Sunderland City Council

# Sunderland Domestic Violence Health Needs Assessment

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**Version 7**

# EXECUTIVE SUMMARY

Health and domestic violence and abuse (DVA) are inextricably linked. DVA has a profound and long-term impact on 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 costs over £80million 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.

Around 6,000 DVA incidents in Sunderland are reported to the Police each year. However DVA is known to be under-reported (by around 50%). It is estimated that there are:

- 12,800 DVA incidents per year in Sunderland
- 10,000 victims aged 16-59 who experienced DVA in the last year
- over 32,000 people aged 16-59 in the city who are currently affected by DVA or have been affected by DVA in the past.

The 2015/16 Crime Survey for England and Wales reported that almost twice as many women (8.1%) as men (4.3%) had experienced "any domestic abuse" in the last year. 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. Taking a broader definition of "any domestic abuse" which includes stalking, almost 27.1% of women reported some lifetime experience of DV, compared to 13.2% of men. Women who were separated had the highest prevalence of any domestic abuse in the last year (19.8%) compared with other marital status groups (such as married/civil partnered 3.6%) or cohabiting (6.6%). 30% of those reporting DV were repeat victims, and this group accounted for 58% of all DV incidents.

DVA is a citywide issue, but there is a strong correlation between reported incidence and deprivation. The distribution of reported DA incidents (2016/17) across the city was inequitable, ranging from a peak of 52.24 per 1000 population in Hendon ward to a low of 8.9 per 1,000 population in Fulwell ward. The data show a marked inequality in the number of DA crimes experienced by ward, but it is important to note that it may be the result, entirely or partly, of working with small numbers.

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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. Limited information was available for on children's services in Sunderland. Police data from 2016/17 shows that 41% of police reported DA incidents in Sunderland involved children. Domestic violence was identified as a factor in 547 (26%) of referrals to Children's Social care.

In 2016-17 there were 3,869 victims (6382 incidents) and of these there were 340 victims aged 55+ which is only 8.8% of all victims (Northumbria Police, 2017). However, Sunderland's female populations aged +55 years is 47,778 (mid-2016 estimates) and given that 1 in 4 women are expected to experience domestic abuse at some point in their lives, those reporting abuse to the police are still a very small minority. However, the level of reporting by those aged 55+ has slowly increased since 2015 and in the first 6 months of 2017-18, there were 224 victims aged over 55 years who reported their abuse to the Police (a +22.4% rise). This means that the proportion of all victims aged 55 or over is at its highest levels in Sunderland and still likely to be as a result of the local awareness raising that continues to be done around abuse in older relationships. The proportion of 16-17 year old victims reporting still remains low at 2.1% (52 victims April-Sept 2017). In 2016-17 there was a drop in the number of BME victims reporting to the Police in Sunderland (-24% or 26 fewer victims) which had taken the proportion of victims who are BME from 2.9% down to 2.2%. The April-Sept 2017-18 figures have shown a continued fall (-10% or 5 fewer victims) and the proportion of BME victims is now only 1.8%.

Multi-Agency Risk Assessment Conferences (MARAC) meet fortnightly to consider those victims who are at highest risk of serious harm or death. Sunderland MARAC data from SafeLives for 12 months to 30 June 2017 show that there have been 605 victims referred to MARAC (with 1044 children) and many of these victims have additional vulnerabilities such as alcohol misuse, drug misuse, mental ill health, learning disabilities, physical disabilities etc. 38% of domestic abuse crimes involved alcohol according to 2016/17 MARAC data. MARAC data for the year to 30 June 2017 shows that 1.3% of victims in MARAC cases have a registered disability. 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. 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.

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Those with complex needs generally have longer term support needs and some may not necessarily be high risk, but have high levels of complexity and a high demand on public services. Multiple complexities often create multiple sites of disadvantage. Multiple markers of difference, such as age, class, gender, ethnicity and sexual orientation, intersect to inform lived experiences which means that some women's experiences of violence against women and girls is not only gendered, but can also be connected to factors such as ethnicity, age, class, disability, sexuality or complex needs.

The Independent Domestic Violence Advisor (IDVA) service supports those victims who are assessed as being at high risk of serious harm or death, and also those in the specialist domestic violence courts. However the IDVA service has significant capacity issues. It is recommended there should be around 470 high risk victims for a population size of Sunderland with 5 IDVAs supporting these victims. Currently there are 605 high risk victims referred to MARAC in the 12 months to June 2017 and based on the actual volume of high risk cases Sunderland should have 6.5 IDVAs but only currently has 4 x FTE IDVAs (3 of which are part of the commissioned specialist domestic abuse provision which includes the manager and the hospital IDVA).

There is currently a cross partnership DVA proposal around the formation of a cross-partnership time limited project group focused on understanding the prevalence and impact of domestic abuse on children, adults and their families , the strategies and plans in place to reduce the level and impact, identify areas/services for improvement and improve outcomes for those affected.

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# 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 (now called SafeLives) |
| 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 |
| DA | Domestic abuse |
| DVA | Domestic violence and abuse |
| FGM | Female genital mutilation |
| FMU | Forced marriage unit |
| HBV | 'Honour' based violence |
| HNA | Health needs assessment |
| HWB | Health and Wellbeing Board |
| 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 |
| LMAPS | Local multi-agency problem solving group |
| LSOA | Lower super output area |
| LSP | Local strategic partnership |
| MARAC | Multi-agency risk assessment conference |
| NI | National indicator |
| NICE | National Institute for Health and Care Excellence |
| PCC | Police and Crime Commissioner |
| PCT | Primary Care Trust |
| SDVC | Specialist Domestic Violence Court |
| SDVP | Sunderland Domestic Violence Partnership |
| SSAB | Sunderland Safeguarding Adults Board |
| SSCB | Sunderland Safeguarding Children Board |
| SSP | Safer Sunderland Partnership |
| STFT | South Tyneside NHS Foundation Trust |
| VAWG | Violence against women and girls |
| WWIN | Wearside Women in Need |

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# INTRODUCTION

This DV updated health needs assessment (HNA) aims to:

- Update the previous HNA from 2013, focusing on epidemiological needs and protected characteristics
- Identify the scale of DVA in Sunderland, including profiling characteristics of victims
- Review the evidence base for service provision models
- Identify gaps in data and areas for further work/research
- Underpin a review of current service provision

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### ***Definition***

In 2012, the Government announced changes to the definition of DVA, 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.*

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## Scope

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.

