Sunderland City Council

Sunderland Domestic Violence

Health Needs Assessment

Glen Wilson
Specialty Registrar in Public Health
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EXECUTIVE SUMMARY

Around 6,000 domestic violence incidents in Sunderland are reported to the Police each year. However domestic violence is known to be under-reported and it is estimated that between 11,600 and 15,600 people living in Sunderland experienced domestic violence in the last year. Over 53,800 adults living in Sunderland are estimated to have experienced DV at some point in their lives.

Domestic violence is a citywide issue, occurring in all wards of the city, but with higher reported prevalence in more deprived wards. The majority of reported cases in the city involved younger, heterosexual, female victims from a white background. However, domestic violence affects all groups in society; demographics of victims spanned the age range, and a substantial minority of victims (15%) were male. Other minority groups, including those from ethnic minorities and lesbian, gay, bisexual and transgender communities, did report experiencing domestic violence but to a lesser extent than expected, indicating potential inequality in awareness of or access to support. Domestic violence was most commonly perpetrated by a current or former partner and alcohol was involved in almost 60% of recorded domestic violence crimes.

The health impacts of domestic violence on victims cover both physical and mental health, with effects ranging from injury to stress and anxiety as well as more severe psychological effects. It is also a root cause of many other social problems including substance misuse, homelessness, sexual exploitation and future involvement in criminal behaviour. It is estimated that domestic violence and its impacts cost £79.6 million per year in Sunderland; comparable to other public health priorities such as smoking and obesity. Evidence shows that prevention and cessation of domestic violence are more cost-effective than dealing with consequences of long-term domestic violence.

Interventions are in place in schools in Sunderland to promote healthy relationships and prevent domestic violence, and successful campaigns have previously run in the city to challenge attitudes to domestic violence in the community and to prevent domestic violence in those at highest risk. A perceived need for more preventative work, both with young people and in the broader community, was a common theme which emerged during this needs assessment. The general public and service users in particular articulated a view that

there was still a culture of acceptance of domestic violence in the community, calling for greater efforts to change social attitudes.

Services also exist in the city to support identification and response to domestic violence, including interventions which aim to prevent escalation and to provide support when escalation does occur. Services largely focus either on 'survival', which focus on achieving safety and ensuring that the perpetrator is no longer able to cause harm, or 'recovery', which focus on supporting the victim and their family to move forward with their lives.

Robust service usage data were not available to enable a reliable estimation of the total number of victims who access services. Assuming that each of the 2,500 contacts with services in the last year represented a separate individual, services appear to reach only a small proportion of the total need in the city, with prevalence estimates indicating that there are likely to be up to 15,600 victims of domestic violence in the city each year.

Stakeholder engagement indicated poor awareness of services and referral routes by professionals as well as victims and the public. Potential barriers to accessing services were identified and included variation in front line response, a reluctance of professionals to raise the issue and uncertainty, particularly among minority groups, regarding access to and responsiveness of services. A range of professionals identified a need for a clearly defined pathway and understanding of the role and service provided by partner organisations across the whole system.

Domestic violence was a factor in around a third of all referrals to Children's Services in Sunderland, and in almost half of all families becoming subject to a child protection plan. Exposure to domestic violence can have significant negative impacts on the health and wellbeing of children, as well as on educational attainment and future risk taking behaviour.

An evidence based service is provided by the NHS to support the recovery of children once the domestic violence has been resolved, however concerns were raised regarding waiting times and a range of stakeholders perceived lack of services for children currently affected by domestic violence.

Recommendations

In order to support a partnership approach to tackling domestic violence, the recommendations of the HNA have been grouped according to the board or organisation likely to be best placed to oversee and lead their implementation.

Adult's Partnership

- Through collaboration with commissioners, review capacity of initiatives to reduce and respond to domestic violence, including the IDVA service.
- Encourage commissioners of all public services to require providers to ensure front line staff are appropriately trained to identify and respond positively to domestic violence.
- Encourage commissioners to require service providers to undertake an equality impact assessment to ensure that commissioned services are responsive to the needs of all victims, including those from minority groups (e.g. male, LGBT and BME victims).

Safer Sunderland Partnership Board

- Review current arrangements for coordination and strategic direction of domestic violence prevention and response to improve outcomes.
- Seek opportunities to challenge acceptance of domestic violence in the community, for example through a zero tolerance campaign, and consider targeting such initiatives in areas with highest reported incidence.
- Review the findings of equality impact assessments to determine whether services are accessible to all victims, including those from minority groups (e.g. male, LGBT and BME victims).
- Develop a care pathway to ensure all organisations are able to respond positively to disclosure of domestic violence and signpost to appropriate services.

Director of Public Health

- Embed domestic violence awareness and signposting training into a new safeguarding module within the Health Champions training programme.
- Ensure that domestic violence features more prominently in the Joint Strategic Needs Assessment, for example through incorporation of intelligence from the Partnership Strategic Intelligence Assessment.

Recommendations (continued)

Children's Trust

- Review and standardise provision of education in schools around promoting healthy relationships and challenging behaviours associated with domestic violence.
- Review commissioning and service provision around emotional support for children living with domestic violence.

Commissioners

- Encourage providers of public services to ensure that front line staff are appropriately trained to identify and respond positively to domestic violence.
- Require all domestic violence services to undertake an equality impact assessment to ensure that commissioned services are responsive to the needs of all victims, including those from minority groups (e.g. male, LGBT and BME victims).
- Specify outcome as well as process measures for services, for example demonstrating impact on emotional wellbeing and social return on investment.

Providers

- Improve routine recording and reporting of data and ensure that barriers to information sharing are tackled as appropriate.
- Undertake an equality impact assessment to ensure responsiveness to the needs of all victims, including those from minority groups (e.g. male, LGBT and BME victims).
- Ensure that front line staff are appropriately trained to identify and respond positively to domestic violence

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ACKNOWLEDGEMENTS

I am grateful to the following stakeholders who provided information, advice or support and without whom this needs assessment could not have been produced. Sincere thanks also must go to the members of the focus groups who generously gave their time to share their views and insights.

Heather Blackburn	Team Manager, Sunderland Primary Care and IAPT Service
Catherine Bramley	Children Safeguarding Team, South Tyneside NHS Foundation Trust
Debbie Cheetham	Lead Nurse Patient Safety, City Hospitals Sunderland NHS Foundation Trust
Joanne Cholerton	Sunderland Strengthening Families Manager, Sunderland City Council
Denise Clark	Detective Inspector, Northumbria Police
Nonnie Crawford	Director of Public Health, Sunderland Teaching PCT
Julie Curtis	Senior Clinical Nurse, Northumberland, Tyne and Wear NHS Foundation Trust
Catherine Donovan	Professor of Social Relations, University of Sunderland
Sian Firth	Named General Practitioner Safeguarding Children
Anna Foster	Performance Manager, Northumberland, Tyne & Wear NHS Foundation Trust
Dorothy Gardner	Manager, Sunderland Mind
Maureen Gavin	Director of Offender Management (Sunderland) & Approved Premises, Northumbria Probation Trust
Rob Gilhespy	Performance and Intelligence Officer, Sunderland City Council
Hazel Hedley	Chief Executive, Impact Family Services
Kelly Henderson	Principal Policy Officer for People & Neighbourhoods, Sunderland City Council
Mary Hull	North East Regional LGBT Domestic Abuse Development Worker, Victim Support North East
Usha Jacob	Performance and Information Manager, Sunderland City Council
Deanna Lagun	Designated Nurse Safeguarding Adults & Children, Sunderland Teaching PCT

Helen Lancaster	Scrutiny Officer, Sunderland City Council
Jackie Leaf	Named Nurse for Safeguarding Children, City Hospitals Sunderland NHS Foundation Trust
Pam Lee	Public Health Consultant, Sunderland Teaching PCT
Julie Lister	Partnerships & Safeguarding Manager, Gentoo
Anita Lord	Assistant Director, Wearside Women In Need
Rachel Lumsden	Children's Commissioning Health Improvement Practitioner, Sunderland Teaching PCT
Jackie Nixon	Promoting Health Engagement Lead, Sunderland Teaching PCT
Stephen Potts	Data Analyst, Sunderland Teaching PCT
Jacqui Reeves	Service Manager, Washington Mind
Irma Shepheard	Family Nurse Supervisor, South Tyneside NHS Foundation Trust
Janette Sherratt	Children's Commissioning Manager, Sunderland Teaching PCT
Lisa Smith	Victim Support Officer, Gentoo
Rick Stifter	Sex & Relationships Education Specialist, Sunderland City Council
Gillian Thirlwell	Senior Service Delivery Manager, Victim Support South of Tyne and Wear
Kevin Ward	Nurse Therapist: Children in Special Circumstances, Northumberland, Tyne and Wear NHS Foundation Trust

ABBREVIATIONS

ACPO	Association of Chief Police Officers
BCS	British crime survey
BMA	British Medical Association
BME	Black and minority ethnic
CAADA	Co-ordinated Action Against Domestic Abuse
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical commissioning group
CHS	City Hospitals Sunderland NHS Foundation Trust
CPS	Crown Prosecution Service
CSEW	Crime survey for England and Wales
CSP	Community safety partnership
DV	Domestic violence
FGM	Female genital mutilation
FMU	Forced marriage unit
HBV	'Honour' based violence
HNA	Health needs assessment
HWB	Health and wellbeing boards
IAPT	Improving Access to Psychological Therapies
IDVA	Independent domestic violence adviser
IMD	Index of multiple deprivation
JHWS	Joint health and wellbeing strategy
JSNA	Joint strategic needs assessment
LA	Local authority
LGBT	Lesbian, gay, bisexual and transgender
LMAP	Local multi-agency problem solving group
LSOA	Lower super output area
LSP	Local strategic partnership
MARAC	Multi-agency risk assessment conference
NI	National indicator
PCC	Police and crime commissioner
PCT	Primary Care Trust
SDVC	Specialist domestic violence court
SSP	Safer Sunderland Partnership
STFT	South Tyneside NHS Foundation Trust
VAWG	Violence against women and girls
WWIN	Wearside Women in Need

INTRODUCTION

Aims

This domestic violence (DV) health needs assessment (HNA) aims to:

- Identify the scale of DV in Sunderland, including profiling characteristics of victims
- Describe existing services currently provided for victims (and their families) which impact on health and wellbeing
- Map need against existing service provision for victims and affected children to develop an understanding of gaps in provision in Sunderland
- Consider areas where a business case may be made to support service development to improve access to and quality of care for those affected by DV, and to work toward equity of access across the city
- Review the impacts of partnership working with regard to preventing and responding to DV

Note: It had initially been intended that this needs assessment would include a profile and assessment of need among perpetrators of DV, however a decision was taken during the data collection stage to focus on victims and their families, enabling a more detailed review around these groups. The beneficial impact of perpetrator services on victims remained within scope, and this area is addressed in relevant sections of the HNA. Discussions with Northumbria Probation Trust confirmed that health needs of perpetrators of DV would be most appropriately considered as part of a separate offender health needs assessment.

Definition

The Home Office (2012a) definition of DV at September 2012 was:

'Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.'

The explanatory text accompanying the definition states that DV includes so called 'honour' based violence (HBV), female genital mutilation (FGM) and forced marriage, and that victims are not confined to one gender or ethnic group. An adult is defined as any person aged 18 years or over. Definitions of HBV, FGM and forced marriage are included in Appendix A.

In 2012, the Government announced changes to the definition of DV, amending it to include coercive control, and extending it to include those aged 16 to 18. (Home Office, 2012a) The new definition implemented in March 2013 is titled 'domestic violence and abuse':

'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, 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 or 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 (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.*

Scope

This HNA was commissioned by Sunderland Teaching Primary Care Trust (PCT) Public Health department and transferred with public health to Sunderland City Council in April 2013. The HNA was based on the government's current definition of domestic violence, as at September 2012 and therefore focussed on DV in the adult population of Sunderland. Calculations were based on 2011 census population estimates for those aged 18 and over in the city, unless otherwise stated.

Although physical abuse of children may co-exist with DV, it was beyond the scope of this needs assessment to explore the issue of child abuse resulting from violence directed towards or resulting in physical harm to the child, as this was out with the definition of DV. However, consideration of the impact that witnessing DV can have on a child's emotional wellbeing, behaviour and development, and on the victim's parenting capacity and ability to care for the child's needs, was of direct relevance and was addressed in the HNA. Similarly, whilst health needs of perpetrators of DV were beyond the scope of the HNA, the potential benefit to victims resulting from services aimed at perpetrators is acknowledged.

Need, services and interventions at all levels were considered, from primary prevention such as awareness raising to secondary and tertiary prevention such as home sanctuary schemes and refuges.

Decision makers will need to consider the recommendations of this HNA in the context of a broadening definition of DV. Recent changes to the definition of DV mean that larger numbers of individuals will be enumerated as DV victims and reported incidence will inevitably increase. Monitoring and evaluation of the impact of any service developments will therefore need to be carefully planned and services will need to be commissioned and delivered appropriately, to meet the needs of the broader range of individuals.

A note on terminology

In the interests of consistency, the term domestic violence has been used throughout this needs assessment, in line with the current government definition and terminology used in the national strategy. It is important to recognise that use of the term domestic violence, rather than domestic abuse, should not imply a bias toward physical violence. This HNA considers all aspects of DV, as defined by the Home Office.

National policy

The current national policy driver for tackling DV is the *Call to End Violence against Women and Girls*, published in November 2010 (HM Government 2010a). Whilst the scope of that document is broader than DV, encompassing all forms of violence against women and girls (VAWG), DV is an important contributor to VAWG and therefore the vast majority of the policy is directly relevant.

The *Call to End Violence against Women and Girls* places **prevention** at the heart of the Coalition government's strategy, with the focus on stopping violence from happening in the first place. While identifying prevention as being the core of the vision, the importance of **provision** of adequate levels of services and support when violence does occur is also recognised. In line with their commitment to the Big Society, the policy makes clear that while some actions need to be taken at national level by central government, there is a fundamental need for **partnership** working at a local level, with critical roles for local authorities (LAs), health and wellbeing boards (HWBs), health services, public health, the voluntary and community sector, community safety partnerships and police and crime commissioners (PCCs). Where violence does occur, the need to **reduce the risk** to victims and ensure that perpetrators are brought to **justice** is also identified as a key issue.

Prevention

Three specific areas for action are identified to support the core aim of preventing violence from occurring in the first place:

- Tackle the attitudes and behaviours that reinforce negative messages on the role of women and facilitate acceptance of VAWG
- Intervene early to ensure that children do not grow up to view VAWG as normal or acceptable
- Ensure that front line partners, particularly the police, are able to identify and prevent vulnerable people from becoming victims, or repeat victims, of violence

Service Provision

Working towards provision of adequate and appropriate services, three specific areas for action are identified:

- Support frontline services to support victims, including the role of the independent domestic violence adviser (IDVA), recognising this as a national priority when setting local priorities and determining expenditure
- Share and foster effective practice, including training of front line professionals to deliver effective outcomes in tackling VAWG, getting the response right the first time
- Pursue joint commissioning arrangements and new models of funding to improve the sustainability of services

Partnership working

There is an emphasis throughout the policy on the responsibility for delivery not only resting with central government but also with local stakeholders working in partnership. An important aspect of partnership working relates to equipping local community and voluntary organisations to engage in negotiations with future commissioners, such as PCCs, clinical commissioning groups (CCGs), public health commissioners in LAs and the HWB to make the case locally for tackling VAWG. This is particularly important as evidence shows that victims are more likely to engage with voluntary or community than statutory organisations. (Smith, 2012)

Risk reduction & the Justice system

A core ambition of the *Call to End Violence against Women and Girls* is to bring more offenders to justice and increase the confidence of victims to access the criminal justice system. The Specialist Domestic Violence Courts (SDVCs) are acknowledged to represent an important partnership approach to dealing with DV, supporting victims through the legal process.

Alongside the aim to bring more offenders to justice, there is a commitment to continue to develop programmes to support the rehabilitation of perpetrators of DV.

There is also a commitment to reduce the risk for victims of DV, and particularly the risk of repeat cases. Multi-agency risk assessment conferences (MARACs) represent an important multi-agency approach to assessing the needs of high-risk victims and to put actions in place to reduce risk.

The Home Office has ensured stable funding for a number of IDVAs and MARAC coordinators for the duration of the current Spending Review period, which runs until March 2015. (HM Government 2011a & HM Government 2012)

As the title of the policy implies, the emphasis is on protecting women and girls, however it is acknowledged that men and boys can be victims of violence, and there is a commitment to include them in this work. (HM Government 2010a) Responding to stakeholder feedback that male victims were underrepresented in the original strategy, the Government recently announced a commitment to begin to address this issue. (HM Government 2012)

Local context

Community safety partnerships (CSPs) were established as statutory bodies under the Crime and Disorder Act 1998. (HM Government 1998) Sunderland Teaching PCT has been a responsible authority on the CSP since its inception in 2004.

Sunderland's CSP is the Safer Sunderland Partnership (SSP), which is part of the wider Sunderland Partnership, the city's Local Strategic Partnership (LSP). The SSP discharges its operations via both area-based local multi-agency problem solving groups (LMAPs) and themed delivery groups.

The LMAPs are coterminous with the council's five area frameworks through which funding decisions affecting local areas within the city are increasingly being made. The area-based focus supports the city council's 'Sunderland Way of Working'; an approach which involves a commitment to decentralisation, maximising the potential of partnership working and getting closer to the population served. A key objective of this approach is to develop a greater understanding of the range of provision in the city, focusing not only on those that are directly under the control of the council, but also on the services provided by other organisations and community groups. (Sunderland City Council, 2012a)

The SSP consists of six responsible authorities:

- Northumbria Police
- Northumbria Probation Trust
- Sunderland City Council
- Tyne and Wear Fire and Rescue Service
- Northumbria Police Authority*
- Sunderland Teaching PCT**

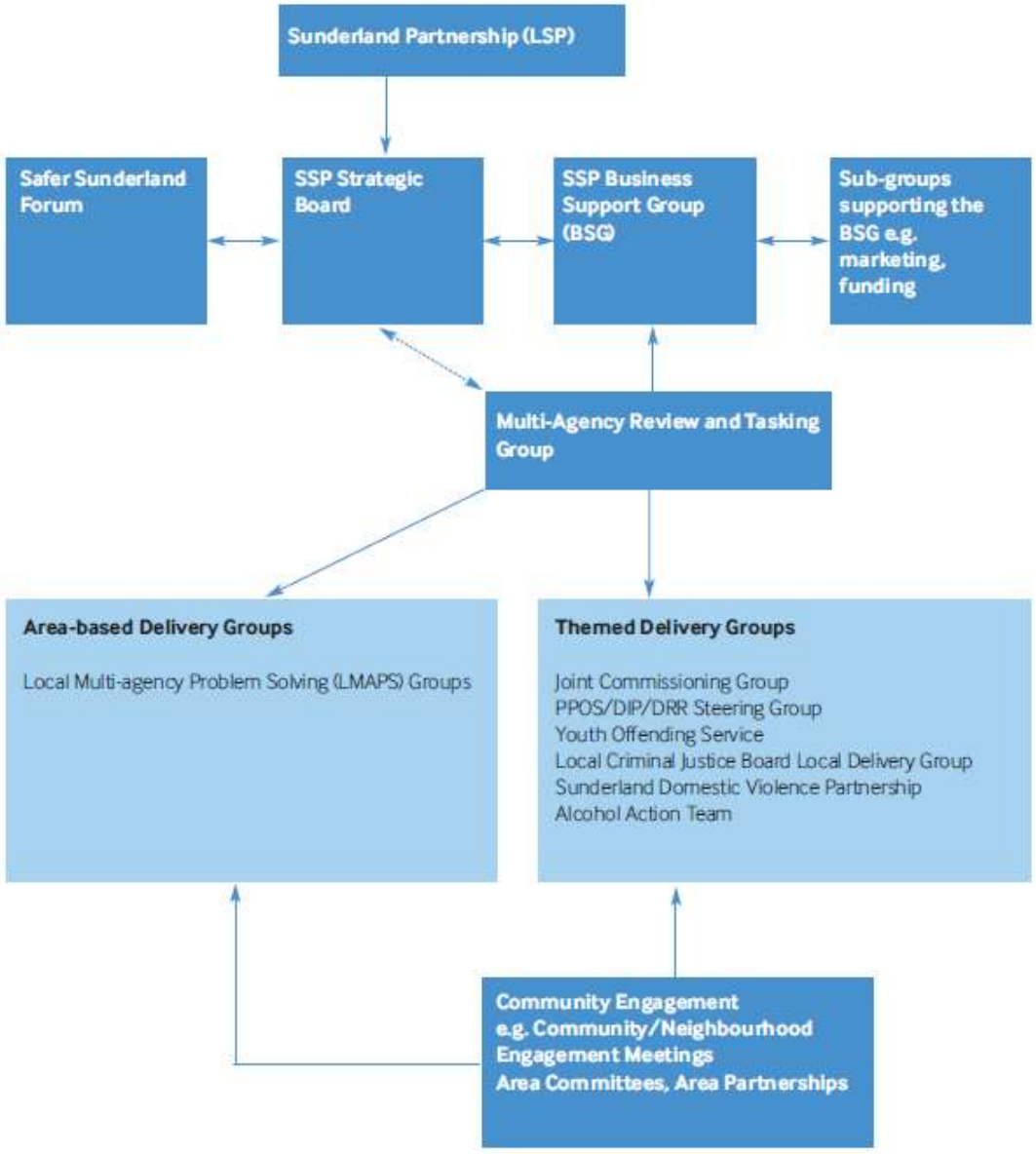
* From 22nd November 2012, police authorities across England and Wales were decommissioned and replaced by PCCs. The PCC has a statutory duty to cooperate with the SSP, but is not a responsible authority.

** The PCT responsibility ceased from 1st April 2013, at which time Sunderland CCG replaced the PCT as a responsible authority on the SSP.

