then PCC for Warwickshire, Mr Ron Ball published his response<sup>35</sup> to the inspection in May 2014.

Warwickshire was one of only eight forces nationally judged to be providing a good service to victims of domestic abuse and confirmed his wish to improve on the current situation thereby strengthening the service provided to victims in Warwickshire. Each of the six recommendations contained in the HMIC report for Warwickshire, together with recommendations to forces in the national domestic abuse inspection report, are included in a Warwickshire and West Mercia Domestic Abuse delivery plan which is being led and driven by the head of Protecting Vulnerable People (PVP). Delivery against this plan is being tracked by a Domestic Abuse Steering Group, which operates across both forces. To ensure that he retains an oversight of progress in this important area of work, he will ensure that a representative from his office is a member of this steering group going forward.

He stated he views domestic abuse is an important element of his Police and Crime Plan and during its review in 2004, he incorporated specific references to achieving an increase in the number of Independent Domestic Violence Advisors (IDVA) to further safeguard high risk victims. In addition, the plan includes priorities to work with perpetrators of domestic abuse, improve the sanctuary scheme and provide greater outreach services aimed at protecting medium risk victims and preventing their escalation to become high risk victims of abuse.

'Clare's Law'<sup>36</sup> has been implemented in Warwickshire and although at an early stage, a number of victims have been protected as a result of using this scheme. In addition, Domestic Violence Protection Orders (DVPO's) are due to be implemented in Warwickshire during June 2014 led by the Head of PVP.

From a training perspective, the College of Policing<sup>37</sup> - Public Protection Training Programme<sup>38</sup>, which includes domestic abuse, will be provided to officers across the alliance and this will be complemented by a range of in force tailored learning products which will help professionalise the force's response to domestic abuse and seek to address any cultural barriers.

He noted with interest the comments in the national report regarding the formation of a Multi - Agency Safeguarding Hub<sup>39</sup> (MASH) as a vehicle to improving the effectiveness of service to victims. The formation of a MASH in Warwickshire is a priority in the Police and Crime Plan and his team will work with partners over the next two years to form such a hub in the County.

<sup>34</sup> Case Administration and Tracking System

<sup>35</sup> <http://www.warwickshire-pcc.gov.uk/wp-content/uploads/2014/12/30.05.14-Response-from-Ron-Ball-to-HMIC-Review-of-Domestic-Abuse-Warwickshire.pdf>

<sup>36</sup> Domestic Violence Disclosure Scheme (DVDS) 2014 – 'Clare's Law' – See Appendix 13.2

<sup>37</sup> <http://www.college.police.uk/Pages/Home.aspx>

<sup>38</sup> <http://www.college.police.uk/News/archive/2014mar/Pages/news-public-prosecution-learning.aspx>

<sup>39</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/225012/MASH\\_Product.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/225012/MASH_Product.pdf)

Since the report was published he met with key partners to discuss the findings and has been reassured that, despite funding pressures, Warwickshire County Council remain committed to provide the funds and therefore the services to victims of domestic abuse as they do now. In the future, he will be seeking ways of utilising funds available for victims commissioning services to further enhance the service provided to victims of domestic abuse in Warwickshire.

From discussions locally there were areas which are not specifically referred to in the HMIC report which he also intends to focus on. Warwickshire Police has a low conversion rate for those persons arrested for domestic abuse who are then prosecuted. He intends to examine this more closely to ensure, that on every occasion, the most appropriate outcome for domestic abuse perpetrators is achieved, thereby protecting the victims. The provision of body worn video equipment alongside other measures will be considered in order to enhance the quality of the police investigation and the level of prosecution.

The other area absent, in his view, is the lack of systems to seek victim feedback which could then be used to improve services and provide an indication of how well the force is performing. He intends to work with the force and partners to build in processes to secure such feedback in the future.

## **Listening and Learning – Improving Support in Warwickshire**

This report was researched and written by the Victims' Services Advocates (VSA) project. The VSA project was commissioned by the former Victims Commissioner in anticipation of the arrival of the police and crime commissioner (PCC) for Warwickshire and delivered by Victim Support<sup>40</sup>. Victim Support is the national charity giving free and confidential help to victims of crime, witnesses, their family, friends and others affected across England and Wales.

The report aimed to summarise current support for victims in Warwickshire; identify what victims need from local services; and propose a course of action by the PCC to meet these needs

The report was commissioned to look particularly at the needs of the following groups:

- Victims of anti-social behaviour
- Victims of domestic abuse
- Victims of sexual violence
- Victims of hate crime
- People bereaved by murder and manslaughter
- Young victims of crime

Five sources of information contributed to the findings of this report:

- A mapping exercise to identify current services for victims in Warwickshire
- The contribution of local organisations and stakeholders
- Focus groups and interviews with victims of crime
- A review of statistical data, mainly from the British Crime Survey

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<sup>40</sup> <https://www.victimsupport.org.uk/>

- Existing local evidence and research on victims of crime

## Report Conclusions Relating to DVA

Statutory and voluntary sector agencies agree that the only way to effectively tackle domestic abuse is to work collaboratively, with each agency bringing its skills, knowledge and specialism. The impact of counselling and IDVA support services are marked, however for many victims, they only become available at the point of crisis.