This report covers epidemiological need, focusing on protected characteristics and markers, and puts forward current evidence of what works in DVA.

This HNA focuses on updated health needs information and an updated review of current policy since the previous HNA in 2013.

Although physical abuse of children may co-exist with DVA, 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. However, consideration of the impact that witnessing DVA 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. The health needs of perpetrators of DV are beyond the scope of the HNA.

This HNA was carried out as a desktop review using data available nationally and locally.

A review of current service provision and gaps has been undertaken outwith this paper. This HNA will underpin that review.

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## National context

In 2014, the Annual Report of the Chief Medical Officer focused on Women's Health, and recommended that CCGs and local authorities ensure initiatives are in place to meet referrals safely for sexual violence, other domestic violence, female genital mutilation, 'honour'-based violence, forced marriages and modern slavery. (Davies, 2014)

In February 2016, NICE introduced a quality standard on domestic violence and abuse. (NICE, 2016) It found that multi-agency partnership working at both an operational and strategic level is the most effective approach. It emphasised the importance of training and ongoing support for individual practitioners to enable them to effectively and safely respond after disclosure.

The Office for National Statistics (ONS) has published the Domestic Abuse in England and Wales: year ending March 2016. This report brings together national and local domestic abuse data from The Crime Survey for England and Wales (CSEW), Home Office incident and police recorded crime data, Home Office Homicide Index data and Crown Prosecution Service (CPS) data including; referrals, prosecutions and conviction. (ONS, 2016e)

An updated Violence Against Women and Girls (VAWG) strategy for 2016-20, *Ending Violence against Women and Girls* was published in March 2016, highlighting the government's commitment to ending DVA (Home Office 2016a). The overall outcomes by 2020 are a reduction in the prevalence of all forms of VAWG, matched by increased reporting, police referrals, prosecutions and convictions. The approach centres around prevention, provision of services, partnership working and pursuing perpetrators. Over the next 4 years it says government will support a transformation in service delivery and a step change in social action to achieve a sustainable long term reduction.

The strategy reflects on work done to improve police, criminal justice and health responses to VAWG (e.g. via HMIC inspections) and how it has strengthened the legislative framework through: the new offence of coercive and controlling behaviour; Clare's Law; FGM mandatory reporting; and new protection orders for domestic violence, sexual violence, forced marriage and FGM. It recognises the need to do more to stop people offending (less than 1% of perpetrators receive a specialist intervention), break the cycle of abuse and provide ways out of difficult circumstances that achieve sustainable and lasting change.

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This national strategy states that government has devolved responsibility for local service provision to local areas. The ambition is to reform services to support earlier models of intervention with victims, perpetrators and their families, at the same time as maintaining crisis provision.

The national statement of expectations (NSE) explains the actions local areas should take to ensure victims of violence against women and girls (VAWG) get the help they need. Men and boys can also be victims of violence and abuse and the approaches set out in this national statement aim to benefit all victims of these crimes.

The NSE sits within the framework of the national VAWG strategy and comes with a support offer from government to help local commissioners fulfil the NSEs and the national offer includes a commissioning ‘toolkit’ which underpins the NSE and should help in developing business cases for funding a whole system approach to all VAWG services (Home Office, 2016b), with associated government funding for “Priorities for Domestic Abuse Services.” (DCLG, 2016)

The NSEs are 5 key statements, each with examples of what government expects local areas to have in place: (summary taken from Julie Smith, Briefing Note: Violence Against Women and Girls – National Statement of Expectations (NSE), Home Office 2016)

1. **Put the victim at the centre of service delivery:** e.g. commissioners should:
    - have a robust consultation process to identify services to meet local need
    - have a forum to ensure victims and service providers can share views and experiences.
    - see victims as part of a wider network (in the context of whole family and wider safeguarding).
    - have sufficient local specialist support provision, including provision designed specifically to support victims from marginalised groups (e.g. outreach, drop-in support, resettlement, counselling, advocacy, group work, IDVAs, ISVAs, refuge accommodation and specialist, dedicated BME-led women’s services).
    - have consideration of complex needs and multiple disadvantage and the services in place to manage these. Commissioners should consider how services that victims come into contact with detect and respond to women’s experiences of VAWG and trauma

- assess and build in access to mental health service provision for victims of all types of VAWG and effectively linking up services
- consider specialist advocates or support workers (e.g. IRIS programme) in local emergency or primary healthcare and GP surgeries, and whether local health professionals generally are trained to spot signs of abuse, understand the impact of trauma and make referrals to specialist VAWG services.
- collaborate and have protocols with other areas to allow victims easy movement from one area to another (cross boundary working).

2. **Have a clear focus on perpetrators in order to keep victims safe;** e.g. commissioners should:

- take a sufficiently proactive and robust approach to perpetrators around both the risk posed and effective interventions to change their behaviour.
- have a clear plan to ensure that perpetrators are brought to justice and that community interventions are not an alternative to justice.
- have work underway to increase knowledge and understanding of perpetrator behaviour
- have a robust consultation process to identify services to meet local need and a forum to ensure victims and service providers views and experiences help shape services for perpetrators.
- understand the family and community context that perpetrators operate within, and wider safeguarding issues
- assess and address local specialist provision, including access to a broad diversity of provision (e.g. DVPPs, screening / routine identification in health settings; specialist workers within Children's Services teams; enhanced police / CJS responses)
- In particular, commissioners may wish to consider:
    - Perpetrators with complex needs and how services and systems detect, respond and manage the risk they pose
    - having specialist workers in local emergency or primary healthcare and GP surgeries.
    - ensuring local health professionals generally are trained to spot signs of abuse and understand the impact of trauma, and know how to recognise it, respond and refer perpetrators to appropriate services.
    - having specialist workers in children's services teams who can work with diverse groups of perpetrators who pose a risk to children and their mothers.