Under the Crime and Disorder Act 1998, the responsible authorities of the SSP have a legal duty to work in partnership toward the reduction of crime and disorder, which includes domestic violence. In addition to the responsible authorities, a wide range of other organisations are also represented on the SSP.

The structure of the SSP is shown in Figure 1.

Figure 1 Safer Sunderland Partnership (SSP) structure



Source: Safer Sunderland Strategy 2008-2023

The SSP has a statutory duty to produce a partnership plan to tackle crime, disorder, substance misuse and re-offending. In April 2008, the SSP produced their 15 year strategy, the Safer Sunderland Strategy 2008-2023. (Sunderland Partnership, 2008) The overall outcome of the Safer Sunderland Strategy is that everyone in the city will be and feel safe and secure. A key long term outcome is that by 2023, **levels of repeat incidents of domestic violence will be at their lowest levels**.

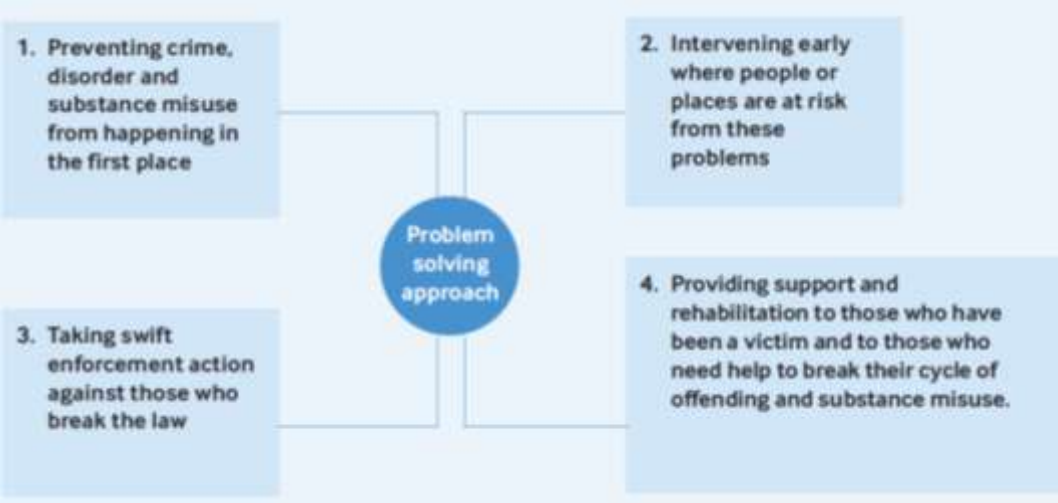
The initial strategy included strategic priorities for the period 2008-2011, one of which was to reduce violent crime, including domestic violence. The strategic priorities were revised in 2012, reflecting the importance of domestic violence; a key strategic priority of the SSP is to **tackle domestic violence (including other violent crime)**. (Safer Sunderland Partnership, 2013)

Tackling DV is supported by a number of other outcomes of the Safer Sunderland Strategy, including: being free from harm, being free from crime, disorder and substance misuse, creating a safe environment and creating active citizens and a supportive family environment. The Safer Sunderland Strategy 2008-2023 identified key priorities around DV to be: improving services to victims, reducing re-offending and reducing levels of repeat incidents.

The Safer Sunderland Strategy 2008-2023 recognises that DV remains a hidden crime, with chronic under-reporting and emphasises the irrefutable link between alcohol misuse and risk of DV. The link between alcohol misuse and DV is also highlighted in Sunderland's Joint Strategic Needs Assessment (JSNA), as is the potential for exacerbation of the problem if the current period of austerity leads to an increase in levels of alcohol and substance misuse in the city. (Sunderland City Council & Sunderland PCT, 2011a)

The strategy employs a problem solving approach, ensuring that activities are balanced around prevention, early intervention, enforcement and support and reassurance, as illustrated in Figure 2.

Figure 2 The Safer Sunderland Strategy problem solving approach



Source: Safer Sunderland Strategy 2008-2023

The Comprehensive Area Assessment, published in 2009, noted that levels of DV in Sunderland remained high, but were reducing. (Audit Commission, 2009)

Many aspects of the Sunderland Joint Health & Wellbeing Strategy (JHWS) are relevant to tackling the DV agenda. The JHWS takes an asset based approach, which seeks to identify those needs which can be best served at a community level through to those that require public service provision. (Sunderland City Council, 2012b) The JSNA for Sunderland recognises that CSPs face significant challenges; being expected to do more, with less. (Sunderland City Council & Sunderland PCT, 2011a) At a time of unprecedented financial pressure, it is more important than ever to ensure that finite resources available are used to tackle the greatest need. Identification of the type of service delivery (community and voluntary sector versus public services) is one means by which resources can be better matched to need, and the recommendations of this HNA will be made with reference to appropriate service delivery models, where relevant.

In line with the Safer Sunderland Strategy problem solving approach, the JHWS places an emphasis on prevention and early intervention. The JHWS also follows the Sunderland Way of Working, based on a principle of joint working to maximise the use of community assets, including family and community relationships and local organisations, partnerships and networks. Importantly, the JHWS also recognises the influence of wider social determinants on health outcomes and on inequalities. The following strategic outcomes of the JHWS are particularly relevant to the DV agenda:

- Promoting understanding between communities and organisations
- Ensuring that children and young people have the best start in life
- Supporting and motivating everyone to take responsibility for their health and that of others
- Supporting individuals and their families to recover from ill health and crisis

DV has been selected as one of the local discretion criteria for the *Family Focus* programme, which is Sunderland's version of the national *Troubled Families* initiative. (personal communication, Joanne Cholerton) The programme aims to provide support to and "turn around" the lives of the most vulnerable families, recognising that DV is likely to be a factor in a substantial proportion of cases. (Department of Health, 2012)

A Scrutiny Policy Review on DV was recently undertaken on behalf of Sunderland City Council Scrutiny Committee. The review aimed '*to evaluate the approach to reducing the number of victims of domestic violence; through awareness raising, increasing the reporting and detection of domestic violence and supporting victims of domestic violence'.* (Lancaster, 2012) Throughout production of this needs assessment, there was close working with the lead scrutiny officer to maximise opportunities for the two pieces of work to support one another, and to minimise duplication.

Safeguarding and promoting the welfare of children

Safeguarding and promoting the welfare of children is defined as *'the process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables them to have optimum life chances and enter adulthood successfully'*. (Department for Children, Schools and Families, 2010)

LAs and CCGs have statutory responsibility to safeguard and promote the welfare of all children. (HM Government 2010a) The Children's Act 1989 defines a child as anyone who has not yet reached their 18th birthday. (Department for Children, Schools and Families, 2010) As such, child victims are specifically excluded from the government's definition of DV as at September 2012, though from March 2013 children aged 16 to 18 will be covered by the revised definition. Although physical abuse of children may co-exist with DV, it is therefore beyond the scope of this needs assessment to explore the issue of child abuse

resulting from violence directed towards or leading to physical harm to the child, as this is out with the definition of DV. However, consideration of the impact that witnessing DV can have on a child's emotional wellbeing, behaviour and development, and on the victim's parenting capacity and ability to care for the child's needs, is of direct relevance and will be addressed in this HNA.

There is an inherent link between DV and safeguarding children, with potential for children to experience both physical abuse and emotional harm, as well as neglect. (Department for Children, Schools and Families, 2010) A 2009 report stated that, of the 11 million children in England, there were 200,000 living in households where there was a known high risk case of DV. (Lord Laming, 2009)

The Department for Children, Schools and Families identified three core objectives around any intervention to tackle DV where children are involved:

- to protect the child/ren, including unborn child/ren;
- to empower the mother to protect herself and her child/ren; and
- to identify the abusive partner, hold him accountable for his violence and provide him with opportunities to change.

The link between DV and child safeguarding in the context of the emotional wellbeing of children who witness DV is emphasised in Sunderland's JSNA. (Sunderland City Council & Sunderland PCT, 2011b) Accordingly, tackling the impact of DV on children and young people is a priority outcome identified in the Children and Young People's plan produced by the Sunderland Children's Trust. Progress against the outcome is monitored using National Indicator (NI) 32, which relates to repeat incidents of DV. While not relating directly to children, NI32 is a relevant performance measure as children and young people would be positively impacted through a reduction in repeat cases of DV. (Sunderland Children's Trust, 2010) Tackling the impact of DV is also identified as a priority area in the current business plan of the Sunderland Safeguarding Children Board. (Sunderland Safeguarding Children's Board, 2011)

Adult Safeguarding

The adult safeguarding agenda aims to ensure that vulnerable adults, who are at risk of abuse, receive protection and support. (Department of Health, 2000) A vulnerable adult is defined as a person aged 18 years or over *"who is or may be in need of community care*

services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation". (Department of Health, 2000)

Unlike cases involving children, it is very difficult for agencies to intervene in cases of DV which involve only adults where the victim has capacity and does not want support. In such situations, options are limited to signposting to services and safety planning. Formal adult safeguarding procedures can only be initiated in cases where an adult has been identified as vulnerable. (Sunderland Safeguarding Adults Board, 2013)

Evidence review

Health impacts of domestic violence

The well documented health impacts of DV have been quantified in a report based on the Crime Survey for England and Wales (CSEW) and summarised in a recent Department of Health publication. (Department of Health, 2012) Data from the CSEW indicates that approximately one in four (27%) victims of DV experienced physical injury. The most common types of injuries sustained were 'minor bruising or black eye' (18%) and 'scratches' (13%). Approximately two in five (39%) victims experienced emotional or mental health problems, which ranged from relationship or trust issues (19%) to suicide attempts (4%). (Office for National Statistics, 2012a)

In addition to direct physical, emotional and mental health impacts, DV can also impact on health related behaviours, such as drug and alcohol misuse. (Department of Health, 2012) A recent report exploring the lives of sex workers in Tyne and Wear identified particularly high rates of DV, as well as mental health problems and 'chaotic lifestyles' among sex workers. (PEER Research Team, 2013) Similarly, it is known that a substantial proportion of female offenders have been or are victims of DV. (personal communication, Maureen Gavin) These observations highlight the potential for the accumulation of risk factors in vulnerable groups, as well as emphasising the impact the DV can have both on individuals, who may be more likely to engage in risky behaviour as a result, and on society, particularly from a criminal justice perspective.

In the most severe cases, DV can result in homicide or suicide. It has been reported that on average there are two DV homicides per week in England and Wales, and around 500 suicides per year occur in women who have experienced DV. In the case of suicides, over one third had visited a hospital on the day they committed suicide. DV is believed to be a factor in approximately one third of all female suicides. (Walby, 2004)

Exposure to DV in childhood has been associated with an increased risk of involvement in violence in later life. Children who witness DV in the home have been shown to be at an increased risk of both suffering and perpetrating DV as adults, as well as increased risk of involvement in youth violence. (Department of Health, 2012)

Each of the health impacts outlined is of particular significance in Sunderland:

- The physical injuries sustained by substantial numbers of DV victims likely contribute to the high levels of demand for emergency care in Sunderland; reducing which is a key priority of the CCG.
- Links to mental health are particularly significant, given a recent report which indicates that rates of depressive illness in Sunderland are the highest in the country. (North East Public Health Observatory, 2013)
- Alcohol related hospital admissions in Sunderland are particularly high and reducing these is a further priority area. The relationship between DV and alcohol misuse in both victims and perpetrators suggests tackling DV may be one approach to reducing alcohol related hospital admissions in the city.

What works: evidence of effective interventions

A 2010 review of the evidence for prevention of intimate partner violence identified five successful or promising interventions (Wood, 2010):

- **School-based education programmes** that promote healthy relationships (successful in reducing violence toward current partners)
- **Routine enquiry** about DV in health care setting by trained health care professionals (successful in increasing disclosure and identification of intimate partner violence; less evidence on protection against future violence)
- **Regulation of alcohol sales** at a community level, for example through increasing prices (associated with reduction in intimate partner violence)
- **Advocacy services** can reduce some forms of physical abuse in the medium, but not long, term (In addition, the use of protection orders and SDVCs have generated successful criminal justice outcomes; these are beyond the scope of this HNA)
- **Substance misuse treatment** among offenders (successful in reducing repeat offending; beyond the scope of this HNA)

The Department of Health recently identified a range of violence prevention initiatives in which health services should have a leading role (Department of Health, 2012):

- **Supporting parents and families** by developing parenting skills and strengthening family relationships (midwives, health visiting and family nurse partnership).

- **Developing life skills in children and young people**, building social and emotional competencies and skills in avoidance of conflict, poverty and crime (social development programmes, with a focus on healthy relationships, gender and prevention of DV).
- **Reducing the availability and harmful use of alcohol**, which is strongly associated with DV (non-health approaches include reducing the density of alcohol outlets and controlling price; health interventions include screening, identification and brief advice).
- **Community interventions**, including multiagency partnership working in areas such as tackling alcohol related DV, and data sharing.
- **Changing social norms**, through approaches such as mass media campaigns, aiming to shift stigma from victims to perpetrators.
- **Identification, care and support** of victims to protect health and wellbeing and break the cycle of violence. Health settings are highlighted as potentially ideal places to both identify and support victims of DV. (Includes use of screening tools, training needs of health professionals, advocacy programmes, and specialist high risk approaches such as MARAC and criminal justice interventions).

The Identification and Referral to Improve Safety (IRIS) programme provides training to primary care staff, prompt in the medical record system to enquire about abuse and referral pathways to advocacy services. It has been shown in a randomised controlled trial to improve identification and referral of DV victims (Feder, 2011) and is highlighted by the Department of Health as an evidence based method of providing DV training to health professionals in primary care settings. (Department of Health, 2012)

It is estimated that a third of DV starts or escalates during pregnancy. (Department for Children, Schools and Families, 2010) A recent Cochrane Review concluded that there was insufficient evidence to assess the effectiveness of interventions for DV in pregnancy and highlighted the need for high quality randomised controlled trial evidence to identify whether interventions prevent or reduce DV incidence during pregnancy, or improve pregnancy outcomes. (Jahanfar, 2013)

The National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) are currently jointly producing public health guidance on preventing and reducing DV. The guidance, expected to be issued in February 2014, will focus on how

social care and health services, in partnership with others, can identify, prevent and reduce DV. (National Institute for Health and Clinical Excellence, 2013)

Financial costs of domestic violence

A study published in 2009 estimated the total cost of DV in England and Wales 2008 to be around £15.7 billion, of which £1.7 billion were health care costs. Table 1 below provides an overview of the estimated costs across service sectors. (Walby 2009)

Table 1 The financial cost of domestic violence in England and Wales

	2008 cost (millions)
Services	**£3,856**
Criminal justice system	*£1,261*
Health care	*£1,730*
Social services	*£283*
Housing and refuges	*£196*
Civil legal services	*£387*
Economic Output	**£1,920**
Human and emotional costs	**£9,954**
Total	**£15,730**

Based on the size of the population of England and Wales in 2008 (54.4 million), this equates to a cost of £289 per head of population. (Office for National Statistics, 2010) Applying this figure to the size of the Sunderland population (275,500), the estimated annual cost of DV to Sunderland is £79.6 million.

It should be noted that these estimates were based on inflation and gross domestic product in 2008; therefore the true cost in 2013 may be markedly different.

The cost of DV is similar to other public health priorities, such as smoking, obesity and alcohol misuse. Table 2 provides a comparison of annual costs for public health priorities in England (note: DV costs relate to England and Wales, so cost to England alone will be lower).

Table 2 Comparison of financial costs of public health priorities

	Estimated annual cost to economy*	Estimated annual cost to NHS per year
Smoking	£5.2 billion	£2.7 billion
Alcohol misuse	£20.0 billion	£2.7 billion
Obesity	£15.8 billion	£4.2 billion
Physical inactivity	£8.3 billion	£1.8 billion
Domestic violence	£15.7 billion	£1.7 billion

* Data for smoking, alcohol misuse, obesity and physical inactivity refers to England, from 2009 (Kings Fund, 2012). Data for domestic violence refers to England and Wales, from 2008 (Walby, 2009)

Prevention and intervention to end violence is more cost-effective than dealing with the consequences of long-term DV. (Department of Health, 2011) A tool produced by the Department for Education estimated average cost of responding to one DV incident to be £23,315. (Centre for Excellence and Outcomes in Children and Young People's Services, 2011) The estimated total cost of DV, £15.7 billion in 2008, was a 32% decrease compared to 2001. This decrease in cost of DV has been partly attributed to investment in public services to prevent and better respond to DV. (Department of Health, 2011)

A recent publication from the Department of Health has reported that the MARAC process saves public services an average of £6,000 per case in direct costs. The NHS accrues 20% of the savings, police 32% and the wider criminal justice system 40%. (Department of Health, 2011) Based on an average of 212 cases per year being discussed by MARAC in Sunderland, it is estimated that the process saves public services approximately £1.3 million per year.

The cost-effectiveness of the IDVA programme has been nationally evaluated; the cost of providing IDVA support to a victim of high risk DV was estimated to be £500. Compared to the costs to public services associated with ongoing DV, IDVAs were therefore found to be highly cost-effective. (Howarth, 2009)

What is Health Needs Assessment?

HNA is a systematic method of identifying the unmet health and health care needs of a population. Ultimately, HNA facilitates targeting of resources to improve services to better meet need and therefore improve health and reduce health inequalities.

The process involves a broad range of activities:

- Assessing need
- Identifying effective
- Mapping existing services
- Making recommendations
- Prioritising
- Plan for monitoring
- Action plan
- Evaluation of the process

In order to assess need it is useful to define the concept. Need is a separate entity to demand, as that which is demanded is not always needed, and vice versa. Need in a public health context has been described as the *capacity to benefit*; (NHS Management Executive 1991) implicit in this definition is a fundamental requirement for a goal, a measurable deficiency from the goal and an effective intervention. (Wilkin 1992, Pencheon 2006)

Determination of need (including what constitutes deficiency from a goal, and what constitutes an effective intervention) depends on perspective and therefore inevitably involves some degree of value judgement (Bradshaw, 1972 & Wilkin, 1992). As such, it is essential that a needs assessment considers need in its broadest sense, incorporating a wide range of views, including those of service users, professionals and broader society. (Wilkin 1992)

Several methods of categorising need have been proposed; one of the most widely cited is that of Bradshaw (1972) which identified four dimensions of need:

- **Normative** need (professional views)
- **Felt** need (can be viewed as an individual's wants or desires, having recognised changes from normal health)

- **Expressed** need (broadly equivalent to demand; the help an individual seeks having recognised changes from normal health)
- **Comparative** need (equity of gap between expressed need and supply of services across different populations)

This taxonomy lacks explicit consideration of the evidence base, epidemiological need, which should be considered in any HNA. The NHS Management Executive proposed a model which considers epidemiological need alongside a 'pragmatic' approach, which included consideration of comparative and corporate needs. (NHS Management Executive 1991) Witkin and Altschuld (1995) proposed an alternative method of classification, which reclassified Bradshaw's four dimensions of need according to the stakeholder group represented. Some or all of these terms may be encountered in HNAs therefore the relationship between the various definitions is summarised in Table 3.

Table 3 Equivalence of definitions in taxonomy of health need

<table>
<tr><th>Bradshaw (1972)</th><th>Witkin and Altschuld (1995)</th><th>NHS Management Executive (1991)</th></tr>
<tr><td>Comparative need</td><td>Resources & systems; the needs of the organisation</td><td>Comparative need</td></tr>
<tr><td>Felt need</td><td rowspan="2">Service recipient views</td><td rowspan="3">Corporate need</td></tr>
<tr><td>Expressed need</td></tr>
<tr><td>Normative need</td><td>Professional views</td></tr>
<tr><td></td><td></td><td>Epidemiological need</td></tr>
</table>

For the purposes of clarity, the following categories and terminology will be consistently used in this HNA:

- Epidemiological need (reflecting the evidence base)
- Normative need (reflecting professional views)
- Expressed need (reflecting demand, through service usage)
- Felt need (reflecting service user and community views)
- Comparative need (reflecting comparison of need and provision with other services)

Whilst referred to as a health needs assessment, the process is more accurately an assessment of health care needs; of the scale of the problem, of the availability and responsiveness of services and preventive initiatives and the evidence of their effectiveness

(the population's capacity to benefit from these services). (NHS Management Executive, 1991; Stevens and Rafferty, 1994) Given the broad scope of DV, involving a range of partners across various organisations (many of which are outside the health system), the needs assessment will consider both health and social care needs, using these terms in their broadest sense.

METHODS

Epidemiological need

National level data

Data on the prevalence of DV in England and Wales is produced by the Office for National Statistics, based on the CSEW, formerly the British Crime Survey (BCS). In 2011/12, approximately 67,000 households were invited to participate in the survey and around 75% of invited households chose to take part. The CSEW is a key data source used by the government to assess the extent of experience of crime in England and Wales on an annual basis. Importantly, this data source includes crimes that may not have been reported to the police; typically the CSEW therefore records higher levels of crime than reported in police recorded incidents datasets. (Office for National Statistics, 2012b)

The CSEW records DV incidents under the broader classification of intimate personal violence, which is a collective term to describe domestic violence, sexual assault and stalking. Data on intimate personal violence are collected using both self-completion questionnaire and face to face interviews. Self-completion questionnaires have been shown to generate markedly higher response rates compared to those achieved when questions were asked by an interviewer; therefore all CSEW statistics quoted are from the self-completion questionnaire. (Office for National Statistics, 2012c) Within the CSEW, intimate personal violence includes the following categories:

- **Any domestic abuse**: non-sexual emotional or financial abuse, threats, physical force, sexual assault or stalking carried out by a current or former partner or other family member.
- **Partner abuse (non-sexual)**: non-sexual emotional or financial abuse, threats or physical force by a current or former partner.
- **Family abuse (non-sexual)**: non-sexual emotional or financial abuse, threats or physical force by a family member other than a partner (father/mother, step-father/mother or other relative).
- **Emotional or financial abuse**: includes being prevented from having a fair share of household money, stopped from seeing friends or relatives or repeatedly belittled.