Awareness is vital if support services are to be effective in reducing the impact on the individual and society of domestic abuse: agencies and victims need to be aware of the context, signs and symptoms of an abusive relationship so that they can recognise abuse for what it is. There also needs to be a widespread awareness of the availability of support services to victims of domestic abuse so that they can be signposted to them and choose whether or not to access them.

These support services are a vital resource for victims of domestic abuse and where possible, these services should be funded through mainstream funding. Where this is not possible, commissioning bodies should seek to award contracts of three to five years as a minimum. The loss of any of these services will have a detrimental impact on the quality of life for hundreds of victims and their families each year.

## Warwickshire Police and Crime Panel – Victims’ Services Review

The Warwickshire Police and Crime Panel was established to scrutinise and support the work of the Police and Crime Commissioner (PCC). The PCC is required to consult with the Panel on his plans for policing, as well as the precept<sup>41</sup> and certain key appointments. In 2015, the PCC was required to state his commissioning intentions with regard to the future provision of support services to victims of crime, acknowledging the existing services currently delivered by Victim Support and other specialist providers.

In its capacity as a ‘critical friend’, the Warwickshire Police and Crime Panel believed that it could offer a valuable role in assisting the PCC in the development of his commissioning intentions by using its key links and contacts to third sector<sup>42</sup> and community organisations. A ‘Task and Finish Group’ was appointed to undertake the review, during which members gathered and received evidence from a wide range of sources. The Task and Finish Group report<sup>43</sup> on Victims’ Services was approved by the Police and Crime Panel and then submitted to the PCC in 2014.

The final report of the Task and Finish Group:

- Summarised current support for victims of crime in Warwickshire
- Identified the needs of victims and expectations from local services
- Made recommendations to the PCC regarding the future of victim support provision in Warwickshire

## Findings and Recommendations Relating to Victims of DVA

<sup>41</sup> The money collected from council tax for policing

<sup>42</sup> The part of an economy or society comprising non-governmental and non-profit-making organizations or associations, including charities, voluntary and community groups, cooperatives, etc.

<sup>43</sup> <http://www.warwickshire-pcc.gov.uk/wp-content/uploads/2014/09/13.01.2015-PSM-2.pdf>

In Warwickshire, there are approximately 9,000 individual cases of domestic violence reported per year and it is widely accepted that, as with other types of crime, it is significantly under-reported. The majority of victims who report incidents to the police and also require support are referred to Stonham, part of Home Group, which delivers the Domestic Abuse Support Service (DASS) on behalf of Warwickshire County Council and, on occasions, Victim Support. Other support organisations in the county include Refuge<sup>44</sup>, Domestic Abuse Counselling Service<sup>45</sup> (DACS), the Sahil Project<sup>46</sup>, ASSIST Trauma Care<sup>47</sup> and Domestic Violence and Relationship Project<sup>48</sup> (DVRAP), which is specifically for children and young people.

Evidence gathered by the Task and Finish Group, through evaluating existing research<sup>49</sup> and by listening to the views of representatives and victims, highlighted the necessity of the support being independent. The Domestic Abuse Support Service, and a number of respondents to the Victims' Survey, reported that victims often felt statutory agencies, such as the police and criminal justice bodies, did not take their complaint seriously, did not understand their needs and / or tried to hurry them through the prosecution process before they were emotionally ready. Victims also believed that the impartiality of the support services enabled them, and the agency acting on their behalf, to challenge actions that were regarded as inappropriate, unhelpful or damaging to them.

The Task and Finish Group considered the role of Warwickshire's two Independent Domestic Violence Advisors (IDVAs) tasked with supporting high risk victims in the Domestic Abuse Support Service, who provide a tailored and intensive, independent advocacy and support service to victim. There was evidence that the intervention and guidance of the IDVAs ensured that the needs of victims were prioritised by criminal justice bodies.

Responses to the Victims' Survey found that 71% of respondents who had reported domestic violence cases to the police did not have their case taken to prosecution stages. The Task and Finish Group believed that the evidence indicates that IDVAs, in their role as representing the victim within the criminal justice system, are key to addressing this issue and believed that the PCC should look to increase funding to this provision.

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<sup>44</sup> [www.refuge.org.uk](http://www.refuge.org.uk)

<sup>45</sup> [www.dacservice.org.uk](http://www.dacservice.org.uk)

<sup>46</sup> Sahil Project was established to support Asian Women who were suffering from stress and isolation.

<sup>47</sup> <http://www.assisttraumacare.org.uk/>

<sup>48</sup> <https://www.respectyourself.info/provider/dvrp-domestic-violence-and-relationship-abuse-project/>

<sup>49</sup> Listening and Learning: Improving support for Victims in Warwickshire (2009)