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3. **Take a strategic, system-wide approach to commissioning acknowledging the gendered nature of VAWG**; e.g. commissioners should:
   - understand need and provision, accessing available data, evidence, service standards and intelligence from local specialist providers and partners
   - map local issues from crime and health data – e.g. develop early intervention plans to prevent escalation to 'crisis' point.
   - consider having trained professionals in hospitals and other healthcare settings to identify and support victims and signpost them to services.
   - understand local crime and other non-criminal justice data about the prevalence of VAWG crimes in the area, and national research on the likely prevalence of VAWG
   - have a robust and useful local VAWG data set
   - have a concise local strategy setting out how the impact of local commissioning will be measured, expectations from services, who is accountable locally and how success will be measured.
   - have a process for measuring victims' satisfaction
   - collaborate across local authority and service boundaries, i.e. some services may be commissioned in partnership or on a regional level.

4. **Are locally-led and safeguard individuals at every point;** e.g. commissioners should:
   - identify a local champion or critical friend to drive and challenge on VAWG issues
   - consider pooling local budgets and funding sources and working with local providers to support a commissioning process that encourages consortia bids without losing smaller local specialist providers.
   - assess new multi–agency approaches, including ways of streamlining structures and meetings whilst improving joined up case management.
   - identify practical steps to ensure learning from DHRs, SCRs, HMIC reports etc..
   - link HMIC and other inspectorate reports on police response and local force action plans into local area strategies, working in partnership with the PCC.
   - make constructive links with troubled families co-ordinators and local DSV co-ordinators to build local networks and capacity.
   - consider how training provided to local professionals is evaluated, and how to ensure it is making a difference, increasing learning and builds in the voice of victims.
   - identify any VAWG initiatives being delivered by the local police force and whether other VAWG initiatives are being delivered locally by the specialist third sector. Consider if they can support local initiatives and if there is learning to be shared.

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5. **Raise local awareness of the issues and involve, engage and empower communities to seek, design and deliver solutions to prevent VAWG** e.g. commissioners should:
   - identify what is happening in local schools.
   - Identify whether the right local connections are in place so that schools know where to ask for specialist advice, including referral pathways to specialist children's domestic or sexual violence services. .
   - map out local women's support groups, including those led by BME women
   - Identify and promote wider touch points in your community, including;
     - what local banks are doing to identify and support victims of coercive control
     - how local disabled people and people with learning disabilities are able to disclose safely to professionals
     - ensuring local health and housing professionals are trained to spot, ask take the appropriate action.
     - local initiatives like 'Ask Me' to develop safe spaces to disclose abuse
     - housing and homelessness policies that include sexual violence.
     - whether local businesses have policies on VAWG
     - sexual violence bystander programmes to raise awareness and reporting.

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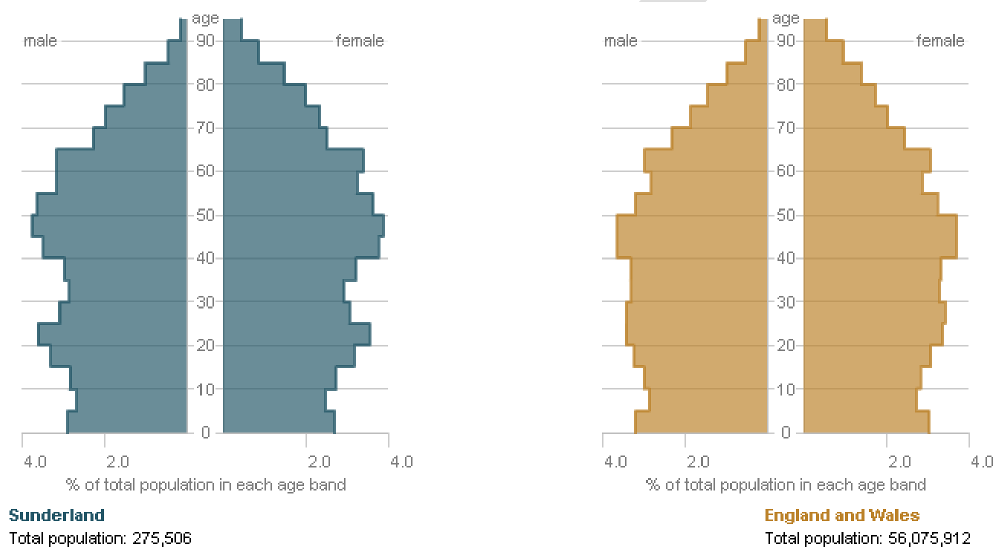
## Sunderland Profile

For the purposes of this part of the HNA, 2011 Census estimates are used, as they contain the most recent data on BME groups. 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 illustrates the population structure for Sunderland, compared to England and Wales, based on 2011 Census estimates.