- **Threats** are classified as an affirmative response to the statement 'frightened you by threatening to hurt you/someone close'.
- **Minor force** is classified as an affirmative response to the statement 'pushed you, held you down or slapped you'.
- **Severe force** involves being kicked, hit, bitten, choked, strangled, threatened with a weapon, threats to kill, use of a weapon or some other kind of force.
- **Sexual assault**: indecent exposure, sexual threats and unwanted touching ('less serious'), rape or assault by penetration including attempts ('serious'), by any person including a partner or family member.
- **Rape** is the legal category of rape introduced in legislation in 2003. It is the penetration of the vagina, anus or mouth by a penis without consent.
- **Assault by penetration** is a legal offence introduced in 2003. It is the penetration of the vagina or anus with an object or other body part without consent.
- **Stalking**: one or more incidents (causing distress, fear or alarm) of receiving obscene or threatening unwanted letters, e-mails, text messages or phone calls, having had obscene or threatening information about them placed on the internet, waiting or loitering around home or workplace, following or watching, or interfering with or damaging personal property by any person, including a partner or family member

It is important to note that the CSEW defines an adult as being 16 to 59 years old, which is not consistent with the government's current definition of DV. However, this is the only source of national level data available.

Local level data

There is no single complete source of data relating to DV in Sunderland. A range of organisations and agencies hold data on cases which are known to them and/or who have used their services. The following were key local data sources relating to **reported** cases of DV:

- Northumbria police
    - Data was provided directly from Detective Inspector Denise Clark at Northumbria Police on officer recorded incidents of DV. Additional information on DV incidents, and information on DV crimes (an incident is

given a crime number when evidence indicates that a criminal offence has been committed), was provided by Stephen Potts, Information Analyst at Sunderland PCT.

- Sunderland Safeguarding Children Board
    - Rob Gilhespy, Performance & Intelligence Officer at Sunderland City Council provided data on the proportion of referrals to children's social care each year which were related to DV, and the proportion of families becoming subject to a child protection plan which were related to DV.
- MARAC
    - High risk DV cases are discussed at MARAC. Detective Inspector Denise Clark, chair of the Sunderland MARAC, provided data on the number of cases discussed and demographics of victims.
- Mainstream NHS Services (routine enquiry)
    - Data was requested from providers of key community (South Tyneside NHS Foundation Trust) and secondary care (City Hospitals Sunderland NHS Foundation Trust) services regarding the number of service users who disclosed experiencing DV on routine enquiry.
- Hospital Episode Statistics
    - Data on hospital admissions relating to DV was requested from the Business Information Team at Sunderland Teaching PCT, however no information was provided.

Domestic violence is an underreported crime (HM Government 2010a), therefore data held by local agencies on reported cases of DV is likely to represent a significant underestimation of the scale of the problem. The HNA therefore additionally attempts to quantify the likely extent of **unreported** DV in Sunderland. In order to estimate the true prevalence of DV in Sunderland, national figures from the CSEW were extrapolated, based on the size of the Sunderland adult population. A further estimation of true prevalence was made based on underreporting rates from the CSEW.

Expressed need

Expressed need can be considered as broadly equivalent to demand; therefore one dimension of this form of need was derived from levels of service usage. Information on activity levels in 2011/12 was requested from the following organisations:

- Victim Support
    - Gillian Thirlwell, Senior Service Delivery Manager at Victim Support South of Tyne and Wear provided data on the number of DV cases in Sunderland where support had been provided by the organisation.
- Gentoo
    - Lisa Smith, Victim Support Officer at Gentoo provided data on the number of cases of DV held by Gentoo, including demographic breakdown. Information is also included on the impact of the Gentoo Victim Support service, assessed according to service user's feelings of safety.
- Sunderland Counselling Service
    - Toby Sweet, Service Manager at Sunderland Counselling Service provided an overview of referrals to the service, including demographic breakdown.
- Impact Family Services
    - Hazel Hedley, Chief Executive of Impact Family Services, provided data on the number of cases from Sunderland accessing Impact services, where DV was raised as an issue.
- Sunderland Mind
    - Dorothy Gardner, Manager at Sunderland Mind provided data on the number of clients who referred in to the service for counselling for DV from 1 April 2012 to 7 March 2013.
- Washington Mind
    - Jacqui Reeves, Service Manager at Washington Mind provided data on the number of individuals referred to the service from 1 April 2012 to 7 March 2013 who reported DV as a reason for referral.
- Wearside Women in Need
    - Anita Lord, Assistant Director at Wearside Women in Need (WWIN), provided data on numbers of calls received at the local helpline and the number of people provided with and refused refuge accommodation in 2011/12.

- Accident & Emergency
    - Sunderland PCT funds a post within City Hospitals Sunderland NHS Foundation Trust (CHS) to collate and share anonymised information relating to A&E attendances following incidents of violent crime (the 'Cardiff model'). The post responsible for providing this data was vacant during the production of this HNA, therefore CHS was unable to provide any 'Cardiff data' for inclusion.
- Child and Adolescent Mental Health Service (CAMHS)
    - Anna Foster, Performance Manager at Northumberland, Tyne & Wear NHS Foundation Trust, provided data on the number of patients discharged in the last year who had DV recorded in their notes, and on the proportion of the current CAMHS caseload where DV is recorded in case notes.

Felt need

Quantitative data on the 'amount' of need based on activity levels of services provides only part of the picture. Inclusion of qualitative data around issues such as perceptions of DV, barriers to accessing services, availability and acceptability of services enables exploration of felt need, and therefore provides a richer assessment of need with regard to DV in Sunderland.

Working in collaboration with Jackie Nixon, Promoting Health Engagement Lead, a number of focus groups were held to explore awareness, perceptions and acceptance of DV in local communities. A basic topic guide was developed, which was refined following an initial pilot that took place with five female promoting health volunteers. The topic guide was developed iteratively following the pilot, and adapted as appropriate for the subsequent focus groups. Dedicated focus groups were conducted as follows:

- Community/voluntary sector workers (five female participants)
- Black and minority ethnic (BME) community (eight female participants)
- Valley Road School peer support group (seven female participants)
- Men's groups (fourteen male participants in two groups of seven)
- Wearside Women in Need – refuge services (fourteen female participants)
- Wearside Women in Need – outreach services (five female participants)

In addition, qualitative feedback was received from a further support group who had undertaken their own focus group, not using the standard topic guide.

A Health Needs Assessment focusing on the lesbian, gay, bisexual or transgender (LGBT) community across South of Tyne & Wear was conducted in 2010. This included qualitative research with members of the LGBT community around domestic violence. The relevant findings are included in this needs assessment.

As part of the City Council's Scrutiny Policy Review, local councillors visited one of the refuges operated by WWIN and met staff and residents. A summary of key themes emerging from that visit are also included in this section of the needs assessment. Local councillors were also invited to contribute their thoughts and experiences on DV in the city directly into this HNA.

Normative need

A meeting of key stakeholders was held at Sunderland Civic Centre on 31 October 2012. The purpose of the meeting was to make all partners aware of the HNA and to agree aims, to collect opinions from front line staff and experts from a range of agencies on the issues that the HNA should consider and to agree the output of the HNA. Representatives were invited to attend from the following agencies:

- Gentoo
- South Tyneside NHS Foundation Trust (STFT) – Health Visiting
- Northumbria Police
- Sunderland City Council – Adult Safeguarding (Health, Housing and Adult Services)
- Sunderland City Council – Child Safeguarding (Children's Services)
- Sunderland City Council – Performance and Intelligence
- Sunderland City Council – Safer Sunderland (People and Neighbourhoods)
- Sunderland Clinical Commissioning Group
- Sunderland Safeguarding Children Board
- Sunderland Shadow Health and Wellbeing Board
- Sunderland Teaching PCT – Public Health
- Sunderland Teaching PCT – Safeguarding
- Wearside Women in Need

A list of attendees at the stakeholder meeting is presented in Appendix B.

Following the stakeholder meeting, more detailed discussions were held with individual stakeholders, to explore the data, intelligence and their views on services. Meetings were held with representatives from primary care (general practice), Sunderland City Council (SSP, Scrutiny, Children's Commissioning), Victim Support, Sunderland University, WWIN, Sunderland Teaching PCT (Safeguarding), CAMHS, CHS and STFT.

Comparative need

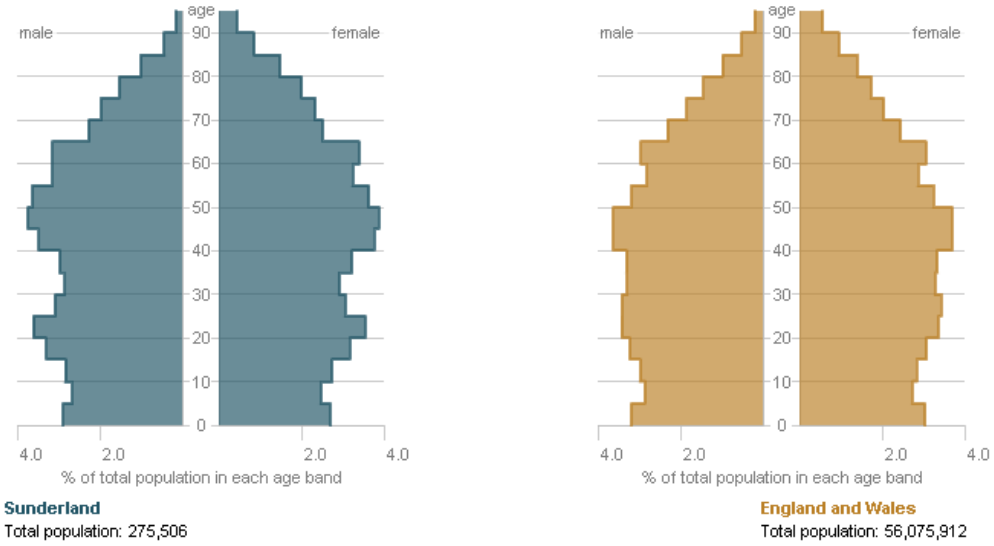
A questionnaire was developed in collaboration with Kelly Henderson, Principal Policy Officer for People & Neighbourhoods, Sunderland City Council and Pam Lee, Public Health Consultant, Sunderland Teaching PCT. The questionnaire was distributed to DV leads in neighbouring LAs and aimed to collect information on the types of services provided across the region. It also collected qualitative data on the opinion of the DV leads as to how well services met local need, aiming to identify areas of best practice and any inequity in provision in different areas.

NEEDS ASSESSMENT

Population Profile

Sunderland has a population size of 275,500 with a slightly higher proportion female than male, reflecting the gender distribution observed nationally. (Office for National Statistics, 2012d) Figure 3 illustrates the population structure for Sunderland, compared to England and Wales, based on 2011 Census estimates.

Figure 3 Population pyramids showing population structure for Sunderland compared to England and Wales



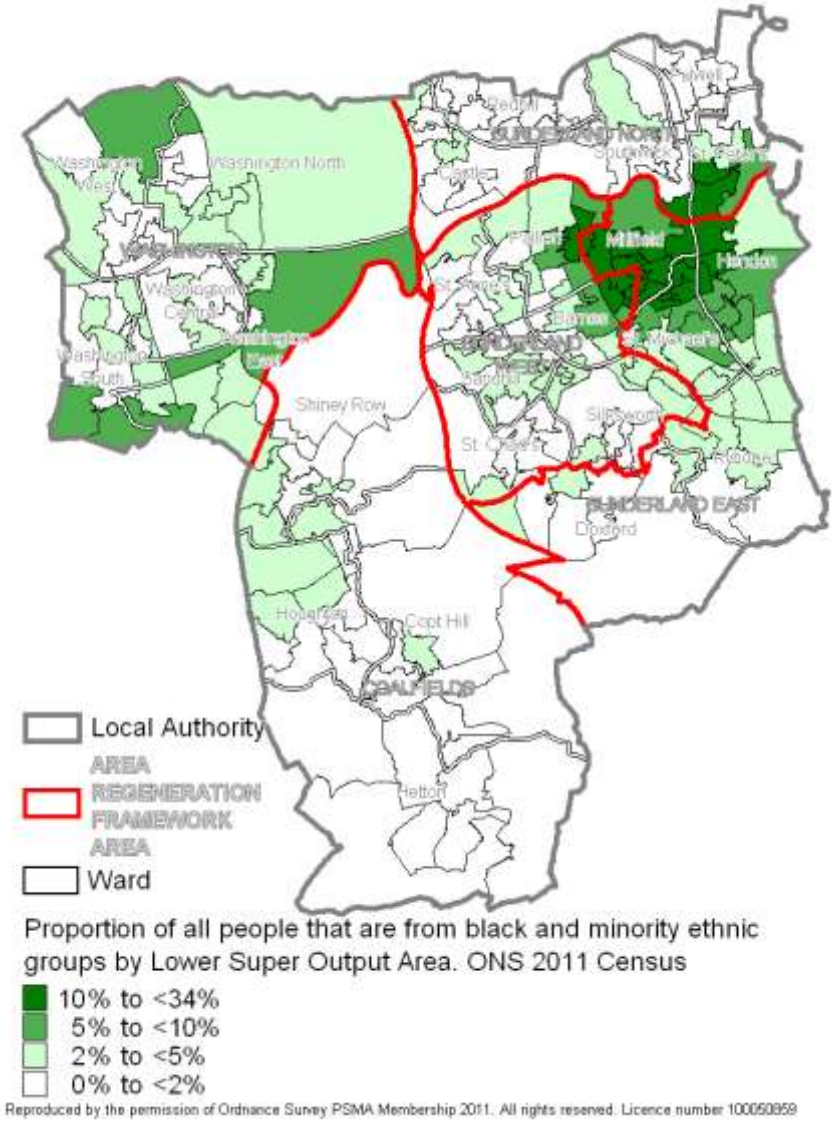
Source: http://www.ons.gov.uk/ons/interactive/vp2-2011-census-comparator/index.html

Sunderland has a lower proportion of both males and females in the range 25 to 40 years and a higher proportion in the range 50 to 65 years, compared to England and Wales as a whole.

The 2011 Census showed that 94.8% of the Sunderland population were white British. A total of 11,224 (4.1%) were from BME groups (excluding white non-British) and the remaining 3,073 (1.1%) were white non-British. (Office for National Statistics, 2012e) The BME population in the majority of wards was between 1% and 5.5%, though there were a small number of wards with substantially higher proportions of the population from BME groups. The highest rate was in Millfield, where almost a quarter (23%) of the population

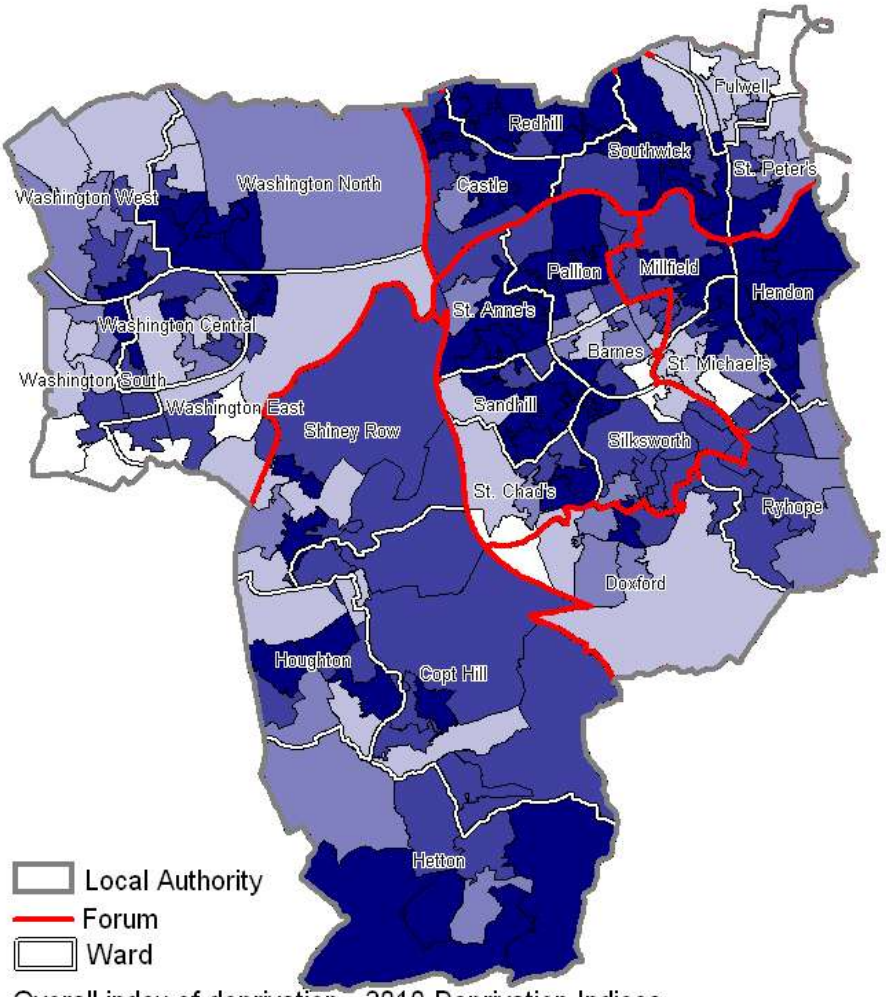
was from BME groups. (Nomis, 2013) Figure 4 shows the proportion of the population in each ward that was from BME groups.

Figure 4 Proportion of population by ward from BME groups



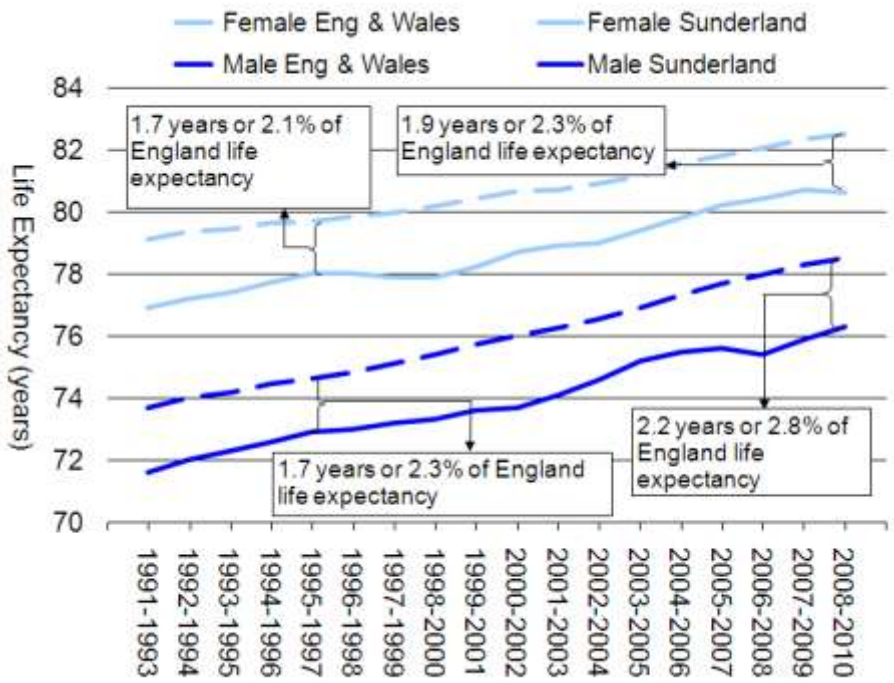
Sunderland is an area with high levels of deprivation; over one third (36%) of the population live in the most disadvantaged 20% of areas in the country. This measure of deprivation is based on a range of domains; the population of Sunderland is most disadvantaged in the employment and health domains, where 50% and 56% of the population respectively live within the 20% most disadvantaged areas in the country. (Sunderland City Council & Sunderland PCT, 2012a) Figure 5 illustrates the variation in levels of socioeconomic disadvantage across the city.

Figure 5 Variation in levels of socioeconomic disadvantage across the city



Life expectancy across Sunderland as a whole is 2 years lower than the England average, and the size of this gap continues to increase, indicating widening inequality. Figure 6 shows the changes in life expectancy for males and females over the last two decades. (Sunderland City Council & Sunderland PCT, 2012c)

Figure 6 The life expectancy gap between Sunderland and England



Source: Sunderland City Council & Sunderland PCT, 2012c

There are marked inequalities in life expectancy within Sunderland. Among males in Sunderland there is a 16 year gap in life expectancy between the wards with the lowest (Hendon, 68.7 years) and highest (Washington South, 85.2 years) life expectancy. For females, the gap is 8 years between wards with the lowest (Hendon, 75.6 years) and highest (Fulwell, 84.2 years) life expectancy. (Sunderland City Council & Sunderland PCT, 2012c)

Over a quarter of children under 16 years old in Sunderland (27%; 13,300 children) live in low income families that are either claiming workless benefits or receiving tax credits and have a household income which is less than 60% of the national median income. This is higher than the average child poverty level of 22% across England as a whole. Again, there is marked inequality within Sunderland, some wards having rates below 5%, while in other wards child poverty rates are more than 60%. (Sunderland City Council & Sunderland PCT, 2012b) Figure 7 illustrates the variation in child poverty rates across the city, with the highest rates largely mirroring rates of socioeconomic disadvantage shown in Figure 5.

Figure 7 Variation in child poverty rates across the city

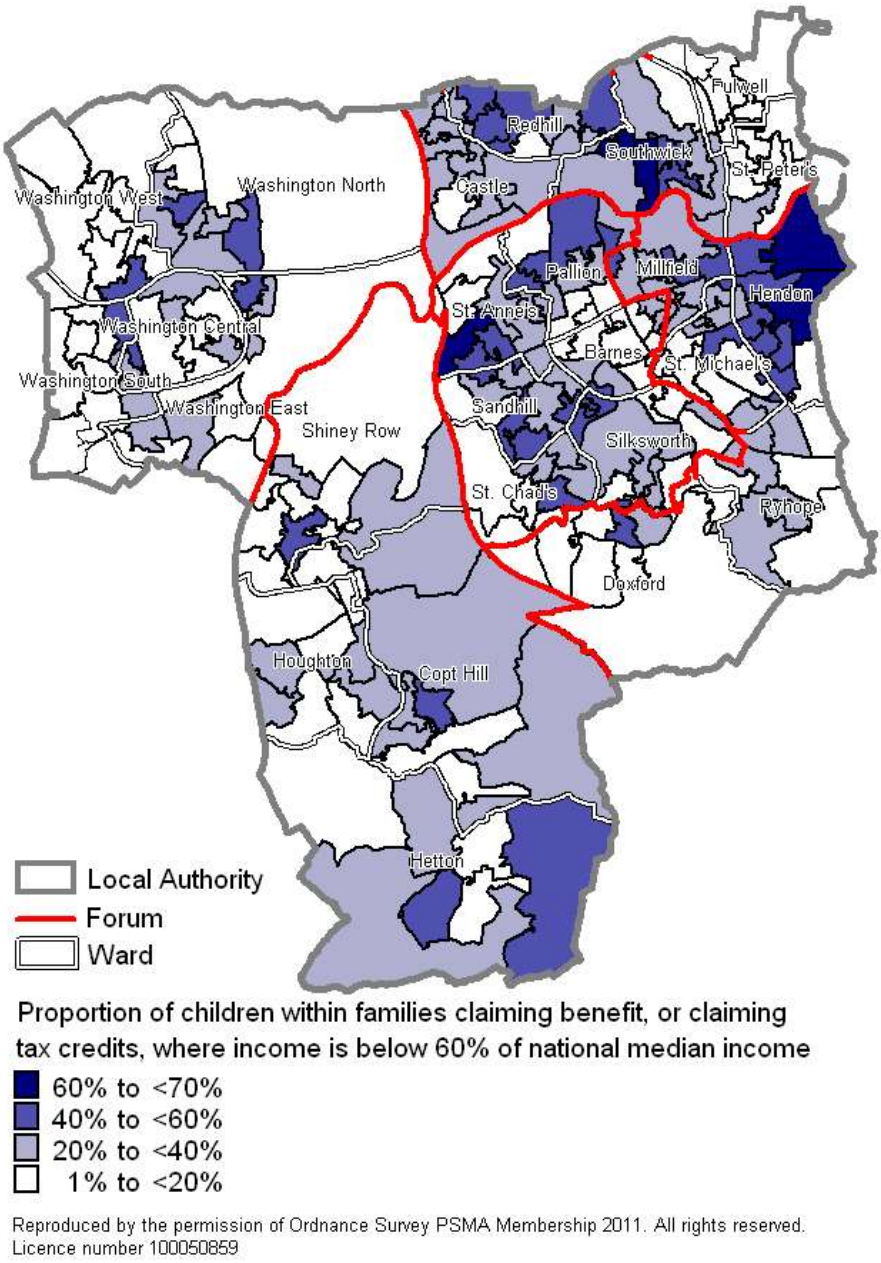
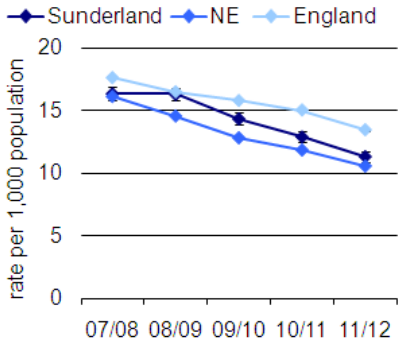


Figure 8 shows that rates of violent crimes against the person in Sunderland have fallen consistently over the last five years and have done so at a faster rate than England as a whole. Rates of violent crimes against the person are significantly lower in Sunderland than the England rate. (Sunderland City Council & Sunderland PCT, 2012a)

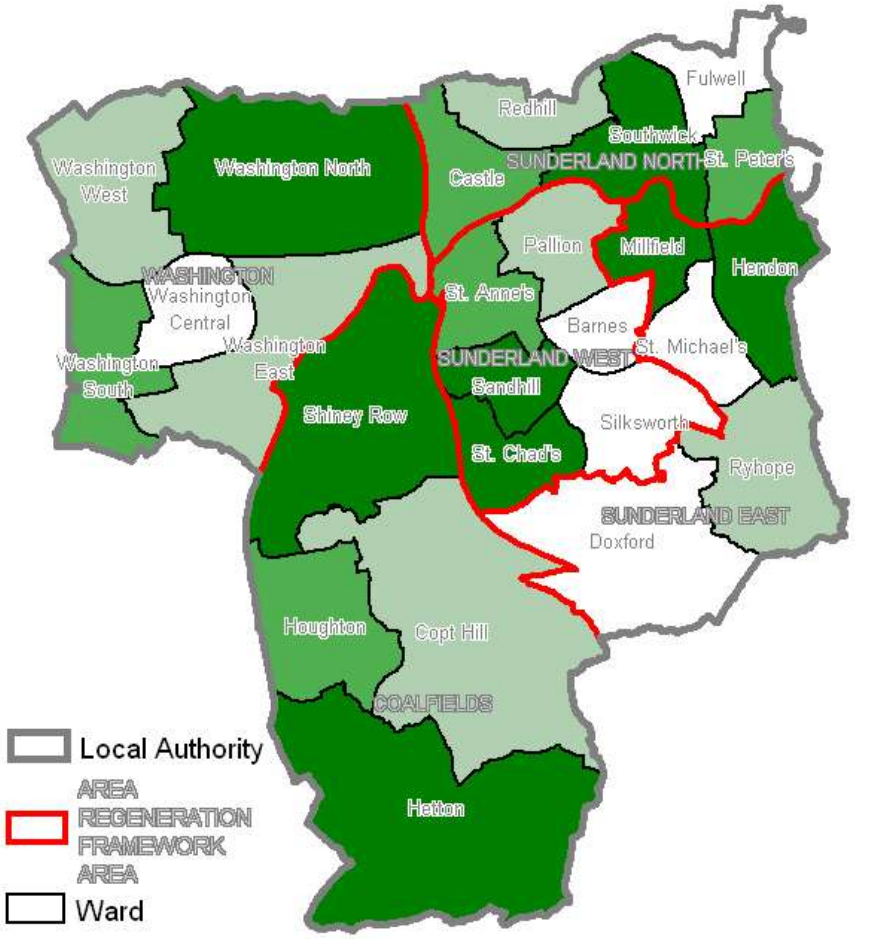
Figure 8 Rates of violent crimes against the person; trend over time



The JSNA for Sunderland states that rates of binge-drinking in Sunderland (28%) are estimated to be significantly higher than England as a whole (18%), and are rising over time. Over 40% of all males in Sunderland aged 18 to 44 were estimated to binge drink at least once a week. Rates of alcohol-attributable hospital admissions in Sunderland are among the highest in England. There does not appear to be a correlation between socioeconomic deprivation and regular binge drinking, but a higher proportion of people from more advantaged communities drink above recommended weekly safe limits. (Sunderland City Council & Sunderland PCT, 2012d)

The Community Mental Health Profile for Sunderland indicated that rates of depression were higher in Sunderland than any other local authority in England. (North East Public Health Observatory, 2013) The Public Health Outcomes Framework, which measures self-reported mental wellbeing, suggests Sunderland has mental wellbeing outcomes similar to or worse than England as a whole. (Public Health England, 2013) Mental wellbeing in Sunderland has recently been measured using the Warwick Edinburgh Mental Wellbeing Scale (WEMWEBS), which gives a numerical result based on responses to a series of 14 questions. There was no significant difference in mental wellbeing between men and women, or between different ethnic groups in Sunderland. A trend of increasing mental wellbeing was found with increasing socioeconomic advantage. Figure 9 shows the distribution of WEMWEBS scores across the city (a higher total score indicates better mental wellbeing). (Sunderland City Council & Sunderland PCT, 2012d)

Figure 9 Mental wellbeing scores by electoral ward



Mean Warwick Edinburgh Mental Wellbeing score by ward in 2012 and comparison with Sunderland average (a higher score indicates better wellbeing)

- 51.0 to <52.0 (below average)
- 52.0 to <52.4 (below average)
- 52.4 to <53.2 (above average)
- 53.2 to <54.3 (above average)

Current Services

There is a wide range of services, largely helplines, provided at a national level. Whilst these services are available to the Sunderland population, local usage data is not routinely available and it was not feasible to contact every national service. This section will therefore consider only those services which are focussed on the Sunderland population, either in the way they are commissioned or provided.

A widely used model in public health is that which classifies services and interventions as primary, secondary or tertiary prevention. Primary prevention is concerned with preventing an event (whether death and disease or abuse and assault) from occurring at all. Secondary prevention is concerned with early detection and, once an event has occurred, reducing the risk of deterioration in conditions, or of adverse effects. Tertiary prevention is concerned with minimising and responding to the negative impacts of a, usually chronic or long term, condition.

In the context of DV, primary prevention would include campaigns and interventions designed to increase awareness and reduce acceptance of DV, with the aim of decreasing incidence. Secondary prevention would include early detection and interventions to prevent escalation. Tertiary prevention would relate largely to the most severe cases, including reducing the risk of repeat victimisation.

Primary prevention

There have been several campaigns and interventions aimed at reducing the incidence of DV in Sunderland in recent years.

In 2011, Gentoo and Wearside Women in Need, with the support of the SSP and Northumbria Police, ran a week long ***'Only Losers Give Bruises'*** campaign. The campaign saw a distinctively liveried bus tour Sunderland, aiming to raise awareness and challenge acceptance of DV, and to put local services in contact with victims of DV. As well as visiting a wide range of community venues across the city, the bus visited schools in the area to specifically tackle the issue of violence in teenage relationships.

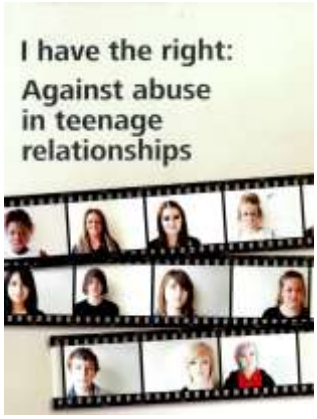
Photo Source: Sunderland Echo

Following the visit of the Only Losers Give Bruises bus in 2011, students from Farringdon Community Sports College were inspired to produce a film specifically to raise awareness of DV in teenage relationships. Launched in September 2012, the film ***'I Have the Right'*** was developed by teenagers to appeal to teenagers and will form part of a teaching pack being developed for distribution to schools across the city. The film was evaluated by 130 audience members present at premieres which took place at Sunderland University and the Sunderland Council Chamber. Respondents included local councillors, NHS staff, community and voluntary sector workers, parents, school governors, police, staff from a wide range of council departments including Children's Services and People & Neighbourhoods, and a range of other stakeholders.

The film was evaluated as 'very effective' by 94% of respondents. The majority of respondents also indicated that they had learned something new from the film, they would be able to recognise the signs of abuse in teenage relationships and would be more likely to seek advice or support if they encountered it. The following were some comments made by those who evaluated the film:

"It takes a serious message and tackles it from a young person's perspective."

"It was really well put together and covered the whole spectrum, and also made the important point that it can happen to girls and boys."



"Personal experiences from the people who have had to deal with the trauma of domestic violence. It's real and happens."

"It was made to engage young people and it hit the mark."

"The reality of victim and perpetrator - this makes people think!"

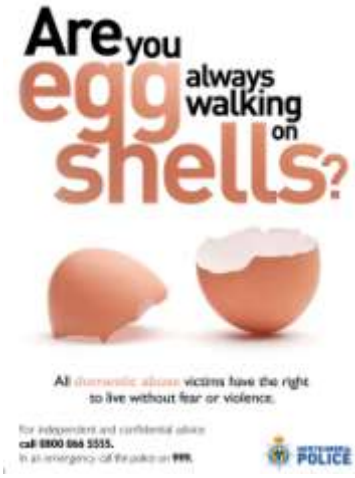
"This was a professional, powerful and informative film for which the students should be very proud of. It highlights the very real problem of Domestic Abuse, how to spot the signs and where to seek support."

"It was an absolute wake up call that these relationships do exist."

"The emphasis that abuse is not only physical, but emotion, sexual, financial & psychological."

In addition to local evaluation, the work of the pupils at Farringdon Community Sports College has also received Home Office recognition and work is ongoing to enable the resource to be shared with schools beyond Sunderland.

In December 2012, Northumbria Police, working with the newly elected Police and Crime Commissioner, launched the ***'Are you walking on eggshells?'*** campaign. The campaign aims to raise awareness of all forms of DV, and to encourage victims to come forward. Posters bearing a freephone helpline number were placed around the city; in shopping centres, doctor's surgeries and on the back of washroom doors. (Northumbria Police, 2012)



Local and regional awareness raising initiatives are supported by national campaigns, such as three new television advertisements that have been launched as part of the national 'This is ABUSE' campaign, which aims to raise awareness of abuse particularly in teenage relationships. (Home Office, 2013a)

The ***Family Nurse Partnership*** is an intensive, preventive home visiting service for vulnerable, first time parents aged under 20 years, who live in areas of deprivation. The service in Sunderland is provided by six specially trained nurses, employed by STFT. The programme begins in early pregnancy and continues until the child reaches 2 years of age. It consists of 14 sessions which cover a range of topics aiming to increase parenting skills, improve resilience and promote healthy family relationships. The programme includes content specific to DV, as well as related topics such as conflict management, each of which can be tailored according to need. The Family Nurse Partnership therefore serves an important primary prevention purpose), raising the issue with all clients, regardless of whether DV has been disclosed, in a vulnerable population (DV incidence being higher among younger ages). If DV is disclosed, the nurse may provide individual support or refer to other services as appropriate. Sunderland is part of a trial of group sessions, which will involve sessions of up to twelve families, and expanded eligibility criteria (under 20's having a second child and 20-25 year olds having a first child). (personal communication, Irma Shepheard)

A standardised ***sex and relationships education*** (SRE) offer has been developed and made to schools across the city, covering various aspects of health and wellbeing including healthy relationships. Uptake of the offer has been variable and, although all schools in the

city are offering some form of Sex and Relationships Education (SRE), it is not known what level of SRE is being delivered in each school. In addition to the core offer, the Risk and Resilience team provide more targeted support on a one to one or small group basis to those individuals identified by schools as being high risk. Feedback from the Risk and Resilience team indicates that there may be benefit in developing a robust referral pathway, so that children can be identified earlier, before their behaviour and attainment are negatively impacted. (personal communication, Rick Stifter)

Secondary prevention

A range of services and interventions are in place in the city to facilitate early detection of DV, and to prevent escalation.

Gentoo

Gentoo is the major provider of social housing within the city and plays a central role in identifying and responding to DV. Gentoo has a dedicated team of ***Victim Support Officers***, who can provide victims with help and advice around housing issues including rehousing, home safety and signposting to refuge services. In addition, Gentoo ***'Cause for Concern'*** is a proactive initiative in which potential victims of DV are identified by front line and maintenance staff trained to recognise specific repairs which may indicate DV occurring in the household. Any of the following leads to a 'Cause for Concern' being raised with Gentoo Victim Support staff, who will discretely make contact with the potential victim:

- external door lock change
- three bathroom lock changes
- two broken windows
- lost keys
- damage to internal doors

The *'Cause for Concern'* initiative therefore represents an innovative approach to identifying DV cases that may otherwise have gone unreported.

Victim Support

Victim Support (South of Tyne and Wear) is the local arm of the national charity that provides free and confidential help to victims and others affected by crime, across England

and Wales. Crimes do not have to be reported to the police in order to access Victim Support.

Impact Family Services

Impact Family Services is a not for profit organisation which provides services for individuals and families who are facing a difficult time due to separation and/or divorce; domestic violence and abuse; and for children and young people affected by family or peer relationships.

The services offered relating to DV include (personal communication, Hazel Hedley):

- Child Contact Centres – offering a safe venue for children to meet a parent they no longer live with. Child contact centres are for private law cases only (charged service).
- Women's Support Worker – works with women using the child contact centres when DV has been an issue and need additional support. This is a free service.
- Domestic Violence Perpetrator Programme – runs in South Tyneside, but accepts men from Sunderland who are going through the family courts for contact with their children following DV. The Judge or Magistrate will make a Contact Activity Order to attend the South Tyneside Domestic Abuse Perpetrator Programme. This is a free service if ordered by the family court.
- Family Mediation Service – an impartial third party that help parents discuss arrangements for children post separation. This applies in cases of DV only if both parents wanted contact and the mediator felt that no-one was being coerced into attending or making agreements. This is a free service for those entitled to legal aid.
- Respect Young Peoples Programme – Impact Family Services are part of a national pilot with Respect, working on an early intervention programme for young people aged between 11-14 years old who are showing signs of being violent within the home. The pilot commenced in February 2013 and will run to September 2015. This is a free service.

Sunderland Counselling Service

Sunderland Counselling Service is commissioned to provide a specialist service for female victims of childhood sexual abuse and adult rape /sexual abuse, but not a specific service for DV. In some but not all cases of sexual violence, there is a clear link to DV. Support is also provided to a small number of cases of DV specifically. In addition, Sunderland Counselling

Service provides a service for male victims of sexual violence, but is not currently commissioned to do so.

Washington Mind

Washington Mind is a local independent charity offering a range of mental health and wellbeing services, as well as training of other agencies to respond to local need. Washington Mind accepts referrals from other agencies and self-referrals from victims of DV and is able to provide emotional support and counselling services.

Sunderland Mind

Sunderland Mind is a local independent charity offering a range of mental health and wellbeing services. Sunderland Mind accepts referrals from other agencies and self-referrals from victims of DV and is able to provide emotional support and counselling services.

Wearside Women in Need

WWIN operate a 24 hour helpline, which is staffed by WWIN staff on a voluntary basis. The helpline provides a range of support from information and advice to crisis response and access to refuge services.

In addition, WWIN operate an outreach service, supporting women living with DV in the community. Users of the outreach service are offered access to IDVA support via group sessions held in community venues.

IAPT

The IAPT programme is delivered by a range of providers in Sunderland and managed by Northumberland, Tyne and Wear NHS Foundation Trust. IAPT is an open access self-referral service and therefore can be accessed by anyone affected by DV, however intervention would only be provided for those experiencing mild to moderate mental health problems. The IAPT service refers severe cases to secondary mental health care services, while those requiring counselling services are referred to third sector organisations.

CAMHS

Northumberland, Tyne and Wear NHS Foundation Trust provide the CAMHS for Sunderland. The CAMHS supports children and young people aged up to 18 who have been affected by DV and are showing signs of psychological effects. In addition to providing individual care,

CAHMS also offers training to organisations that work with children and young people who have been affected psychologically by DV.

Mainstream NHS services

Whilst not necessarily commissioned or provided specifically to respond to DV, a wide range of health care services are provided by the NHS. Individuals may access NHS services as a direct or indirect result of DV, or individuals experiencing DV may access services for an unrelated issue. NHS services therefore are in a position to both respond to DV and to identify victims who could then be referred on or signposted to appropriate services.

The domestic abuse policy for STFT, provider of NHS community health services in Sunderland, states that there is a commitment to *"ensuring that domestic abuse is recognised, and that both clients and staff are provided with information and support to minimise risk"*. In support of this commitment, the policy endorses routine enquiry, the practice of asking all clients direct questions about domestic abuse, as a skill in which all frontline staff should be trained. (South Tyneside NHS Foundation Trust, 2010) This is in line with national guidance. (Home Office, 2004, Department of Health, 2005 & Department for Children, Schools and Families. 2010) It is important to note that routine enquiry is not screening. Routine enquiry is a more flexible approach than screening as it enables health professionals to adapt the mode of questioning according to individual patient circumstances.

CHS does not currently have a DV policy in place. Routine enquiry is undertaken in midwifery and sexual health departments, while selective enquiry is undertaken by Accident & Emergency. (personal communication, Jackie Leaf)

A recent Ofsted report found that the impact of domestic violence in families on children was well understood by health practitioners in Sunderland, rating the contribution of health agencies to keeping children and young people safe as 'Good'. The same inspection also rated partnership working as 'Good', finding that A&E staff referred appropriately to children's social care services and that a specialist health visitor was in place to work with homeless families and with the local domestic violence refuge. One limitation noted was that there is no consistent link from CHS into the MARAC. (Ofsted, 2012)

Tertiary prevention

There are a number of services and initiatives in place in Sunderland to support high risk DV cases and to reduce the risk of repeat victimisation.

MARAC

MARAC is recommended by the Home Office as best practice for addressing high risk cases of DV. The MARAC is a multi-agency approach which involves sharing information to assess the needs of high-risk victims, enabling action planning to reduce risk. The Sunderland MARAC, chaired by Detective Inspector Denise Clark, takes place fortnightly and has representation from a broad range of agencies. The MARAC aims to ensure that agencies work together to minimise risk to those at the most serious risk of harm.

A recent Ofsted inspection of safeguarding and looked after children services in Sunderland reported that partnership working to tackle domestic abuse was robust, though the report highlighted that CHS are not fully signed up to the local MARAC process. (Ofsted, 2012)

IDVA service

Sunderland has two IDVAs who work with and support high risk victims of DV. IDVAs are trained specialists who aim to secure the safety of victims and their children. They are a primary point of contact for high risk victims and provide support from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans. (Home Office, 2013b)

Wearside Women in Need

WWIN operate five residential projects in the city. There are three 'mainstream' refuges for female victims of DV and their children. In addition, the Beechwood project provides specialist refuge accommodation for women suffering from DV with mental health disorders, whilst 'TZ' provides refuge accommodation for 16 to 18 year old females suffering from DV.

Home Security and Sanctuary Scheme

The Safer Sunderland Partnership supports victims to remain in their home if they wish to do so, by providing additional home security. Referrals are generated via Northumbria Police, and home adjustments carried out by Gentoo.