**Figure 1 Population pyramids showing population structure for Sunderland compared to England and Wales**

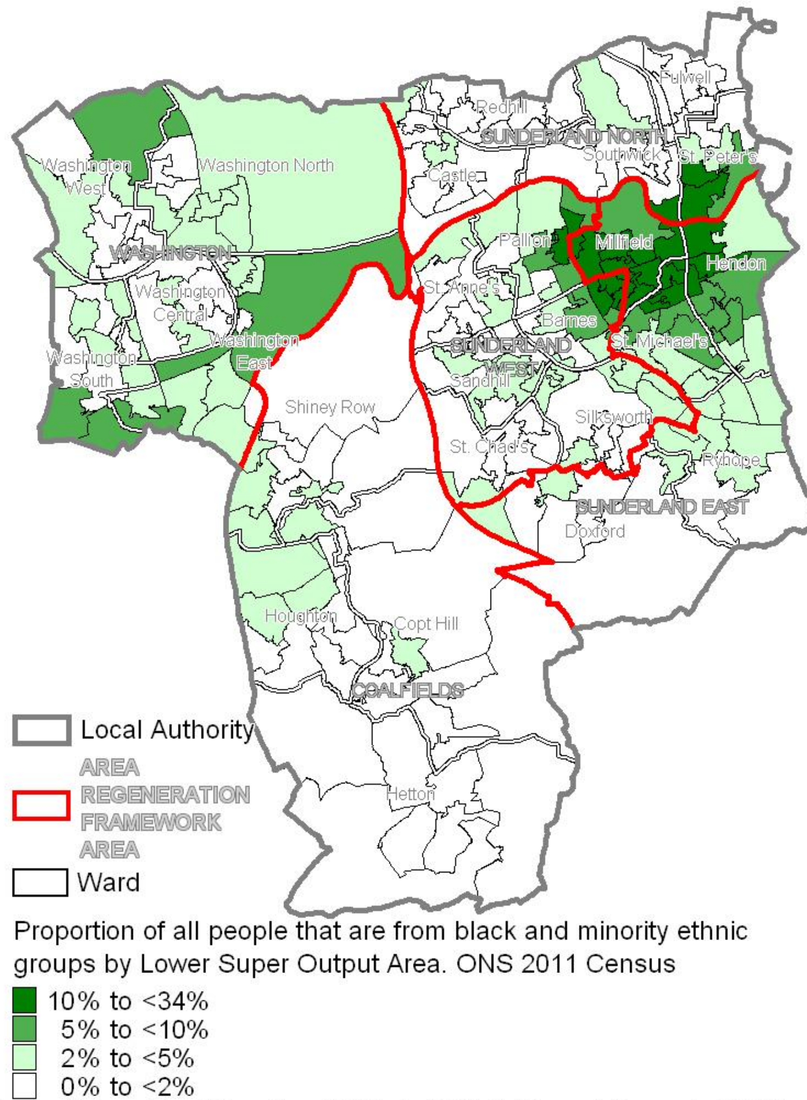



*Source:* [*http://www.ons.gov.uk/ons/interactive/vp2-2011-census-comparator/index.html*](http://www.ons.gov.uk/ons/interactive/vp2-2011-census-comparator/index.html)

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, which is similar to that in the 2015 mid-year population estimates.

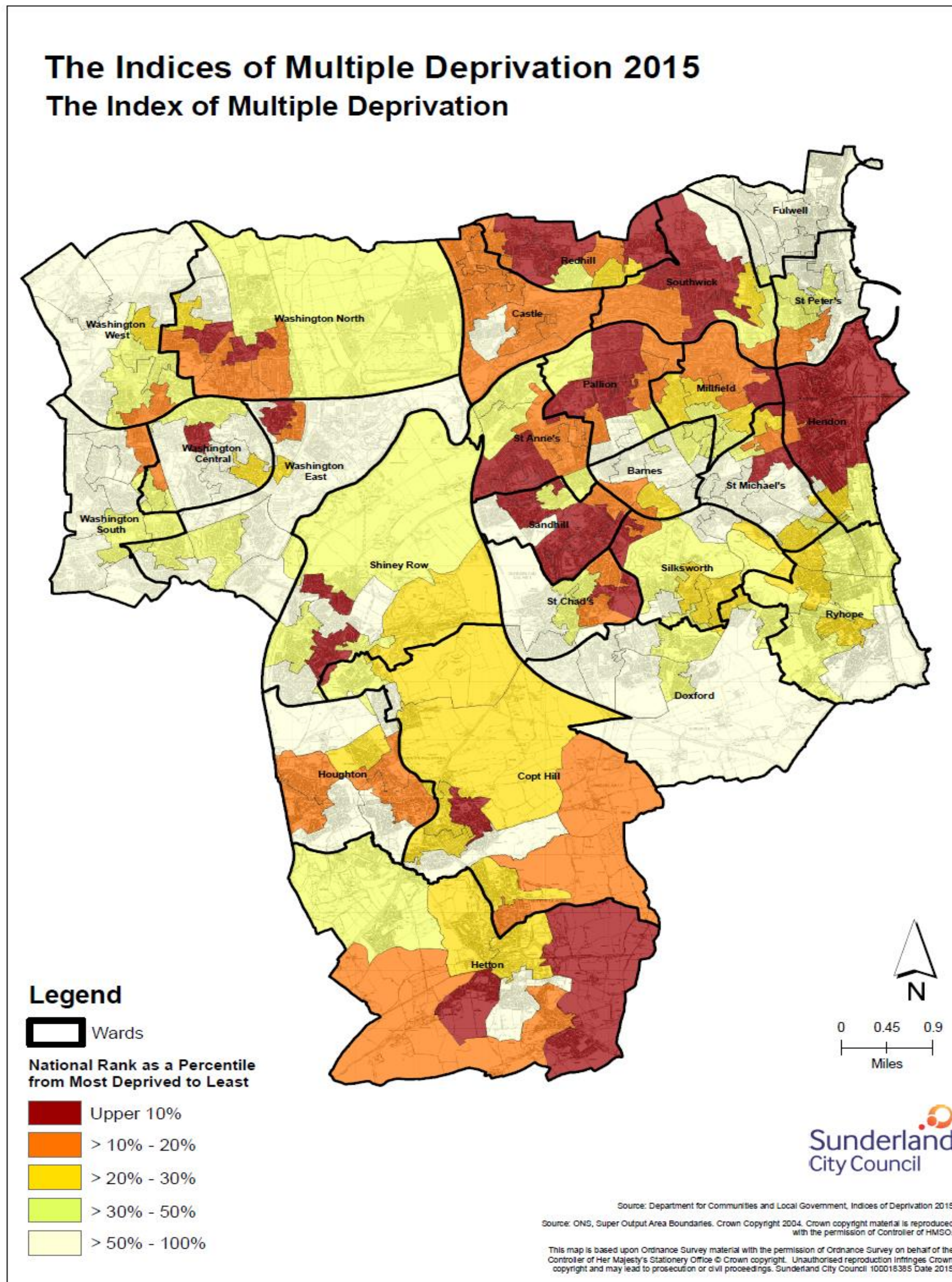
The 2011 Census showed that 94.8% of the Sunderland population were white British. A total of 11,224 (4.1%) were from BME groups (excluding white non-British) and the remaining 3,073 (1.1%) were white non-British. (Office for National Statistics, 2012e) The BME population in the majority of wards was 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 2 shows the proportion of the population in each ward that was from BME groups.