Accident & Emergency

CHS provides Accident & Emergency services in Sunderland. While it is known that a minority of victims access health services, the most severe cases are most likely to attend Accident & Emergency departments. Accident & Emergency provides health care to attend to acute injury and can refer to other NHS services for management of ongoing physical or mental health problems. In addition, selective enquiry is undertaken at Sunderland Royal Hospital Accident & Emergency department, aiming to increase the chance of disclosure of DV and support risk assessment in specific patients. (personal communication, Jackie Leaf)

Perpetrator services

There are a number of initiatives in place to support and rehabilitate offenders, aiming to reduce the risk of re-offending. These are provided by organisations such as Northumbria Probation Trust and WWIN. In addition, Sunderland has a SDVC and while it is beyond the scope of this HNA to describe services targeted at perpetrators of DV or relating principally to the criminal justice system, it is important to acknowledge their potential benefit for victims through impacting on repeat offending, and repeat victimisation rates.

Other services

There is a range of other specialist services which are provided to meet specific needs where there is likely to be considerable crossover into DV, though their primary purpose is not around DV. As such, it is beyond the scope of the HNA to describe these services in detail; however it is important to recognise that such services have an important role to play in protecting and supporting the most vulnerable members of society, many of whom may have previously or currently be experiencing DV.

Examples of such services include (but are not limited to):

- rape crisis
- homelessness charities
- *Wear Out*, an LGBT service working in Sunderland
- *The Women's Hub*, provided by Northumbria Probation Trust for the rehabilitation of female offenders or those at risk of offending, a group known to be at high risk of DV and unlikely to access mainstream services

Epidemiological Need

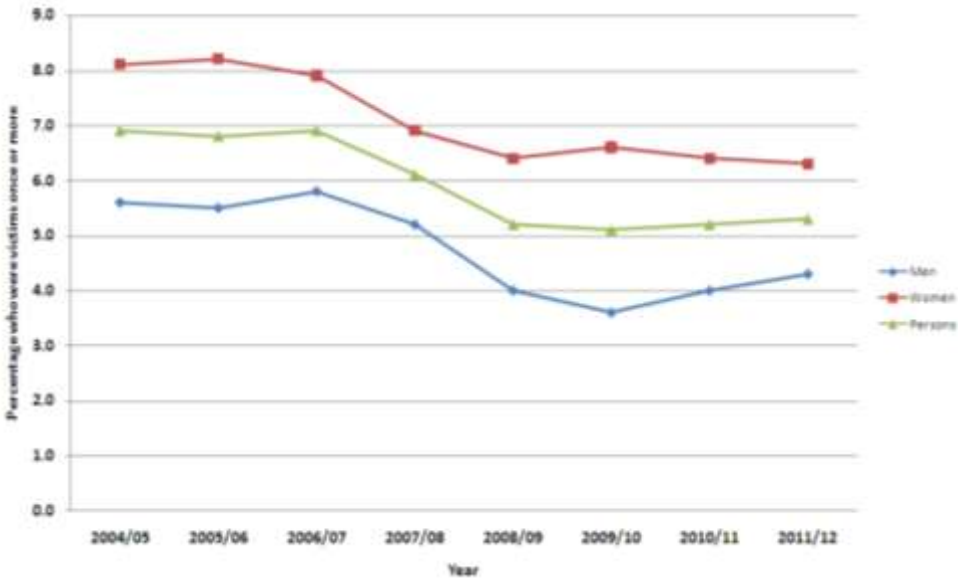
All of the statistics quoted in this needs assessment should be interpreted with caution since, due to the nature of DV, a significant proportion of cases are likely to go unreported and therefore will not be included in statistical estimates.

National level data

The CSEW indicates that in 2011/12, 5.3% of adults had experienced 'any domestic abuse' (defined as partner or family non-physical abuse, threats, force or sexual assault) in the last year, with a higher rate (6.3%) in women compared to men (4.3%). Based on 2011 census estimates, this equates to approximately 1.0 million female and 0.7 million male victims aged 16 to 59 reporting having suffered DV within the last year in England and Wales. (Office for National Statistics, 2012a & Office for National Statistics, 2012f)

Figure 10 depicts the trends in self-reported prevalence of 'any domestic abuse' across England and Wales over the last eight years. Reported prevalence has fallen for both sexes compared to baseline in 2004/05, though it appears that reported prevalence rates among males has begun to increase in recent years. (Office for National Statistics, 2012a)

Figure 10 Trends in self-reported prevalence of domestic abuse in England and Wales



In addition to providing data on experience of 'any domestic abuse' within the previous year, the CSEW also reports on lifetime experience of 'any domestic abuse'. A slightly broader definition, which includes stalking, was used by CSEW when reporting this measure. Lifetime prevalence rates were markedly higher than in-year prevalence; almost a quarter of adults (24.4%) reported having experienced DV at least once since the age of 16. Almost one in three women (31.0%) reported some lifetime experience of DV, compared to almost one in five men (17.8%). Based on 2011 census estimates, this is equivalent to around 5 million female and 2.9 million male victims aged 16 to 59, across England and Wales. (Office for National Statistics, 2012a & Office for National Statistics, 2012f)

Taking partner abuse and family abuse as distinct forms of DV, the CSEW further classifies abuse within these two areas. Table 4 presents these data, illustrating that DV is most likely to involve non-physical rather than physical abuse.

Table 4 Prevalence of different forms of partner and family abuse

	Partner abuse	**Family abuse**
Any	18.5	8.1
Non-physical abuse (emotional, financial)	12.5	4.9
Threats	5.7	1.7
Force	12.2	4.5

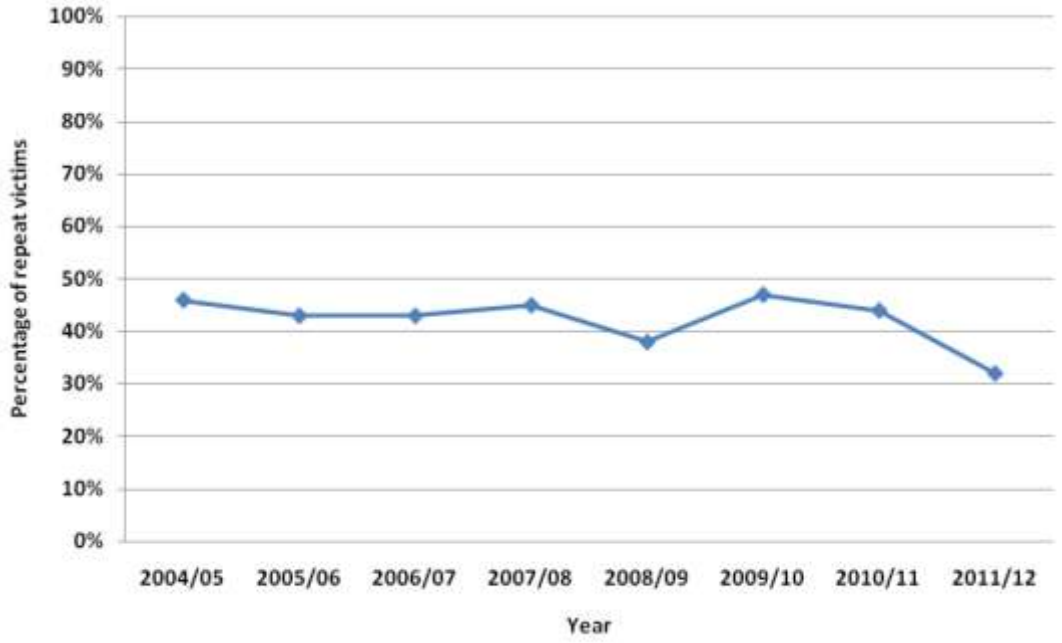
Figures are percentages who were victims once or more since the age of 16

Source: (Office for National Statistics, 2012a)

Repeat victimisation

The CSEW also provides data on repeat victimisation. In 2011/12, 32% of those reporting DV were repeat victims, the lowest rate ever recorded. Figure 11 shows the trend in repeat victimisation rates. (Office for National Statistics 2012a)

Figure 11 Trends in self-reported repeat victimisation of domestic abuse in England and Wales



While around a third of DV victims are repeat victims, these account for almost two thirds (63%) of all DV incidents.

Each year, a specific aspect of intimate personal violence is the focus of an expanded report. Key findings from 2010/11, which focussed on partner abuse and 2009/10, which focussed on risk factors for being a victim of DV, are summarised here.

Risk of DV in specific groups

The Equality Act 2010 makes illegal the unfair treatment of people because of protected characteristics. (HM Government 2010b) The nine protected characteristics set out in the Equality Act are:

- age
- disability
- gender identity
- marriage/civil partnership
- pregnancy/maternity
- race
- religion/belief
- sex
- sexual orientation

Detailed analysis of data from the 2009/10 BCS included findings from logistic regression analysis, which was used to determine the extent to which a range of variables contributed to the likelihood of being a victim of DV. Several individual factors, including many of the protected characteristics, were found to be independently associated with risk of DV. Those factors independently associated with an increased risk of DV victimisation are listed in Table 5 below. It is important to note that association does not necessarily imply a causal relationship with DV. (Smith, 2011)

Table 5 Independent risk factors for DV victimisation

- use of any drug in the last year
- people who are separated, divorced or widowed
- having a long-term illness or disability
- sex (being female)
- household structure (higher risk where single adult with child(ren) in household)
- age (generally lower risk with higher age)
- household income (generally lower risk with higher income)
- alcohol consumption (lower risk among non-drinkers)
- housing tenure (higher risk for tenants than owner occupiers)
- number of visits to a nightclub in last month (higher risk with higher frequency)
- occupation (lowest risk among students and intermediate occupations)

Of the protected characteristics, ***age, sex, marital status*** and ***disability*** were found to be independently associated with risk of DV.

The BCS found that ethnicity was not independently associated with risk of DV, however some specific forms of DV, such as forced marriage, so-called 'honour' based violence and female genital mutilation, are disproportionately distributed by ***race*** or ***religion/belief***. (HM Government 2010a) There is very limited specific data on rates these individual forms of DV however that which does exist is presented here.

The Forced Marriage Unit (FMU) reported that in 2011 there were 1,468 instances where support or advice was provided in relation to a possible forced marriage. Over three quarters (78%) of those receiving support or advice were women. A small proportion

involved those with disabilities (4.5%) and 0.7% involved those who identified themselves as LGBT. (Foreign and Commonwealth Office, 2012)

There is a lack of robust data available on the prevalence of HBV in the UK. Recent research from the charity *Iranian and Kurdish Women's Rights Organisation* suggested that there was likely to be around 3,000 cases of HBV each year in the UK. This figure was based on extrapolation of data provided by a sample of police forces across the country on the number of incidents of HBV that were reported in 2010. (Iranian and Kurdish Women's Rights Organisation, 2011) The Government have recently stated that there are believed to be approximately 12 honour-related killings annually, but that actual prevalence could be much higher. (HM Government 2011b)

Robust data on the prevalence of FGM in the UK is similarly lacking, though it is known to be more common in certain ethnic groups. A recent report into the issue from the British Medical Association (BMA) stated that the majority of cases in this country were refuges, particularly those from Egypt, Eritrea, Ethiopia, Gambia, Iraq, Kenya, Kurdistan, Liberia, Mali, Nigeria, Northern Sudan, Sierra Leone and Somalia. FGM can be encountered in the UK in women and girls who have already been mutilated, and in girls who might be. The most common age for FGM to occur is from 7 to 9 years. (BMA 2011)

A Department of Health funded study (Forward, 2007) reported that:

- An estimated 65,790 women resident in England and Wales in 2001 had undergone FGM, with over half being from Kenya or Somalia.
- In 2004, there were an estimated 9,032 maternities to women who were likely to have undergone FGM.

The other protected characteristics were not analysed as part of the 2009/10 BCS, however a recent equality impact assessment summarises current evidence. (HM Government 2011b) It reported that experience of DV varied according to ***sexual orientation*** and ***gender identity***, with bisexual and transgender people more likely to experience DV than lesbians and gay men. No comparison was made between these groups and the heterosexual population.

It has been estimated that around one third of cases of DV start during ***pregnancy***, and that almost one in ten women are thought to be abused during or following pregnancy, with particularly high rates among teenage mothers. (HM Government 2011b)

Drugs and alcohol

While the 2009/10 BCS reported that the frequency of alcohol consumption was associated with risk of DV, there was no evidence of a linear relationship with frequency. All levels of consumption were compared to a frequency of three times per week or more; only those who had not consumed alcohol in the last year had a significantly reduced risk of DV. There was no statistically significant reduction in risk, for example, among those who consumed alcohol less than once a week. (Smith, 2011)

In the 2010/11 BCS, victims of partner abuse were asked whether they believed the offender had been under the influence of alcohol or illicit drugs, and whether they (the victim) had been. Alcohol use was more commonly suspected than illicit drug use (21% compared to 8%), with female victims most likely to perceive both forms of substance misuse. Victims were more likely to report that they themselves had been under the influence of alcohol (10%) than illicit drugs (2%), with no statistically significant difference between male and female victims. These results should be interpreted with caution due to large numbers of respondents being unable or unwilling to answer. (Smith, 2012)

Mental health

A recent systematic review and meta-analysis has shown that the prevalence of DV is significantly higher in both men and women with mental health disorders, compared to those without. For specific forms of mental health disorder (depression, anxiety and post-traumatic stress disorder) in women where sufficient data was available, the authors were able to produce numerical estimates of condition-specific increases in the risk of experiencing DV. Risk of DV among these women ranged from two to seven times higher than in women without mental health disorders. (Trevillion, 2012) It should be noted that mental illness may be both a cause and effect of DV therefore care should be taken when interpreting the numerical risk estimates quoted. Nonetheless, the association between DV and mental illness means that those working with individuals with mental illness should be aware of the vulnerability for DV to be present, and vice versa.

Help seeking behaviours

The 2010/11 CSEW report described help seeking behaviours of victims of partner abuse. The majority of victims did tell someone about the abuse they had suffered; most commonly a friend, relative or neighbour. Various forms of support were provided, ranging from listening (87%), provision of advice (29%), onward referral (18%), financial support (14%) and provision of accommodation (10%). (Smith, 2012)

Less than half of female victims and fewer than one in five male victims sought support from a professional organisation. Around one quarter of partner abuse victims reported the abuse to the police. Reasons for not involving the police included the perception that the abuse was too trivial to report, that it was a private matter and not the business of the police, or lack of confidence that the police could help. (Smith, 2012) In 2011/12, the proportion who stated that they had reported the incident to the police was higher, at 39%. (Office for National Statistics 2012a)

Engagement with health professionals was particularly uncommon, especially among men; only 4% of male and 19% of female victims of partner abuse reported telling a health professional. Although around a quarter of all partner abuse victims sustained a physical injury, only around a quarter of these received any medical attention. The overwhelming majority (over 80%) of those receiving medical attention did so from a GP surgery, with less than one in five attending Accident & Emergency. (Smith, 2012)

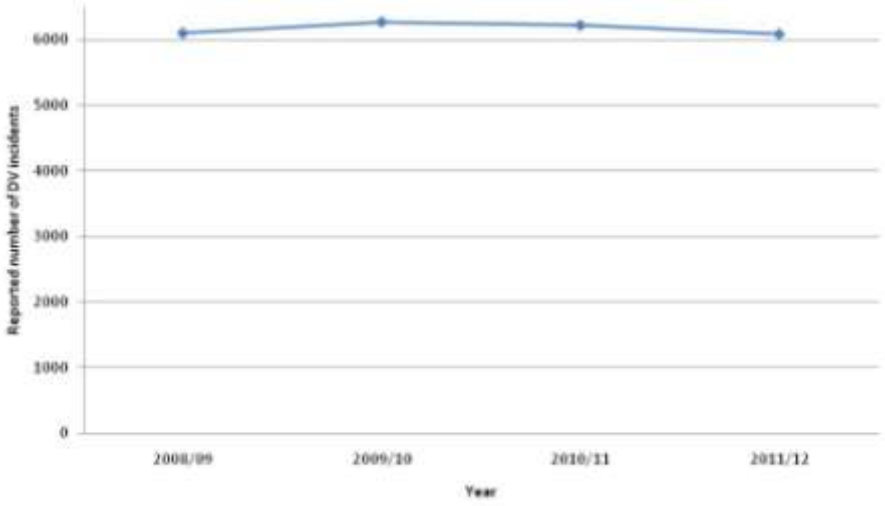
Local data: Northumbria Police incidents

Data relating to the number of DV incidents, gender of victims, sexuality of victims, distribution across police sectors and repeat victimisation was provided directly by Northumbria Police. All other data relating to DV incidents was obtained from extracts of the Northumbria Police data as supplied to the SSP. Data extraction from the SSP database was undertaken by Stephen Potts, Data Analyst at Sunderland Teaching PCT.

Number of incidents

Northumbria Police reported that they responded to a total of 6,091 DV incidents in Sunderland during 2011/12. This was a decrease of 136 on the previous year however, as Figure 12 shows, the number of reported incidents has fluctuated around 6,000 for the past four years without evidence of any discernible trend.

Figure 12 Trend in number of reported DV incidents in Sunderland



Victims

The 6,091 DV incidents reported to Northumbria Police in 2011/12 involved 3,865 victims, 3,012 (78%) of which were female and 853 (22%) male. Just over one in ten DV incidents occurred in same sex relationships (667; 11%).

Table 6 shows the distribution of the 3,865 victims of DV across each of the seven police sectors in Sunderland in 2011/12. Note the figures for each sector should not be added as the same victim could be recorded in separate sectors.

Table 6 Number of reported victims of DV incidents by police sector, 2011/12

Central	East	South	West	North	Washington	Houghton
407	431	333	745	797	672	599

The repeat victimisation rate was 49.9%, representing a total of 3,037 recorded incidents.

Further data on DV incidents was extracted from the dataset available to the SSP. In this dataset, it was not possible to identify only *adult* victims of DV incidents. Therefore any reference to incidents herein refers to victims of all ages, which is broader than the definition of DV outlined in the scope of this HNA.

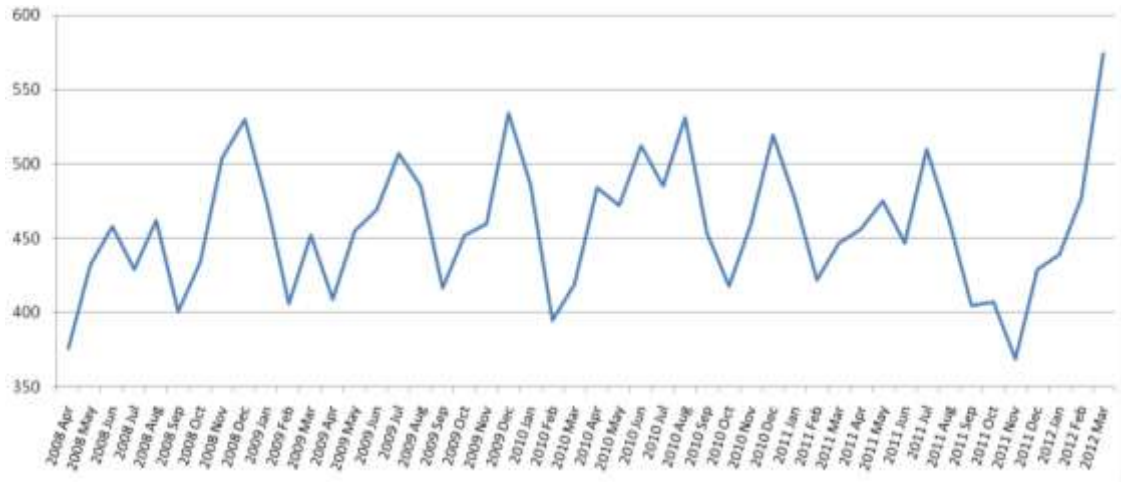
It is important to note that the total number of DV incidents included in the dataset provided from the SSP differs from that provided directly by Northumbria Police. The SSP dataset included a total of 5,449 DV incidents in 2011/12. The data from SSP is based on recorded

DV incidents while the data provided from Northumbria Police is based on 'domestic abuse records' created by officers. On attending an incident where DV has not been identified, an officer may suspect DV and create a record. As such, there are a greater number of DV incidents included in the dataset provided by Northumbria Police than that from the SSP. This discrepancy is recognised by Northumbria Police and discussions are in hand to standardise data provided to Las, (personal communication, Denise Clark)

Seasonal distribution of DV incidents

The number of reported DV incidents fluctuates around 400 to 500 per month in Sunderland. Figure 13 shows the number of reported DV incidents per month over the last four years. This figure illustrates the pattern of incidents with no discernible trend, apart from a seasonal peak around December in each year. The number of reported incidents has continued to increase each month from November 2011 to the highest level in four years at the end of 2011/12. It should be noted that this may be due to random variation, however the continuing trend should be monitored.

Figure 13 Number of reported DV incidents per month from 2008/09 to 2011/12



Geographical distribution of DV incidents

The distribution of reported DV incidents (2011/12) across the city was inequitable, ranging from a peak of 49.6 per 1000 population in Hendon ward to a low of 11.2 per 1,000 population in Fulwell and Doxford wards. Table 7 shows the number and rate per 1,000 population of reported DV incidents in each ward of the city.