**Figure 2 Proportion of population by ward from BME groups**



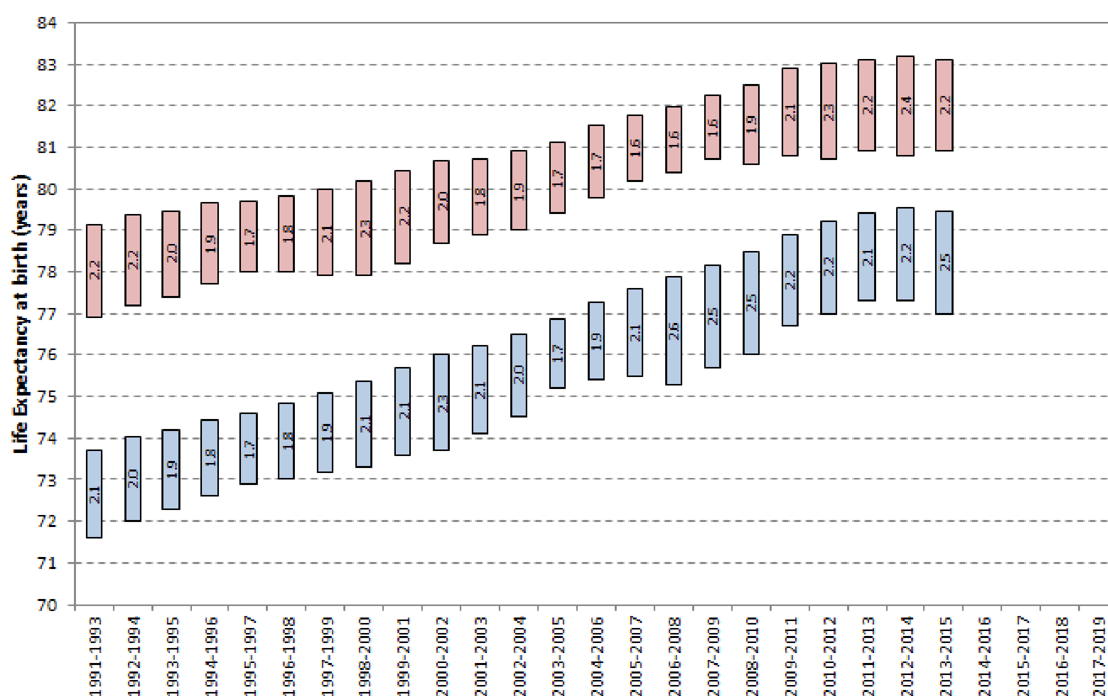

Sunderland is an area with high levels of deprivation; 38% of the population live in the most disadvantaged 20% of areas in the country. This measure of deprivation is based on a range of domains; the population of Sunderland is most disadvantaged in the employment and health domains, where 48% and 64% of the population respectively live within the 20% most disadvantaged areas in the country. (IMD 2015). Figure 3 illustrates the variation in levels of socioeconomic disadvantage across the city.

**Figure 3** **Variation in levels of socioeconomic disadvantage across the city**




Life expectancy across Sunderland as a whole is 2 years lower than the England average. Figure 4 shows the changes in life expectancy for males (in blue) and females (in red) over the last two decades. (Sunderland City Council, 2016)

Figure 4	Trends in Life Expectancy at Birth 1991-1993 to 2013-2015, Sunderland compared to England, by sex




Source: Life expectancy at birth and at age 65, England and Wales, 1991-93 to 2013-15, Office for National Statistics

Life expectancy for both men and women is lower than the England average. Life expectancy is 9.9 years lower for men and 7.6 years lower for women in the most deprived areas of Sunderland than in the least deprived areas (Public Health England, 2016).

Over a quarter of children under 16 years old in Sunderland (26%; 12,615 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 (source: *2017 Child Health Profile for Sunderland, Public Health England*). This is higher than the average child poverty level of 20.1% across England as a whole. Again, there is marked inequality within Sunderland, with detailed analysis in 2012 showing some wards having rates below 5%, while in other wards child poverty rates are more than 60%. (Sunderland City Council & Sunderland PCT, 2012b) Figure 5 illustrates the variation in child poverty

rates across the city, with the highest rates largely mirroring rates of socioeconomic disadvantage shown in Figure 3.