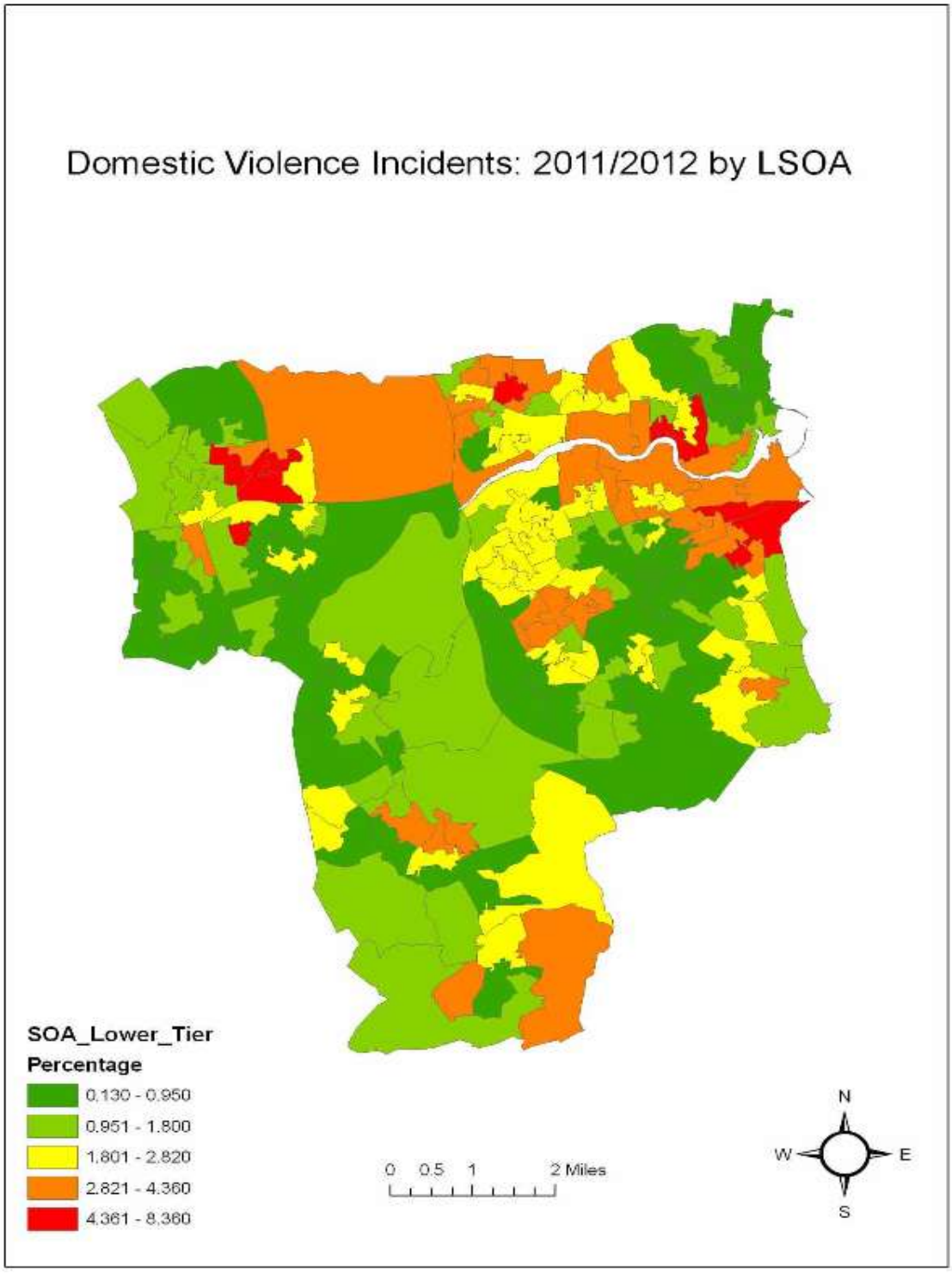
Table 7 Reported DV incidents across the city

Ward	Number of reported DV incidents	Total adult population†	DV incidents per 1,000 population
Hendon	488	9,830	**49.6**
Washington North	403	9,225	**43.7**
Millfield	360	9,674	**37.2**
Southwick	321	8,725	**36.8**
Redhill	338	9,407	**35.9**
Sandhill	305	8,850	**34.5**
Pallion	275	8,437	**32.6**
St. Anne's	235	9,017	**26.1**
Castle	237	9,296	**25.5**
Ryhope	200	8,481	**23.6**
Hetton	209	9,219	**22.7**
Silksworth	192	8,997	**21.3**
Copt Hill	194	9,108	**21.3**
St. Michael's	195	9,175	**21.3**
Washington Central	191	9,367	**20.4**
Houghton	170	9,398	**18.1**
St. Chad's	141	8,009	**17.6**
Washington West	157	9,250	**17.0**
Shiney Row	172	10,337	**16.6**
St. Peter's	143	9,364	**15.3**
Washington South	113	8,455	**13.4**
Washington East	109	9,106	**12.0**
Barnes	105	9,174	**11.4**
Doxford	93	8,281	**11.2**
Fulwell	103	9,190	**11.2**
SUNDERLAND	5,449	227,372	**24.0**

† Adult population based on mid-2010 ward population estimates (experimental statistics), published by the Office for National Statistics. These data differ slightly from the mid-2011 estimates, however this is the most recent release of the ward level statistics.

Figure 14 illustrates the distribution of reported DV incidents across the city, proportional to population size. Dark green represents the lowest rates of DV per capita, with light green, yellow and amber representing increasing rates, up to the highest rates, shown in red. The map shows the highest rates of DV (where incidence is equivalent to up to 8.4% of the population) were found in pockets around Hendon, Southwick, Redhill and Washington North wards.

Figure 14 Map showing the geographical distribution of reported DV incidents in Sunderland

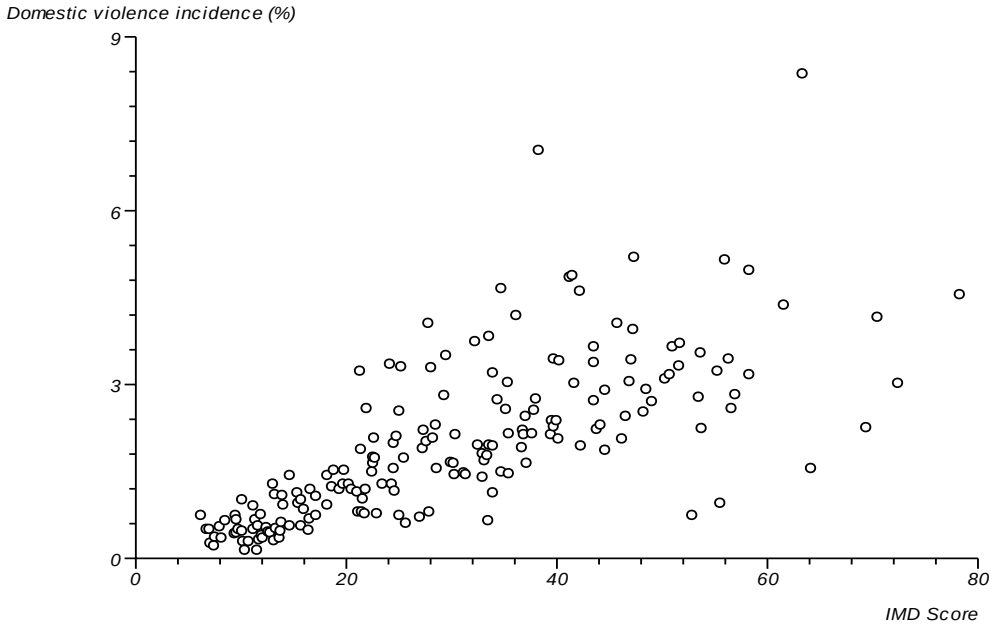


Association with deprivation

Lower Super Output Areas (LSOAs) are small level geographies containing between 1,000 and 3,000 people. As such they are much smaller than wards and were designed to improve the reporting of small area statistics. (Office for National Statistics, 2013a) Every LSOA has been assigned a deprivation score, (Index of Multiple Deprivation, IMD) with lower scores indicating lower levels of deprivation. (Department for Communities and Local Government, 2010)

It is possible to explore the correlation between rate of reported DV incidents and deprivation at LSOA level. Figure 15 illustrates a clear trend that LSOAs with higher deprivation scores, tend to experience higher rates of reported DV incidents.

Figure 15 Scatter plot showing correlation between DV incidence and deprivation score



The correlation between deprivation and incidence of reported DV is highly statistically significant (Spearman's Rank Correlation Coefficient r_s=0.82, p<0.0001).

While these analyses suggest that DV incidence is significantly higher in more deprived areas, it is important to note that this refers only to *reported* DV incidence. There is conflicting opinion as to whether DV is equally common but less reported by more affluent women, (Walby, 2004 and Harne, 2010) or the prevalence is genuinely lower in more affluent communities. (Renzetti, 2009) A recent Department of Health publication describes a strong socioeconomic gradient for violence, likely attributable to a clustering of risk factors

for violence in deprived communities. (Department of Health, 2012) It should however be noted that DV incidents were reported in every ward of the City in 2011/12, so although some areas have higher reported rates than others, DV is a citywide issue in Sunderland.

Incidents involving children

Data extracted from the SSP database indicates that in 2011/12 over a third (35%) of police reported DV incidents in Sunderland involved children. These statistics have been ascertained from those incidents where one or both of the following applied: 'Concern for Safety Persons Under 17 years old' or 'Vulnerable Child/Young Person'. It is not possible from these data to estimate the number of children affected, as it is likely that a number of cases will be in households with more than one child. A total of 1,914 incidents reported in 2011/12 involved children, therefore the most conservative estimate would indicate that at least 1,914 children were involved, though the actual number is likely to be considerably higher.

Alcohol related incidents

Although the number of alcohol related DV incidents in Sunderland has increased over the last four years, this has not been accompanied by an increase in alcohol related DV crimes. There are recognised limitations in the recording system for incidents, in which a limited number of associating factors (codes) can be entered for any one incident, meaning that not all alcohol related DV cases may be recorded as such. Due to this data quality issue, data on alcohol related DV *incidents* will not be included in this HNA. Data on alcohol related crimes, which is a more reliable measure, is included in the relevant part of the next section.

Risk level

Northumbria Police and partner agencies undertake risk assessment of DV incidents to determine the severity and ongoing risk. Incidents are rated as Standard, Medium or High risk, with High Risk cases being managed through the MARAC process. Northumbria Police were unable to provide details of the risk level of DV cases over the period 2011/12.

Local data: Northumbria Police crimes

All information on DV crimes was provided from the SSP dataset by Stephen Potts, Information Analyst at Sunderland PCT. Whilst only limited information is available for incidents, once it is established that a crime has been committed, additional information

pertaining to the crime, victim and perpetrator is collected. Of the 5,449 DV incidents in the SSP dataset for Sunderland in 2011/12, 910 were recorded as crimes. These cases represented 45% of all recorded violent crime in adults in Sunderland.

The following narrative refers to the 910 DV crimes.

Sex

In 85% of recorded DV crimes in 2011/12, the victim was female (774 of 910). While these data indicate that the majority of victims were female, almost one in six victims was male (15%; 136 of 910) therefore the potential impact of DV on male victims should not be overlooked.

In addition, DV is known to be an underreported crime; therefore it is likely that these estimates for both sexes do not provide a true representation of the scale of the issue. Men are generally less likely to engage in help-seeking behaviours (Courtenay, 2000, O'Brien 2005 and Smith, 2012) and therefore may be less likely than females to report DV.

Age

Table 8 shows the age distribution of victims of DV crimes as a rate based on stratified population size.

Table 8 Reported DV incidents in Sunderland, by age

Age band	Number of reported DV incidents	Total adult population†	DV incidents per 1,000 population
18	19	3,642	5.2
19	30	4,066	7.4
20-24	198	19,709	10.0
25-29	163	16,945	9.6
30-34	110	15,877	6.9
35-39	107	17,040	6.3
40-44	81	19,937	4.1
45-49	77	20,944	3.7
50-54	60	20,020	3.0
55-59	26	17,577	1.5
60-64	15	18,011	0.8
65-69	16	13,198	1.2
70+	8	33,595	0.2
SUNDERLAND	***910***	***220,561***	***4.1***

† Adult population based on 2011 Census. (Office for National Statistics, 2013b)

This clearly shows that, while 20-24 year olds report the highest rates, DV can and does occur at all ages.

Ethnicity

The vast majority of reported DV crimes were committed against those of white ethnic origin (97.8%). A small proportion of reported crimes (1.5%) were committed against victims of Asian or Asian British ethnic origin, with less than 1% committed against those of Black or Black British ethnicity.

Census estimates indicate that approximately 5.2% of the Sunderland population are from the BME community. (Office for National Statistics, 2012e) Since national data indicate that there is no significant association between DV incidence and ethnicity, these data suggest that DV incidents are disproportionately underreported in BME communities.

Sexual orientation

Data on sexual orientation was not readily available from the data available to the SSP; however, through cross-tabulation of the sex of both victim and perpetrator, it was possible to identify those crimes committed by a member of the same sex as the victim. Restricting this analysis to those crimes where the perpetrator relationship was recorded as 'partner' enabled estimation of the number of same sex DV crimes.

A total of 39 DV crimes (4.3%) occurred in same sex relationships, where the perpetrator was recorded as either the partner or an ex-partner. Twenty cases were female and 19 were male. While this implies an equal burden of same sex DV crimes, when considering the total number of DV crimes in each gender, a different pattern emerges. The 20 cases of same sex DV in females accounts for 2.6% of the 774 female DV victims, while the 19 cases of same sex DV in males accounts for some 14.0% of the 136 male DV victims.

Information on the other protected characteristics (disability, gender reassignment, marriage/civil partnership, pregnancy/maternity and religion/belief) was not available from police data.

Relationship

A total of 3,248 DV crimes were recorded during the period 2008/09 to 2011/12. Of these, 45% were perpetrated by a partner, and a further 25% by a former partner.

Following partners and ex-partners, children were the next most likely group to perpetrate DV, against their parents. Child to parent DV accounted for a total of 415 DV crimes (13% of the total) over the four year period. Other family members such as siblings, parents and extended family members comprised the vast majority of the remainder of cases.

Alcohol related DV crimes

Within crime recording, there are specific flags for both DV and alcohol-related. As such, crime data on alcohol related DV is far more robust than incident data. In Sunderland, there has been a 24% decrease in alcohol related DV crimes over the last year. The number and proportion of alcohol related DV crimes recorded by Northumbria Police over the last four years is summarised in Table 9.

Table 9 Number and proportion of alcohol related DV crimes

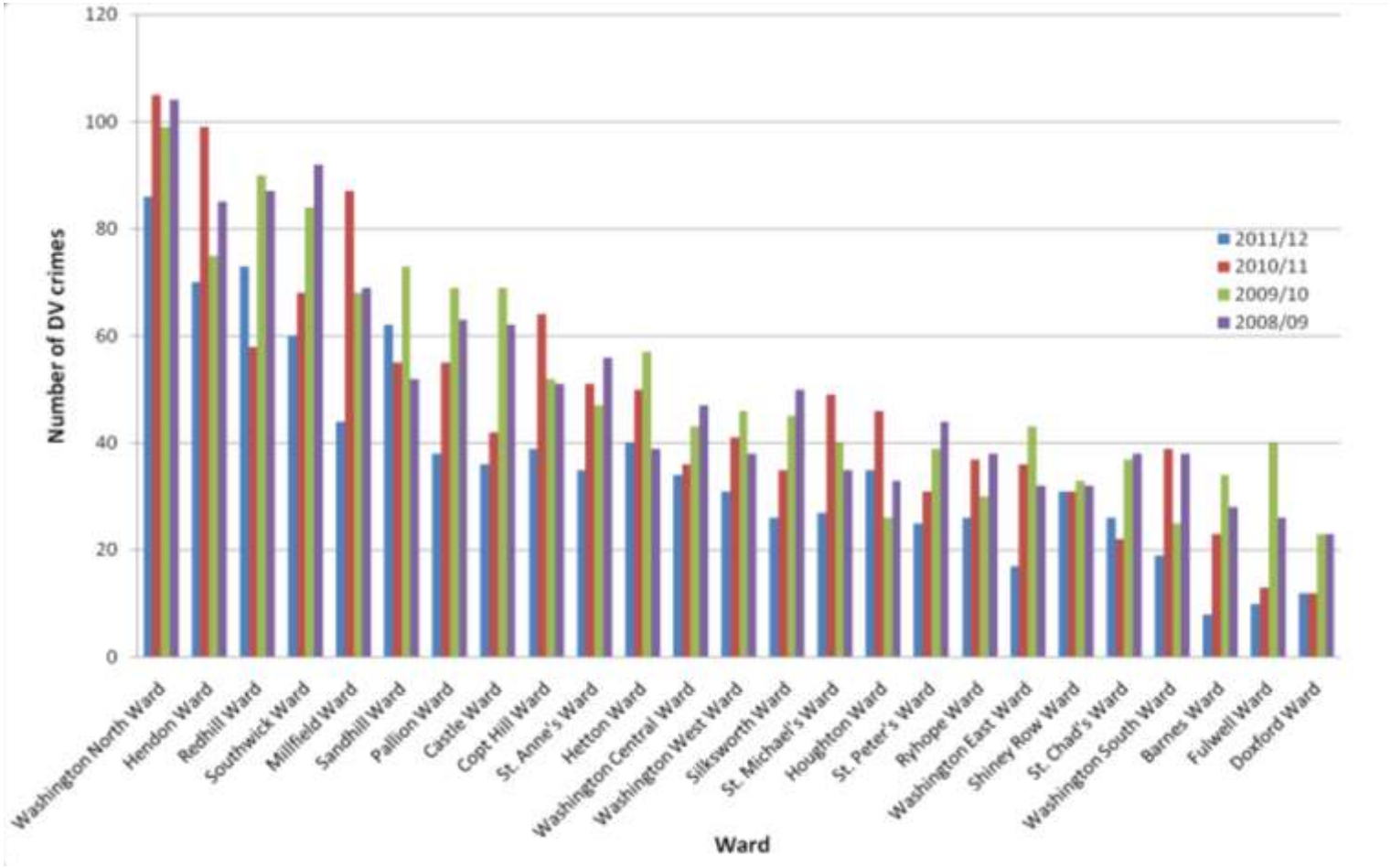
	Total DV crimes	Alcohol related
2008/09	1269	794 (63%)
2009/10	1295	795 (61%)
2010/11	1187	713 (60%)
2011/12	914	542 (59%)

Geographical distribution

As with incidents, there was marked variation in the prevalence of DV crimes across the city. Figure 16 illustrates this variation by ward, as well as showing the trend in number of DV crimes for each ward over the last four years.

The data show marked inequality in the number of DV crimes experienced by ward, and in trends in numbers of DV crimes over the last four years. There have been marked and consistent decreases year on year in the number of DV crimes in some wards, such as Southwick, Silksworth and St. Peters. In other wards, including Shiney Row and Sandhill, there is less evidence of significant change. While this apparent variation warrants further investigation, it is important to note that it may be the result, entirely or partly, of working with small numbers.

Figure 16 Variation and trends over time in numbers of DV crimes by ward (2008/09 to 2011/12)



Estimate of true local prevalence

DV is known to be an underreported crime, meaning that a substantial number of victims are likely to be missing from police and other official data sources. Through extrapolation of national estimates derived from the CSEW, the rate of DV in Sunderland can be estimated. The 2011/12 CSEW found that 5.3% of the adult population had experienced DV within the previous year. The adult population of Sunderland is estimated to be 220,561. (Office for National Statistics, 2013b) Therefore, based on crude extrapolation from the national CSEW data, there would be approximately 11,690 cases of DV in Sunderland in 2011/12. As reported in the previous section, approximately half this number of incidents was reported to Northumbria Police.

It should be noted that the CSEW 2011/12 showed that only 39% of DV incidents were reported to the police. (Office for National Statistics, 2012a) A total of 6,091 incidents were reported to the police in Sunderland in 2011/12. If the reported incidents represented just 39% of all incidents, the total number may have been as high as 15,618 (equivalent 7% of the adult population of Sunderland). This would suggest that the rate of DV in Sunderland may be substantially higher than the national average. It should be noted that this assumes reporting behaviours in Sunderland mirror the national picture; if a higher proportion of DV was reported in Sunderland than that suggested nationally by the CSEW, the figure of 15,618 would be an overestimate.

It is also possible, though extrapolation from CSEW, to estimate the number of people living in Sunderland who have experienced DV at any time in their adult life. National data suggest that 24.4% of the adult population have been affected by DV, therefore based on the adult population of Sunderland, it is estimated that approximately 53,817 people in the city have been or are currently affected by DV.

Local data: Multi Agency Risk Assessment Conference

DV is a complex issue which no single agency can address alone. It has been recognised nationally that MARACs represent best practice in managing the highest risk cases of DV. (HM Government 2010a) The MARAC process enables the identification and management of high risk DV cases through information sharing by a number of agencies and organisations. Sunderland's MARAC is chaired by Detective Inspector Denise Clark from the Domestic Abuse & Rape Investigation Crime Department within Northumbria Police.

Collated information on MARAC activity levels are presented in Table 10. These data indicate no discernible trend in MARAC activity levels over recent years, and that over three hundred children per year in Sunderland continue to live in households where there is considered to be a high risk of DV.

The data indicate that between 4% and 8% of victims in MARAC cases have a registered disability. While there are no official statistics available on the proportion of the population that are registered disabled, the Office for Disability Issues prevalence estimates indicate that there are 0.6 million disabled people in the North East; equivalent to approximately 24% of the population. (Office for Disability Issues, 2012 and Office for National Statistics, 2011) Since national data demonstrates an increased rate of DV among those with a disability, it is likely that only a small proportion of high risk disabled victims are known to the MARAC.

Similarly, the MARAC has discussed very small numbers of cases where the victim was male, or from the LGBT community, again suggesting that these groups may be underrepresented in the MARAC data. This is consistent with research evidence which shows under-representation of LGBT victims at MARAC at both national and regional level. (Donovan, 2010) Census estimates indicate that approximately 5.2% of the Sunderland population are from the BME community. (Office for National Statistics, 2012e) Those from BME communities appear to be underrepresented in the MARAC data, though to a lesser extent than the other groups described above.

Table 10 **Sunderland MARAC activity levels 2009/10 to 2011/12**

	Number of cases discussed	Number (%) of repeat cases	Number of children in households	% from BME communities	% of LGBT cases	% where victim has a registered disability	% male victims
2012/13*	200	44 (22.0)	346	5.5	<1.0	<2.0	3.0
2011/12	203	31 (15.3)	330	2.5	0.0	4.4	3.0
2010/11	221	44 (19.9)	379	3.2	<1.0	7.7	4.5
2009/10	212	26 (12.3)	343	2.4	<1.0	4.7	<2.0

*year to date (data correct to 14 November 2012)

Local data: Sunderland Safeguarding Children Board

Data from the Sunderland Safeguarding Children Board indicates that, on average, Children's Social Care receive approximately 5,000 referrals related to DV per year. Data on the proportion of referrals to children's social care in Sunderland which were related to DV are available for the last three complete financial years (Table 11). Note that a referral refers to a child, rather than a family, and it is possible that one incident may be reported more than once in the data. This occurs when a referral is received from more than one agency. Although there is annual variation, the data show that approximately one third of all referrals to Children's Social Care in Sunderland are related to DV.

Table 11 Domestic violence related referrals to Children's Social Care in Sunderland, 2009/10 to 2011/12

	2009/10	2010/11	2011/12	Three year average
Number of referrals related to DV	3,952	5,705	5,116	4,924
Proportion of referrals related to DV	28.2%	36.9%	32.5%	32.7%

Table 12 shows the proportion of families becoming subject to a child protection plan (CPP) which were related to DV over the same time period. Again, there is annual fluctuation, however the data show that just under half of all families becoming subject to a CPP in Sunderland were related to DV.

Table 12 Domestic violence related Child Protection Plans in Sunderland, 2009/10 to 2011/12

	2009/10	2010/11	2011/12	Three year average
Number of CPP related to DV	101	150	139	130
Proportion of CPP related to DV	41.6%	54.3%	46.0%	47.5%

Local data: Mainstream NHS Services (routine enquiry)

Both health visitors and midwives in Sunderland undertake routine enquiry around DV with families as part of their standard service and refer to appropriate agencies where relevant.

Routine enquiry therefore potentially identifies victims who may not already be known to services, or be recorded in police data, and enables signposting to support services. However, whilst the discussion around DV is recorded in an individual's case notes, there is no routine mechanism by which this information can be audited to identify numbers of cases identified through this process. (personal communication, Gillian Lund & Catherine Bramley)

Within CHS, the Named Nurse for Safeguarding Children is informed of all cases of DV in which children are involved. Where appropriate, Child Protection referrals are made and/or there is signposting for onward referral to other services. Anecdotal evidence indicates that the vast majority of DV referrals to the Named Nurse for Safeguarding Children come from Accident & Emergency. (personal communication, Jackie Leaf)

Within CHS there is no formal mechanism for reporting cases of DV in which children are not involved, unless Adult Safeguarding processes are implemented following identification of an adult as 'vulnerable', as defined by the Department of Health. (Department of Health, 2000) The Adult Safeguarding Lead may be made aware of cases in other individuals, but through an informal advisory rather than statutory reporting route, again signposting to services for onward referral. (personal communication, Debbie Cheetham) As such, it is not possible to ascertain the number of DV cases identified by CHS through routine and selective enquiry, where children are not involved.

DV is included in the core content of the Family Nurse Partnership programme. Families where DV is identified are supported either by the Family Nurse, or are referred to specialist services as required. While data on the number of cases of DV identified by the Family Nurses was not available, it has been estimated that DV is a factor in 50-75% of families in contact with the Family Nurse Partnership. The Family Nurse Partnership in Sunderland can support up to 150 families, therefore when operating at capacity the service could potentially support 75-110 families where DV is occurring. (personal communication, Irma Shepheard)

Local data: Hospital Episode Statistics

The coding system used within hospitals means that it should be possible to identify DV related admissions. Data was requested from the Business Information Team at Sunderland Teaching PCT, but was not received.

Expressed Need

Health services

It is known from national data that less than a quarter of victims of DV with physical injuries attend health services, and that physical injuries account for only part of all DV. Therefore, it is inevitable that health data sources will produce an underestimate of the scale of DV, though they may likely encounter or identify the more severe cases.

National guidance encourages information sharing between the NHS and other organisations for A&E attendances relating to violent injury. As it is known that only a small proportion of those who attend hospital with violent injury are also recorded by the police, (Department of Health, 2013) information sharing aims to improve community safety and wellbeing by providing a more complete picture of violent crime in a local area. Guidance states that anonymised information relating to various factors including the time, location and type of incident should be shared (the 'Cardiff model'). While CHS previously provided data to the SSP, the post responsible for providing this data was vacant throughout the production of this HNA, therefore no 'Cardiff data' was available for inclusion in this document.

The Sunderland CAMHS service was able to provide a snapshot of their workload around DV. Of the 3,500 patients on the CAMHS active caseload on 6th March 2013, nine had current or historic experience of DV. CAMHS were also able to provide data which showed that a total of 28 discharged patients from 1st April 2012 to 6th March 2013 had current or historic experience of DV. (personal communication, Anna Foster) Clinical CAMHS staff, however, estimated that DV is a factor in approximately 25% of CAMHS referrals. (personal communication, Kevin Ward) The CAMHS service had not received any requests to provide specific training in relation to DV. (personal communication, Anna Foster)

The IAPT service was unable to provide an estimation of the scale of their caseload related to DV.

Victim Support

During the period 1 April 2011 - 31 March 2012, Victim Support in Sunderland supported 169 domestic violence victims. It was not possible to break down the data for further analysis,

however Victim Support South of Tyne and Wear report that they are due to introduce a new case management system, which will facilitate the production of more detailed statistics in the future (personal communication, Gillian Thirlwell).

WWIN Helpline

In 2011/12, the WWIN helpline received 1,339 calls; the majority but not all of these related to specific DV cases. In approximately half of the calls (682) there was at least one child resident with the DV victim. While the majority of calls were received between 9am and 9pm, approximately 10% were received outside of these hours, indicating that the service is meeting an expressed need for support outside of normal working hours. Just over half of the calls (53%) to the helpline were from the Sunderland area. The location of the caller was not known in a further 15% of cases, and the majority of the remainder were from elsewhere in the North East.

The majority of calls to the WWIN helpline were from women and related to requests for refuge accommodation (29%), advice (20%), outreach services (10%), and follow up calls for ongoing situations (37%). A minority of calls (1%) related to male victims of DV.

Gentoo

Victim Support Officers at Gentoo provided support in 48 cases of DV in 2011/12. All 48 victims were white British, and 94% (45) were female. Of the three male victims, two were in same sex partnerships. None of the female victims were in same sex partnerships.

The age distribution largely mirrored that at city level, with more cases in the age range 20-30, but with cases occurring in all age groups up to age 51-60.

Of the 48 cases, two had been identified through the Cause for Concern initiative. Whilst small numbers, it is important to note that these cases may not otherwise have been identified by other agencies.

Data was also provided by Gentoo enabling evaluation of the impact of their Victim Support service. At the start of support, just over one in five (21%) felt fairly or very safe. At the time of reporting, 42 cases had ended support. All of those who remained in contact with Gentoo (25/42; 60%) felt very safe. Gentoo were unable to contact the remaining 17 cases.

Counselling services

From 1 April 2012 to 7 March 2013, a total of 25 individuals who accessed services at Washington Mind reported DV as a reason for referral. Over the same period a total of 19 individuals accessed Sunderland Mind for counselling for DV. The majority of victims were female, but a small number of male victims were also supported. Ages ranged from 19 to 51 years.

Sunderland Counselling Services estimated that in 2012 they had received approximately 20 referrals for DV specifically. In addition, they were able to provide activity data for their women's service which is commissioned to provide a specialist service for female victims of childhood sexual abuse and adult rape/sexual abuse. During 2012 they had supported 107 women, with most being self-referrals or IAPT referrals. The majority were aged 16-35, though all age groups were represented, and most were of white ethnicity, with less than 4% recorded as BME. There is a clear link overlap between DV and sexual assault. Although it is not known what proportion of these women had experienced DV, it was recorded as a presenting issue in eight of the cases.

Although not commissioned to do so, Sunderland Counselling Services also support men who have been affected by childhood sexual abuse and adult rape/sexual abuse. A total of 12 men received support during 2012. Due to small numbers, it is not appropriate to include further demographic details here. Again, while acknowledging the overlap between DV and sexual assault, it is not known what proportion of these men had experienced DV.

Impact Family Services

Impact Family Services reported the following activity levels relating to DV victims in Sunderland in 2011/12:

- Family Mediation Services – 203 cases
- Child Contact Centre – 53 cases

All were offered support by the Women's Support Worker, 29 took up the offer.

Refuge & outreach services

During 2011/12, the WWIN violence intervention team received 746 referrals which were reviewed by the IDVA service. Of these 666 were new referrals and 80 were repeat

referrals. Of the new referrals, 46 were refused due to non-consent or inappropriate referral. Of the remaining 620 referrals, 293 were assessed as high risk; 274 of these engaged and were supported by the IDVA service. Of the remaining 327 referrals which were not assessed to be high risk (non IDVA cases), 303 were allocated to the WWIN outreach service and 24 were allocated to WWIN residential projects.

In total, WWIN provided refuge accommodation for 300 women and 144 children in 2011/12. Over the same period, 225 women and 185 children were refused refuge accommodation. In the majority of cases (71%), refusal was due to lack of space. In these situations, alternative support was offered or refuge accommodation was sought in neighbouring areas.

Mapping service provision to need

There were 6,091 DV incidents reported to the police in 2011/12 and an estimated 'hidden' need of between 5,599 and 9,527 unreported cases in the city in the same period. In total, between 11,690 and 15,618 people living in Sunderland are estimated to have experienced DV in 2011/12. Some 53,817 adults living in Sunderland are estimated to have experienced DV at some point in their lives.

Against a background of these prevalence estimates, Table 13 summarises the number of people accessing services; representing 'met need'. Note in some cases these figures are estimates, reporting periods may not match exactly and the same individual may be represented more than once, however these data can be considered an indicative estimation of expressed need.

Table 13 Summary of number of people accessing DV services in Sunderland

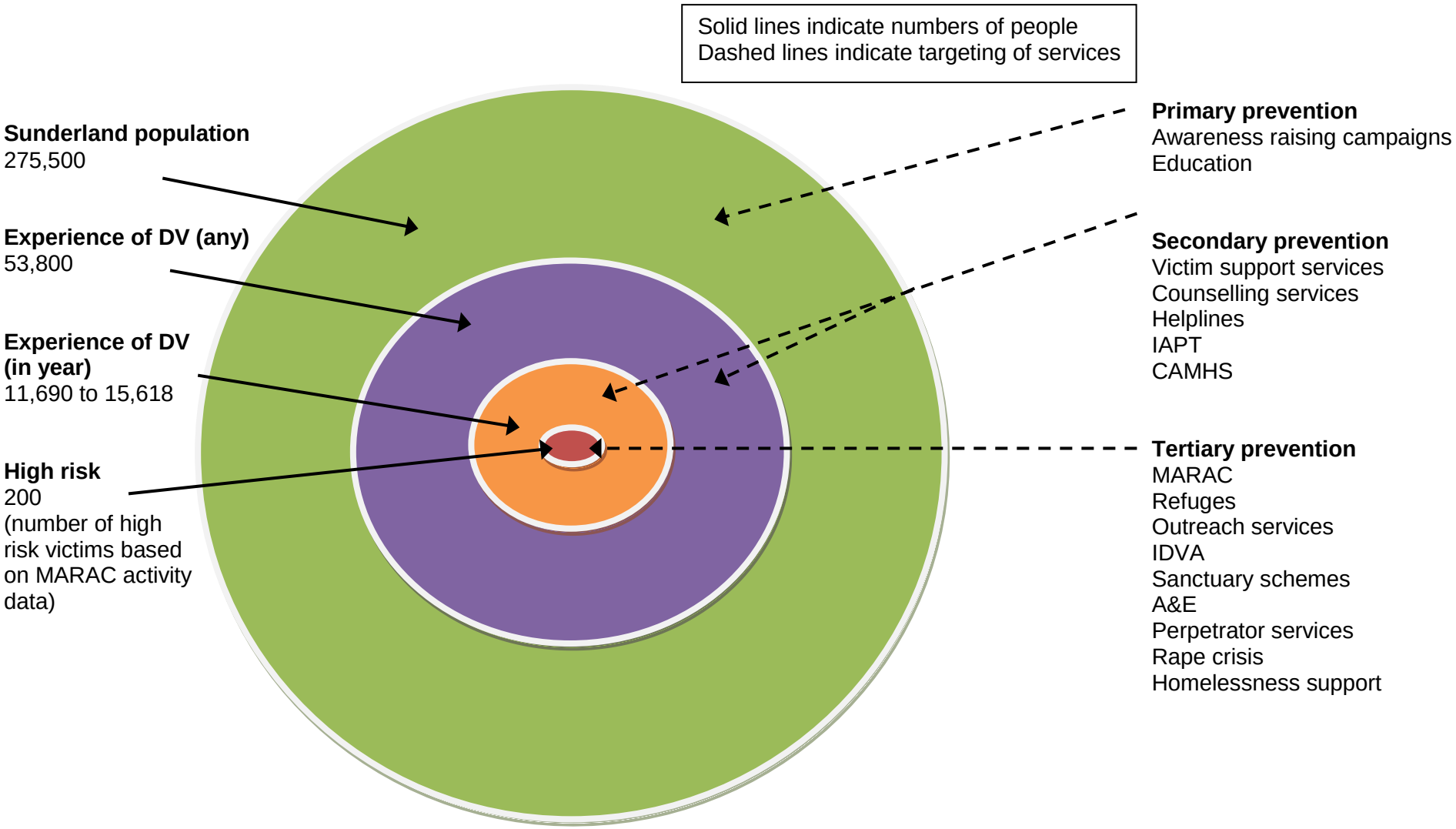
Service	Approximate number of people who accessed the service due to DV
CAMHS	30
Gentoo	48
Impact Family Services	256
Sunderland Counselling Services	20
Sunderland Mind	19
Victim Support	169
Washington Mind	25
Wearside Women in Need	1,888*

* combined estimate from helpline, refuge and outreach service activity levels, accounting for potential double counting as far as possible

The data in Table 13 indicate that, compared to levels of known and estimated prevalence there are likely to be high levels of unmet need in Sunderland, with services appearing to reach only a small proportion of the total estimated number of DV incidents.

Figure 17 shows a schematic representation of the levels of known and estimated need in Sunderland, together with the services targeted at different levels of need. The majority of services, and particularly investment, is focused on tertiary prevention, supporting and protecting those at the highest risk of harm.

Figure 17 **Schematic representation of present mapping of service provision to need**



Felt need

Felt need was assessed through focus groups with service users, members of the public and community and voluntary sector workers. Additional dimensions were added through dialogue with local councillors and through consideration of the findings of a recent LGBT HNA.

Perceptions of domestic violence

There was a widely held perception that DV was accepted within local communities and it remained a largely '*hidden harm*'. Views were expressed that DV was often viewed as a private issue, not talked about, and that a blind eye was frequently turned. It was suggested that in order to be able to tackle the issue more effectively, there needed to be a greater acceptance that it happens. Some respondents reported reluctance to report or seek help due to fear of repercussions, blame, stigma or being 'made to feel needy'. Members of the BME community highlighted the importance of understanding the role of women, and the role of violence, in different cultures. Some respondents felt that DV was viewed as unimportant, and called for a campaign promoting zero tolerance.

NHS South of Tyne and Wear conducted an HNA on the LGBT populations of Sunderland, Gateshead and South Tyneside in 2010. DV was identified as an issue within the LGBT community locally and it was felt that there had been a lack of awareness raising initiatives to highlight that DV does occur in LGBT relationships. It was particularly noted that DV is almost always portrayed, including on posters and leaflets, as being carried out by men, against women. (NHS South of Tyne and Wear, 2010)

Prevention

Three broad themes emerged relating to prevention of DV. Several respondents felt that early intervention was essential in tackling culture and attitudes to DV and called for more work to be done in schools, some stating that this should start in primary school. A second theme related to a perceived need for more proactive campaigns to tackle DV and demonstrate that it will not be tolerated in the city. The 'Only losers give bruises' campaign was highlighted as an example of a previous effective initiative. The third theme relating to

prevention related to community development; views were expressed that, particularly in deprived areas, there was a need to do more to strengthen community resilience and challenge attitudes.

Awareness of services

Those attending focus groups were asked about awareness of services or sources of support. The majority were unaware of services and one view was that *'It should be easy, but it's very hard to get help'*. Of those who were able to identify sources of support, the majority named 'Google', 'the police' or 'the refuge'. There was a general view that there insufficient information was accessible to the public about services available in the city to support victims of DV.

Initial response

There was a strong view expressed in a number of focus groups that removal of the victim, rather than the perpetrator, from the home was unfair, and may discourage reporting of incidents due to fear of separation from children. A recurring theme was that there was still a tendency for DV incidents to be viewed as 'a domestic', both by the public and by front line staff in organisations. Several respondents highlighted the police in particular as requiring training in understanding and empathy when responding to an incident. Some called for additional specially trained female police officers to respond to DV incidents.

One suggestion was to consider methods of making it easier for victims to disclose DV discretely. An example was given in the health setting, when providing a urine sample, women could be encouraged to place a sticker or mark on the sample bottle to confidentially and safely disclose DV.

Service provision

There were mixed views on the accessibility of services. Some responses indicated a perception that services are not accessible, while others felt that services were simply not known about, but once approached were very accessible and supportive. A number of responses indicated a need for concise, up to date information on available services to be available to both the public, and professionals. It was recognised that for those victims who

are unable to leave the house due to the controlling nature of their partner, accessing services can be particularly difficult.

The earlier HNA identified that members of the LGBT community found it difficult or impossible to access services. Although it was noted that there had been improvements, it was felt that services and organisations had been slow to address same-sex domestic violence. Mainstream DV services were perceived to view LGBT identity as a barrier to providing support, due to lack of expertise. (NHS South of Tyne and Wear, 2010)

While the majority of responses regarding the quality of current services were positive, not all participants agreed. Some felt that individuals were disempowered by services which did not 'move them on' to regain their independence, while others cited a need for a greater choice in sources of support for victims. It was also reported that there were lengthy waiting lists for counselling services.

While services which aim to provide safety and security for women affected by DV were viewed largely positively, there was a perception that there was a lack of services in place to support recovery. Some called for development of a network of peer mentors who were able to provide ongoing support to women following DV.

Several focus group participants, both male and female, perceived there to be a lack of support for male victims of DV with services being targeted at female victims.

Children

The impact on children of witnessing DV was raised by a large number of participants. It was felt that there was a risk that children who witness DV may be more likely to perpetrate or experience DV in later life, and that this group needed support. Several focus groups perceived there to be a lack of services available to support children and young people exposed to DV. It was felt that there was a need for counselling services to be available to these children and young people, and it was identified that in the past support workers had gone into the refuge but that this no longer occurred. Service users reported that there was a two year waiting list for a CAMHS appointment.

Perspective from local councillors

The members of the City Council's Scrutiny Policy Review panel who recently visited a local refuge noted that there were examples of excellent multi-agency working having supported women, however there were also examples of less robust systems. One case highlighted by the members of the Scrutiny Review panel was that of a female victim who following discharge from hospital reported receiving no support or signposting to services; ultimately her family stepped in to identify support via WWIN. None of the women who spoke to members of the scrutiny review panel reported receiving any support or advice from health services to help them end their experience of DV. (Lancaster, 2013) Whilst it should be noted that this anecdotal evidence reflects a limited number of cases and does not necessarily imply an endemic problem, it does warrant further investigation.

Other key findings from the Scrutiny Review panel visit to the refuge included: (Lancaster, 2013)

- Recognition of the value women feel for the IDVA service, in supporting them and giving them courage to act.
- One of the most significant concerns identified for many victims was a fear of being separated from their children.
- There was a perceived lack of focus on preventative activity, particularly in schools, where healthy relationship and DV were felt to have been given a significantly lower profile than other issues, such as teenage pregnancy.

The Sunderland City Council Scrutiny Review identified that DV was very rarely raised with local councillors at ward surgeries, nor discussed alongside other crime data at Area Committees. (Sunderland City Council, 2013) At a meeting of the scrutiny review panel, it was noted that by the time victims are identified to be 'high risk', they have already experienced considerable DV. Local councillors called for earlier intervention to prevent victims from becoming high risk. The scrutiny panel also recommended better, more consistent signposting for all victims of DV, stating that this should become a matter of routine for frontline staff as well as community leaders.

Normative Need

Prevention

Several stakeholders felt that there was a need for more preventative initiatives, particularly in schools. There was a perception that healthy relationships and DV were not topics that were widely covered in schools, but that this was vital to truly have an impact on changing attitudes and reducing the incidence of DV in the future.

It was suggested that the SRE offer should be reviewed to ensure that content relating to healthy relationships, including DV, is adequately developed. There was also some concern as to the potential for variation in coverage within different schools, and a call for all schools to provide a defined standard of education on healthy relationships.

Initial response

A view broadly shared by those consulted was that, once identified as a victim of DV and in contact with specialist services such as those offered by WWIN, or the Protecting Vulnerable People team within the police, the quality of service was very high. There was less confidence that there was a consistently high quality response from all front line staff. Concerns in particular were raised with the consistency of response of front line police and health services, largely attributed to need for training and increased awareness of referral mechanisms. The Police and Crime Commissioner has identified DV as a priority in the Police and Crime Plan for the Northumbria Police force, and as part of this has made a commitment to improving training for frontline police officers. The IRIS initiative was proposed by several professionals as a possible mechanism for training and supporting front line health professionals in raising and responding to DV.

A concern was expressed that cuts to public funding could lead to scaling back of training of staff, risking a loss of organisational memory as experienced staff leave.

A further theme related to acknowledgement that some victims will not access police or other statutory organisations to report or seek help for DV. As such, a number of those consulted indicated that use of community based assets to signpost to services should be maximised,

which requires greater general awareness of available services. Some stakeholders described a need for a renewed focus for advertising and promotion of services, though this was balanced with a view that capacity of existing services needed to be reviewed first, to ensure that any increase in demand could be met.

Particular issues were identified in primary care, largely relating to the pressures of a time limited consultation, and continuity of care. DV is an inherently complex issue, requiring either longer appointments or a series of appointments. It was identified that this presented a challenge as some practice appointment systems can make it difficult to obtain planned appointments with the same doctor.