**Figure 5 Variation in child poverty rates across the city**

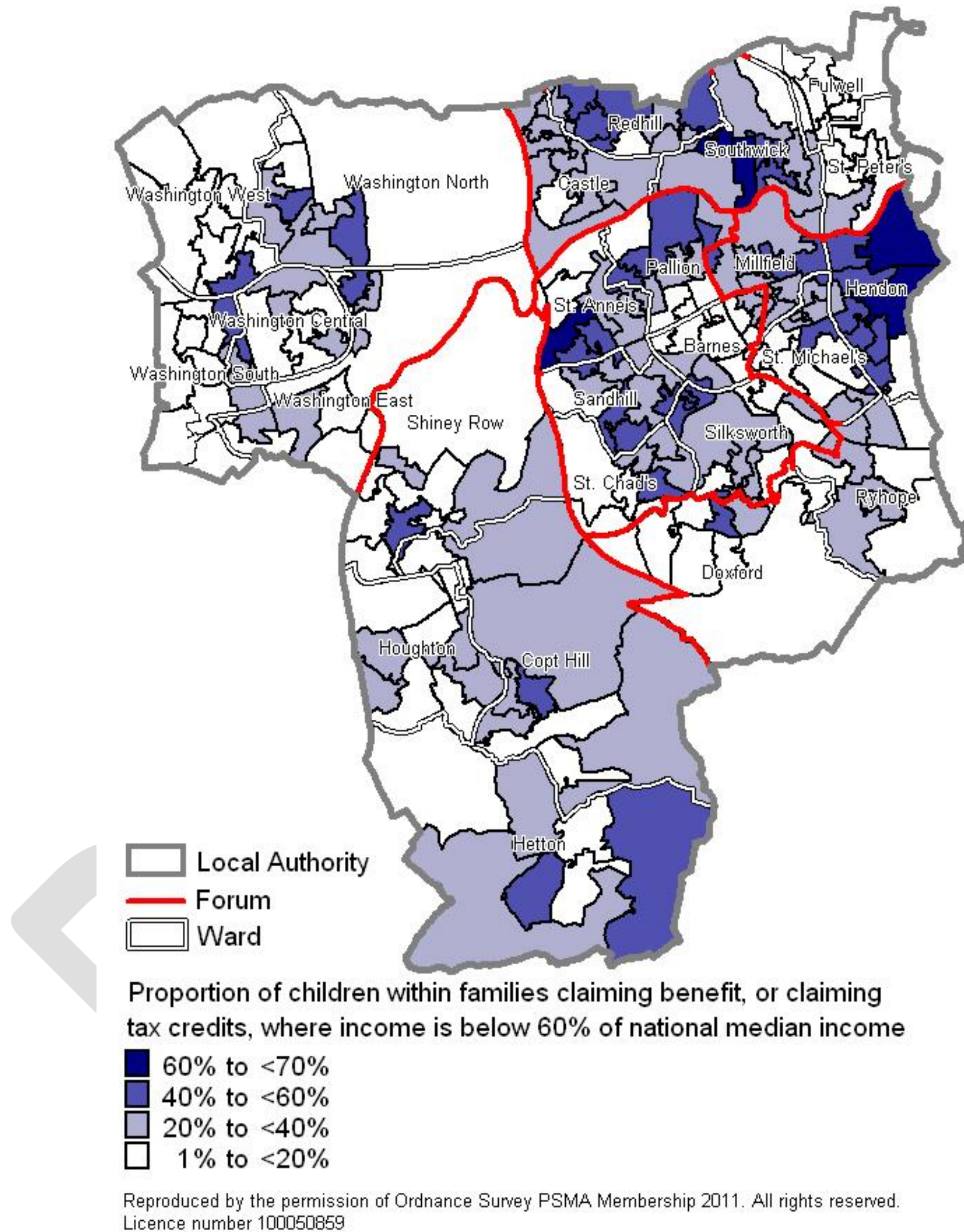



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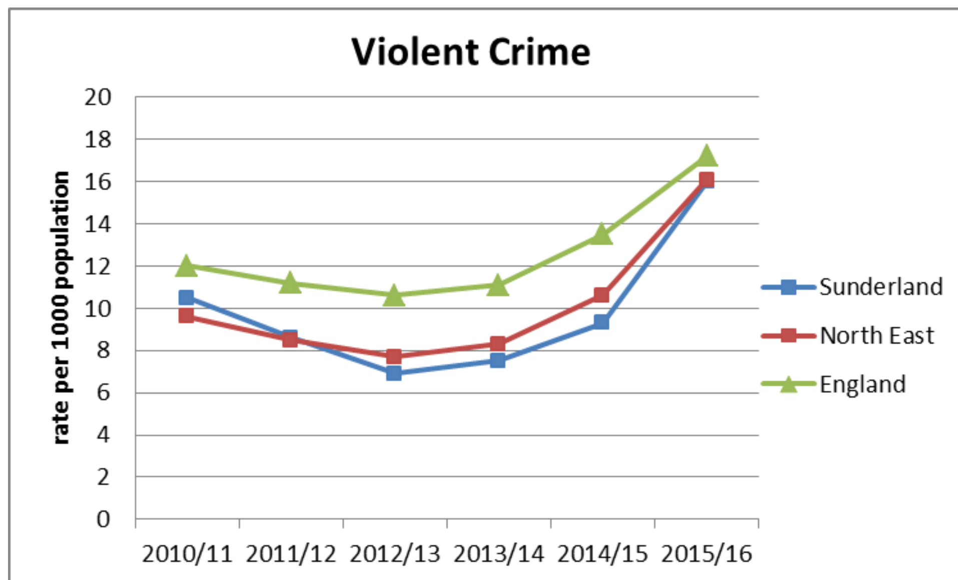
Figure 6 shows that rates of violent crime in Sunderland have risen significantly since 2013/14. This pattern has also been seen in the North-East and England. This increase over the last 2 years is primarily as a result of a combination of increased confidence of victims to report incidents to the police and improved compliance with the National Crime Recording Standard (NCRS) and similar increases have been seen in most police forces. It is unclear when the impact of the NCRS will level-off and a truer baseline established.

**Figure 6 Violent Crime rate**




The Public Health Profiles for Sunderland state that the percentage of adults binge drinking on their heaviest drinking day in Sunderland (22.4%) are estimated to be significantly higher than England as a whole (16.5%) in the period 2011-2014. (Public Health England 2017) Around 35% of males aged 18 to 44 who took part in the Sunderland Adult Lifestyle Survey in 2017, said they were drinking more than 6 units on their heaviest drinking day, which is classed as binge drinking by the World Health Organisation.

The prevalence of depression and anxiety in 2016/17 was the highest in the region (17.8% of respondents aged 18 and over in Sunderland compared with 16.5% for Cumbria and the North East, and 13.7% nationally). (GP Patient Survey, NHS England, cited on Public Health England 2017) Figure 7 shows the mental wellbeing scores by electoral ward.

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**Figure 7 Mental wellbeing scores by electoral ward**

## Epidemiological Need

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

### National data

The ONS has published the *Domestic Abuse in England and Wales* report for the year ending March 2016 (ONS, 2016e) with the following key findings:

- There were an estimated 2.0 million adults aged 16 to 59 who said they were a victim of domestic abuse in the last year, according to the year ending March 2016 CSEW. Women were more likely to report having experienced domestic abuse than men.
- A large number of domestic abuse-related incidents were recorded by the police (1.03 million) in the year ending March 2016. Following investigations, the police concluded that a domestic abuse-related criminal offence was committed in approximately 4 in every 10 (41%) of these incidents (421,000).
- Domestic abuse-related crimes recorded by the police accounted for approximately 1 in 10 of all crimes. The majority of domestic abuse (78%) consisted of violence against the person offences. A decision to charge was made for 70% of domestic abuse-related cases referred to the CPS by the police. Convictions were secured for three-quarters of domestic abuse-related prosecutions. In 68% of the domestic abuse cases referred to CPS the defendant pleaded guilty, so most of the cases recorded as successful outcomes were due to guilty pleas (91%). Over half of unsuccessful prosecutions (53%) were due to either victim retraction, victim non-attendance or evidence that the victim did not support the case. Victims may not want to be involved in the prosecution for a number of reasons, for example due to the level of fear and control exerted by the perpetrator. In 22% of unsuccessful prosecutions the defendant was acquitted by a jury or magistrates after a trial.

Data on the prevalence of DV in England and Wales is also produced by the Office for National Statistics, based on the CSEW, formerly the British Crime Survey (BCS). In 2015/16, approximately 50,000 households were invited to participate in the survey and around 75% of invited households historically have chosen to take part. The CSEW is a key

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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 crime (Office for National Statistics, 2012b)

The CSEW indicates that in 2015/16, 6.2% 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 (8.1%) in women compared to men (4.3%). Based on mid 2016 population estimates, this equates to approximately 1.4 million female and 720,000 male victims aged 16 to 59 reporting having suffered DVA within the last year in England and Wales. (Office for National Statistics, 2016a & Office for National Statistics, 2017a) Recent research by Walby drilled down into the CSEW data (the uncapped data) to uncover more about the gendered nature of DVA (Gayle, 2015). The published CSEW data is the capped data which means they place a cap on the number of violent crime people report in the survey. The restriction to the first five incidents in a series has been applied since the CSEW began in order to ensure that estimates are not affected by a very small number of respondents who report an extremely high number of incidents and which are highly variable between survey years. When they looked at which victims experienced the most frequent and most severe DVA, it was predominantly women and this gets masked by the 1 in 4 women and 1 in 6 men statistic. Whilst 1 in 6 men may have self-reported experiencing DVA, it was predominatly a one off incident, but those experiencing repeated and severe DVA were mostly women. (Walby et al, 2016)

Figure 8 depicts the trends in self-reported prevalence of 'any domestic abuse' across England and Wales for adults aged 16 to 59, by gender, for the year ending March 2005 to the year ending March 2016, based on CSEW data. 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, 2016a)

In addition to providing data on experience of 'any domestic abuse' within the previous year, ONS also reported on lifetime experience of 'any domestic abuse', within the publication on "Intimate personal violence and partner abuse," (March 2016) a slightly broader definition, which includes stalking. Lifetime prevalence rates were markedly higher than in-year prevalence; 20.2% adults reported having experienced DV at least once since the age of 16. Almost 27.1% of women reported some lifetime experience of DV, compared to 13.2% of men.

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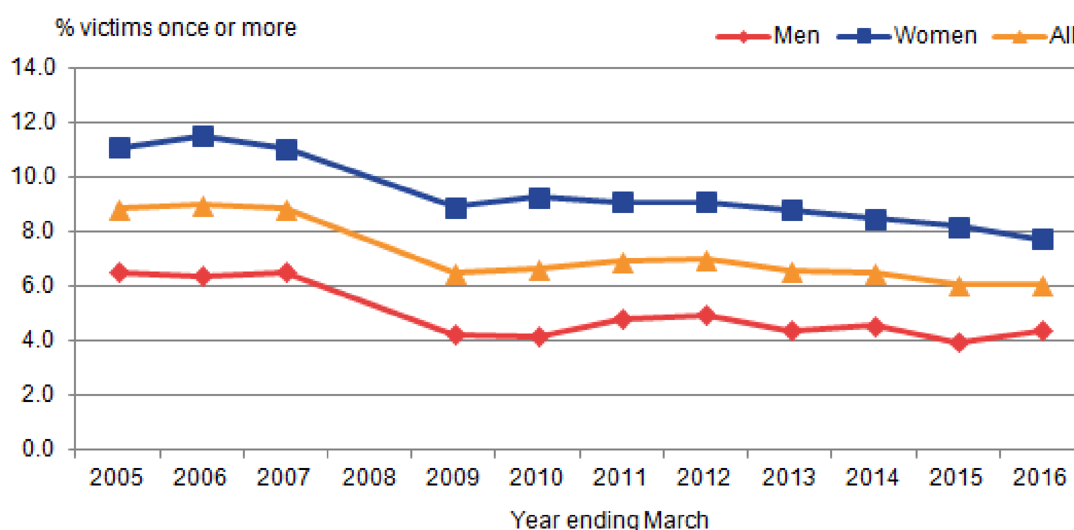
**Figure 8** **Trends in self-reported prevalence of domestic abuse in England and Wales**[1]




Taking partner abuse and family abuse as distinct forms of DVA, the CSEW further classifies abuse within these two areas. Table 1 presents these data, illustrating that DVA is most likely to involve non-physical abuse when it relates to partner abuse.

**Table 1** **Prevalence of different forms of partner and family abuse**

| | Partner abuse | Family abuse |
|---|---|---|
| **Any** | 17.1 | 7.8 |
| **Non-physical abuse (emotional, financial)** | 9.1 | 3.0 |
| **Threats** | 12.2 | 2.9 |
| **Force** | 10.6 | 3.7 |

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

*Source:* (Office for National Statistics, 2016)