It was noted that CHS did not have a written policy for how services provided by the Trust should respond to disclosure of DV. Key staff groups have received training, though it was identified that there would likely be capacity issues if DV policy and training were to be further developed.

A suggestion from health services was to revisit previous initiatives which aimed to enable patients to disclose DV discretely and safely. While best practice is for patients to be able to discuss such issues in private, it was identified that there are occasions where victims feel unable to disclose due to presence of their partner. One example of a successful previous initiative was to advise patients to 'put a red dot' on their urine sample if they need to talk to the nurse in private.

Services

Several services identified a distinction between 'survival' and 'recovery', and a lack of appreciation of the distinction by many referrers. The 'survival' phase focusses on achieving safety. During this period, agencies work with the victim and their family to identify the steps required to establish a safe living environment. Once a safe living environment has been reached and the perpetrator is no longer able to cause harm, the 'recovery' phase focusses on supporting the victim and their family to move forward with their lives. This might include addressing issues such as substance misuse, emotional and behavioural effects in both the victim and their children. It is important to note that stakeholders identified that while this model implies a linear model with passage from 'survival' to 'recovery', in reality the pattern is often cyclical and the period of most severe danger can be during the transition(s) from

'survival' to 'recovery' as some services step back to enable recovery to occur. Several services emphasised that the transition from 'survival' to 'recovery' was a particularly fragile period and called for greater multiagency support.

There was a general perception that there was a lack of awareness of the range of services that were available, and how to access them as a victim or how to refer to them as professionals. During stakeholder consultation, it was apparent that victims may contact one service which might signpost to an alternative without ensuring that they are able to provide the required intervention or support, risking victims getting 'lost' in the system.

Related to this, a number of stakeholders suggested that there was a need for a defined multiagency care pathway, with robust referral mechanisms. Such an approach was considered necessary to ensure that, regardless of the initial point of contact for a victim, they can be signposted or referred appropriately. It was also considered that the existence of a defined pathway would facilitate a better supported transition between 'survival' and 'recovery'.

There was a perceived need for greater recognition of the potential impact of historic DV by mainstream services. In particular this related to increasing awareness of DV, willingness to raise the issue and ability to respond among health services such as drug and alcohol and mental health services. In addition to development of a care pathway which may support this, a further approach, suggested by a number of stakeholders, was to appoint a coordinator or dedicated IDVA within acute and primary health care settings.

Co-ordinated Action Against Domestic Abuse (CAADA) produces evidence-based recommendations on tackling DV, particularly among high risk victims. A recent CAADA report recommended that secure funding should be identified for four IDVAs and one MARAC coordinator per 100,000 adult female population. In Sunderland, this would equate to approximately four IDVAs and one MARAC coordinator; substantially greater than levels currently available. A further recommendation of the same report was that IDVAs should be located in Accident and Emergency or maternity services, highlighting also the importance of development of robust care pathways and staff training in signposting and referral. (Co-ordinated Action Against Domestic Abuse, 2012)

There was a perception that services were focussed almost exclusively on heterosexual female victims. Whilst acknowledging that the majority of DV victims were from this group,

some stakeholders identified the needs of other groups such as male victims and those from minority groups (for example BME, LGBT and disabled people) as being potentially unmet.

There were two themes relating to this point; one relating to the risk that such victims fall between services, and a second that there was a potential for some individuals to feel excluded from certain services. The risk of falling between services was cited as a perception that mainstream DV services may refer, for example, LGBT victims to an LGBT advocacy service for specialist LGBT support, while that advocacy service may refer back to the DV service for specialist DV support. Rather than calling for a specialist LGBT DV service, better training of mainstream DV services in LGBT (and other) issues, and LGBT (and other) services in responding to DV, was suggested as a preferred way forward.

Some stakeholders identified that there was a lack of clarity as to whether all services were available to all members of society, and whether the services made this clear. Examples included whether male victims were able to access WWIN, and whether the name of the organisation was a barrier. A further example related to the LGBT community, where simple modifications such as the inclusion of the 'rainbow' logo provides reassurance that such services are accessible to the LGBT community. The general perception was that all services should be explicit in highlighting who is welcome to access services, to avoid inadvertently discouraging some victims from seeking support.

There was a range of perceptions and beliefs around the data relating to male victims of DV, with some suggesting that males may be less likely to report the issue or seek help, while others questioned the accuracy of the national CSEW data as a potential overestimate of the proportion of male victims.

Children

A number of professionals, both from health services and other sectors, perceived a lack of service provision for children and young people affected by DV. Waiting lists at CAMHS were cited as a particular issue, as was a lack of emotional wellbeing services for children continuing to live in environments affected by DV. The CAMHS service reported that waiting times have decreased, from around nine months to around six months, and that efforts are ongoing to ensure that the waiting time continues to decrease; however there remain approximately 1,000 children on the current waiting list for an initial assessment appointment.

The CAMHS service typically undertakes intervention three to six months after DV has ceased, once a safe and stable environment has been assured. As such, CAMHS can be described as a service which responds during the 'recovery' rather than 'survival' phase. During the 'survival' phase, services for children are largely provided through safeguarding and WWIN, with broader issues of establishing a safe future supported for example by housing, police and Gentoo. Several stakeholders raised concerns however that such services were not necessarily in a position to provide specialist emotional wellbeing support to children while they continued to live in the environment affected by DV.

Comparative Need

The response rate to the questionnaire that was sent to other local authorities in the region to identify levels of DV provision elsewhere was very poor. Despite multiple requests, of the five authorities contacted only North Tyneside provided any response.

In North Tyneside, Children's Social Care fund one to one support (male or female) and group work (female only) for parents who are or have been affected by DV. In addition, a joint funded project provides counselling, play therapy and support on a one-to-one and group basis for children and young people 4 to 18 years old. Adult and Children's Social Care provide funding for a refuge in the locality. Other reactive services include IDVAs, Victim Support and a Sanctuary Scheme. A number of preventative approaches, including provision of training, delivery of awareness raising campaigns and a Preventative task force which develops sessions in schools, are also provided. (personal communication, Lesley Pyle)

The domestic abuse coordinator in North Tyneside advised that services generally meet local need, though there is a waiting list for children's counselling services. It was also highlighted that there had been a reduction in one to one support for adults who don't have children under 18. (personal communication, Lesley Pyle)

The Northumbria Police Protecting Vulnerable People Unit is currently in the process of collating details of all DV services provided across the Force area. Once completed this will be a valuable source of information to guide signposting, and may also be an alternative approach to beginning to explore comparative need across the Northumbria police force area.

RECOMMENDATIONS

Strategic

DV is still viewed by some as a minority issue and in a time of considerable economic pressure, there is a need to ensure that it remains a priority for action in the City. The Scrutiny Review Panel recently considered DV, demonstrating a commitment to the issue within the council. Given the findings of the Scrutiny Review and this HNA, together with organisational changes within the council and continuing difficult economic conditions, it would be timely to review the strategic direction with regard to DV.

Recommendation: Review current arrangements for coordination and strategic direction of domestic violence prevention and response to improve outcomes.

In order to ensure that DV remains on the agenda, it is essential that up to date evidence and intelligence are available to stakeholders, to monitor both the direction of travel and impact of any initiatives undertaken or changes to funding.

Recommendation: Ensure that domestic violence features more prominently in the Joint Strategic Needs Assessment, for example through incorporation of intelligence from the Partnership Strategic Intelligence Assessment.

Prevention

A perceived need for more preventative work, both with young people and in the broader community, was a common theme which emerged during this needs assessment. The general public and service users in particular articulated a view that a culture of acceptance of domestic violence continued to prevail in the community and among some professionals. Previous successful initiatives such as the 'Only losers give bruises' campaign were frequently cited and there was a general call for greater renewed efforts to change social attitudes and end tolerance of DV.

Recommendation: Seek opportunities to challenge acceptance of domestic violence in the community, for example through a zero tolerance campaign, and consider targeting such initiatives in areas with highest reported incidence.

Both professionals and lay people consulted as part of the HNA identified a need for prevention to start from a young age, with education around healthy relationships and domestic violence in schools viewed as being essential. The 'I Have the Right' film, produced by students at Farringdon Community Sports College, was recognised as an example of excellence and it was thought that the film should be used as the basis for teaching around DV in every school in the city. Queries were raised around the extent to which the current SRE offer addresses the issue of DV, as well as whether individual schools took up the full SRE offer.

Recommendation: Review and standardise provision of education in schools around promoting healthy relationships and challenging behaviours associated with domestic violence.

Data

Services were unable to provide sufficiently robust service usage data to enable a reliable estimation of the total number of victims who access services. Some services, particularly health services, were unable to provide any data on activity targeted at identifying or responding to DV. In some instances, information was reported to be recorded on paper records but not entered into an auditable system, while in other instances data flows had ceased due to staff vacancies. The latter issue related particularly to the lack of provision of 'Cardiff data' from CHS. Some progress has already been made with CHS on this issue, however data flows are not consistently available and the reasons for this should be investigated and resolved. A range of resources that could support this work are freely available. (Department of Health, 2013)

There were also concerns that some organisations, again largely health services, could be reluctant to share information due to confidentiality and data protection regulations. Guidance to support health services in information sharing is available at https://www.gov.uk/government/news/striking-the-balance-guidance-on-information-sharing and summarised on page 18 of the following guidance: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147352/dh_125938.pdf.pdf.

Recommendation: Services should improve routine recording and reporting of data and ensure that barriers to information sharing are tackled as appropriate.

Professionals expressed concerns that the current economic climate caused significant concerns relating to ongoing funding. One way to increase the likelihood of maintaining or improving funding would be to measure and report the impact of services on outcomes, in addition to activity levels, to enable commissioners to more easily identify and support those services which have the greatest impact.

Recommendation: Outcome as well as process measures should be developed for services, for example to demonstrate impact on emotional wellbeing and social return on investment.

Initial response

National data shows that DV continues to be an underreported crime. This may in part be due to victims' concerns that the response of front line staff may not be sufficiently supportive, as well as a reluctance of professionals to raise the issue. It was viewed that health professionals in particular may be reluctant to raise DV due to concerns over a lack of time in a consultation, a lack of knowledge and a lack of awareness of referral routes. Similar barriers were also identified in a Department of Health report (Department of Health, 2011). Given the clear associations with DV, there is a need to ensure that all front line staff working in areas such as drug and alcohol and mental health services are able to identify and respond appropriately to DV and likewise that staff in DV advocacy services are able to identify and respond to drug, alcohol or mental health problems.

Professionals, service users and members of the public consulted as part of this HNA cited variation in quality of response from front line staff, particularly in the police and health service, as a barrier to accessing support. The Police and Crime Commissioner for Northumbria has committed to ensuring all frontline police officers will receive training, led by survivors. (Baird, 2013)

Recommendation: Front line staff in public services should be appropriately trained to identify and respond positively to domestic violence.

Service users and members of the public suggested that some victims would be unlikely to engage with services as the process of doing so can lead them to feel 'needy'. This finding is supported by data from the CSEW, which shows that while many victims may not approach statutory services, the majority of victims *do* tell someone about their experience;

often a friend, relative or neighbour. This emphasises the importance of community resilience and the role of peer support for such individuals. Sunderland has a large and growing network of Health Champions; members of local communities who work or volunteer in the Sunderland area and have received basic training in a range of issues relevant to health and wellbeing. An evaluation has recently shown the Sunderland Health Champions to work effectively in their 'circles of influence' to provide information on health issues and signpost people effectively to services provided both by statutory organisations and the voluntary and community sector. Health Champions are uniquely positioned, offering broad accessibility and, through personal face to face contact, provide novel opportunities to engage with local people. (Warwick-Booth 2012)

Health Champions could therefore play an important role in responding to disclosure of DV, but to do so safely will require training in awareness of the issue and providing a safe an appropriate response, including awareness of relevant safeguarding procedures. The role of Health Champions in regard to DV should be to respond positively to any disclosure, but not to undertake any form of enquiry to identify the issue, which would be beyond the scope of their role.

Recommendation: Embed domestic violence awareness and signposting training into a new safeguarding module within the Health Champions training programme.

Services

While data quality issues preclude an accurate assessment of the total number of victims accessing services in the city, it does show that services are reaching only a small proportion of those affected by DV. Any initiatives aimed at increasing awareness, tackling acceptance, or improving access to services, will therefore likely lead to an increased number of victims accessing services. Some providers reported operating close to or beyond capacity, with lengthy waiting lists in some cases. In addition, the IDVA service was highly valued by those who had received support from an IDVA, however Sunderland has substantially fewer IDVAs to support victims than is recommended in national guidance. There is evidence to support placing an IDVA in a health setting to identify and support victims; the potential of a health-based IDVA should be explored as part of a review of the capacity of the IDVA service as a whole.

Recommendation: Review capacity of initiatives to reduce and respond to domestic violence, including the capacity of the IDVA service.

Stakeholder engagement indicated poor awareness of services and referral routes by professionals as well as victims and the public. A range of professionals identified a currently unmet need for a clearly defined pathway and greater understanding of the service provided by partner organisations across the whole system. This included a need for services and referrers to better understand where other providers were able to offer support across the spectrum, from survival to recovery, and greater awareness of appropriate referral routes. It was felt important that once a victim had contacted a service, they should not be 'lost' between services, and the aspiration should be for seamless navigation across organisational boundaries.

Figure 18 illustrates the suggested elements which should be included in a care pathway. In this figure, services shown in pale red are those which support victims and children through **survival**, the period of instability during which DVs is ongoing, which may be cyclical. Services shown in pale green are those which support victims and children through **recovery**, the period following DV, either through separation from the perpetrator and/or rehabilitation of the perpetrator. The initiatives shown in the surrounding blue area represent **preventative** approaches in the wider population, which aim to shift cultural norms and tackle acceptance of DV.

Figure 18 Service provision at different stages of domestic violence

Recommendation: Develop a care pathway to ensure all organisations are able to respond positively to disclosure of domestic violence and signpost to appropriate services.

Potential barriers to accessing services were identified and included variation in front line response, a reluctance of professionals to raise the issue and uncertainty regarding access to and responsiveness of services, particularly among minority groups. There was a general perception that services in the city were targeted largely at heterosexual white females, and that whilst this group accounted for the highest proportion of incidents, DV affected all groups in society.

Recommendation: All services should undertake an equality impact assessment to ensure that services are responsive to the needs of all victims, including those from minority groups (e.g. male, LGBT and BME victims).

Concerns were raised regarding waiting times and a range of stakeholders perceived lack of services for children currently affected by domestic violence. An evidence based service is provided to support children and adolescents in the recovery stage. However, this service is currently offered only three to six months after DV has ceased and a safe and stable environment has been assured. In addition there is currently a six month waiting list for this service. Some stakeholders expressed the view that this left an unmet need for emotional support, such as counselling, for children and young people who were still living with or had recently experienced DV.

Recommendation: Review commissioning and service provision around emotional support for children living with domestic violence.

Summary of recommendations

DV is a complex issue which cannot be solved by any single agency in isolation, therefore like the response to an individual DV incident, improvements to the system can only occur through partnership working. In order to support a partnership approach to DV, the recommendations of the HNA have been grouped below, according to the board or organisation likely to be best placed to oversee and lead their implementation.

Adult's Partnership

- ***Through collaboration with commissioners, review capacity of initiatives to reduce and respond to domestic violence, including the IDVA service.***
- ***Encourage commissioners of all public services to require providers to ensure front line staff are appropriately trained to identify and respond positively to domestic violence.***
- ***Encourage commissioners to require service providers to undertake an equality impact assessment to ensure that commissioned services are responsive to the needs of all victims, including those from minority groups (e.g. male, LGBT and BME victims).***

Safer Sunderland Partnership Board

- ***Review current arrangements for coordination and strategic direction of domestic violence prevention and response to improve outcomes.***
- ***Seek opportunities to challenge acceptance of domestic violence in the community, for example through a zero tolerance campaign, and consider targeting such initiatives in areas with highest reported incidence.***
- ***Review the findings of equality impact assessments to determine whether services are accessible to all victims, including those from minority groups (e.g. male, LGBT and BME victims).***
- ***Develop a care pathway to ensure all organisations are able to respond positively to disclosure of domestic violence and signpost to appropriate services.***

Director of Public Health

- ***Embed domestic violence awareness and signposting training into a new safeguarding module within the Health Champions training programme.***

- ***Ensure that domestic violence features more prominently in the Joint Strategic Needs Assessment, for example through incorporation of intelligence from the Partnership Strategic Intelligence Assessment.***

Children's Trust

- ***Review and standardise provision of education in schools around promoting healthy relationships and challenging behaviours associated with domestic violence.***
- ***Review commissioning and service provision around emotional support for children living with domestic violence.***

Commissioners

- ***Encourage providers of public services to ensure that front line staff are appropriately trained to identify and respond positively to domestic violence.***
- ***Require all domestic violence services to undertake an equality impact assessment to ensure that commissioned services are responsive to the needs of all victims, including those from minority groups (e.g. male, LGBT and BME victims).***
- ***Specify outcome as well as process measures for services, for example demonstrating impact on emotional wellbeing and social return on investment.***

Providers

- ***Improve routine recording and reporting of data and ensure that barriers to information sharing are tackled as appropriate.***
- ***Undertake an equality impact assessment to ensure responsiveness to the needs of all victims, including those from minority groups (e.g. male, LGBT and BME victims).***
- ***Ensure that front line staff are appropriately trained to identify and respond positively to domestic violence.***

AREAS FOR FURTHER RESEARCH

Given the scale of the topic area, it was not possible to explore in detail every aspect of DV. As this needs assessment was undertaken from a health perspective, it was decided to focus on those services and interventions which were most likely to have a direct effect on health and wellbeing of victims of DV.

Whilst by no means an exhaustive list, three broad areas for further research are identified below. The first two were beyond the scope of this HNA, but are highly relevant to the overall topic and likely have significant indirect health impacts on victims of DV and their families, as well as perpetrators. The third area emerged as one which required further development during data collection and analysis, relating to the impact of interventions.

Health needs of perpetrators of domestic violence

This needs assessment has shown a clear and strong relationship between DV and alcohol misuse, supported by evidence from CSEW and other research which has shown that a large proportion of perpetrators of DV use alcohol harmfully. Like other offenders, perpetrators of DV may be also more likely to suffer from substance misuse and have mental health problems. As with other offenders, there is a risk that perpetrators of DV will reoffend, therefore interventions to address the root causes of offending and to bring about behaviour change to rehabilitate offenders may have a significant impact on DV prevalence. There are examples of such interventions both in the city and across the country. It may be useful to investigate how well these services meet the health and social care needs of perpetrators of DV, and to examine the impact on reoffending and DV prevalence.

Criminal justice system

The criminal justice system has an important role to play in risk reduction, aiming to ensure that a perpetrator is unable to cause further harm to a victim. A range of perceptions of the effectiveness of the criminal justice system were expressed by service users and the public while undertaking this HNA. Given the importance of the criminal justice system in reducing both the immediate risk and longer term risk of reoffending and repeat victimisation, it may be beneficial to further explore both perceptions and impact of the criminal justice system on DV in the city.

Impact of interventions

Against an increasingly challenging financial landscape, it is especially important that services are able demonstrate their impact in terms of tangible outcomes. The majority of services outside of the NHS were able to provide some level of data to support this HNA, though largely this was limited to activity data. Whilst activity data is important to enable assessment of the degree to which services meet the need in the population, they provide no information on the real impact of interventions. There is some research evidence, previously referenced, which supports specific forms of intervention, however there is a need for a greater evidence base on which to base commissioning decisions. Future research should therefore focus on supporting services in measuring the effect that interventions have on outcomes. For example, there are validated tools which would enable measurement of impact on emotional wellbeing; such outcome measures should be developed to use alongside process measures such as activity levels, reoffending and repeat victimisation rates.

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APPENDICES

Appendix A Definitions of specific forms of DV

The Crown Prosecution Service (CPS) and Association of Chief Police Officers (ACPO) define HBV as “a crime or incident which has or may have been committed to protect or defend the honour of the family and/or community”. HBV can be distinguished from other forms of violence as it is often committed with some degree of approval or collusion from family or community members. (Crown Prosecution Service 2012)

HBV predominantly (but not exclusively) affects women, where it is used to assert male power in order to control female autonomy and sexuality. Examples of HBV include, but are not limited to, murder, un-explained death (suicide), fear of or actual forced marriage, controlling sexual activity, domestic abuse (including psychological, physical, sexual, financial or emotional abuse), child abuse, rape, kidnapping, false imprisonment, threats to kill, assault, harassment, forced abortion. (Crown Prosecution Service 2012)

FGM includes procedures that intentionally alter or injure female genital organs for non-medical reasons. FGM procedures can cause severe bleeding and problems urinating, and later potential childbirth complications and newborn deaths. It is illegal to practice FGM in the UK and it is internationally recognised as a violation of the human rights of girls and women. The Home Office estimates that up to 24,000 girls under the age of 15 in the UK are at risk of FGM. (Home Office, 2012b)

There are several variations on the definition of forced marriage. (Crown Prosecution Service 2012) A representative definition is that used by the UK Border Agency, defining forced marriage as “a marriage that takes place without the full and free consent of both parties”. A victim of forced marriage may be coerced into marriage through physical threats, emotional blackmail or psychological abuse. It is important to note that forced marriage is not synonymous with arranged marriage. (UK Border Agency 2012)

Appendix B Attendees at initial stakeholder meeting

Catherine Bramley	Children Safeguarding Team, South Tyneside NHS Foundation Trust
Denise Clark	Detective Inspector, Northumbria Police
Rob Gilhespy	Performance and Intelligence Officer, Sunderland City Council
Kelly Henderson	Principal Policy Officer for People & Neighbourhoods, Sunderland City Council
Usha Jacob	Performance and Information Manager, Sunderland City Council
Helen Lancaster	Scrutiny Officer, Sunderland City Council
Julie Lister	Partnerships & Safeguarding Manager, Gentoo
Anita Lord	Assistant Director, Wearside Women In Need
Lisa Smith	Victim Support Officer, Gentoo