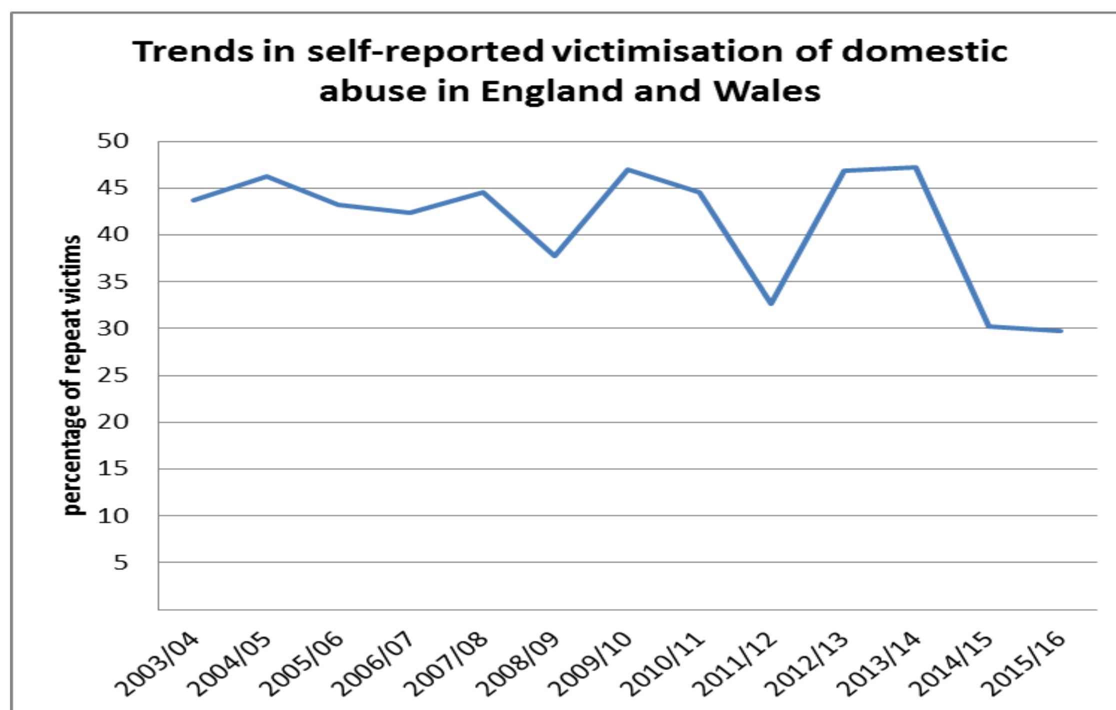
<u>Repeat victimisation</u>

The CSEW also provides data on repeat victimisation. In 2015/16, 30% of those reporting DV were repeat victims, but this group accounted for 58% of all DVA incidents (Office for National Statistics, 2016) Figure 9 below shows the trend in repeat victimisation rates, which is showing an overall decline, although the data shows a high level of volatility. (Office for National Statistics 2016) The repeat victimisation rate for all DVA victims who report to the police is 42% (April-Sept. 2017) – or

[1] (No data point is available for the year ending March 2008, because comparable questions on stalking, an offence that makes up the domestic abuse category, were not included in that year)

39% for 2016-17. The rate of repeat victimisation of high risk victims in MARAC in Sunderland is 33% (Table 2).

**Figure 9 Trends in self-reported victimisation of domestic abuse in England and Wales**

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## Local data

DVA 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 DVA in Sunderland can be estimated. The 2015/16 CSEW found that 6.2% of the adult population (aged 16 to 59) had experienced DVA within the previous year. The adult population of Sunderland aged 16-59 is estimated to be 160,697. (Office for National Statistics, 2016) Therefore, based on crude extrapolation from the national CSEW data, there would be approximately 9,963 victims of DVA aged between 16-59 in Sunderland in 2015/16. As reported in the previous section, approximately half this number of incidents was reported to Northumbria Police.

In the CSEW 2015/16 showed that only 50% of DVA incidents were reported to the police. (Office for National Statistics, 2016c) A total of 6,382 incidents were reported to the police in Sunderland in 2016/17. If the reported incidents represented just 50% of all incidents, the total number may have been as high as 12,764.

The CSEW (2015/16) reported that to estimate the number of people who have experienced any domestic abuse (partner or family non-physical abuse, threats, force, sexual assault or stalking) since the age of 16 was 20%. Based on an estimated adult population aged 16-59 in Sunderland of 160,697 (aged 16-59 yrs, as this is the age-group who took part in the CSEW questionnaire), it is estimated that approximately 32,129 people within this age group in the city may have been or are currently affected by domestic violence (ONS mid-2015 estimates).

### Police recorded DVA incidents

Data relating to the number of DVA incidents, gender of victims and repeat victimisation was provided directly by Northumbria Police. All other data relating to DVA incidents was obtained from extracts of the Northumbria Police data using a police computer and iBase software.

Northumbria Police responded to a total of 6,382 DVA incidents in Sunderland during 2016/17 a rise from 6,121 the previous year. The number of reported incidents has fluctuated around 6,000 for the past four years without evidence of any discernible trend.

Public Health England reports the number of incidents of domestic abuse recorded by the police. This shows the crude rate per 1,000 population aged 16 and over of DV in Sunderland are amongst the lowest reported levels in the region:

**1.11 - Domestic abuse-related incidents and crimes - current method** 2015/16 Crude rate - per 1000

| Area | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|
| England | - | 22.1 | 22.0 | 22.1 |
| North East region | - | 30.4 | 30.2 | 30.6 |
| County Durham | - | 38.4 | 37.9 | 38.9 |
| Darlington | - | 38.4 | 37.9 | 38.9 |
| Stockton-on-Tees | - | 33.5 | 33.0 | 34.0 |
| Redcar and Cleveland | - | 33.5 | 33.0 | 34.0 |
| Middlesbrough | - | 33.5 | 33.0 | 34.0 |
| Hartlepool | - | 33.5 | 33.0 | 34.0 |
| Gateshead | - | 25.7 | 25.4 | 26.0 |
| Sunderland | - | 25.7 | 25.4 | 26.0 |
| South Tyneside | - | 25.7 | 25.4 | 26.0 |
| North Tyneside | - | 25.7 | 25.4 | 26.0 |
| Newcastle upon Tyne | - | 25.7 | 25.4 | 26.0 |
| Northumberland | - | 25.7 | 25.4 | 26.0 |

*Source: Office for National Statistics (ONS)*

and Sunderland is not an outlier when compared with statistical neighbours:

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**1.11 - Domestic abuse-related incidents and crimes - current method** 2015/16 Crude rate - per 1000

| Area | Neighbour Rank | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|---|
| **England** | - | - | 22.1 | 22.0 | 22.1 |
| Redcar and Cleveland | 5 | - | 33.5 | 33.0 | 34.0 |
| Hartlepool | 6 | - | 33.5 | 33.0 | 34.0 |
| Tameside | 11 | - | 30.1 | 29.9 | 30.4 |
| Salford | 14 | - | 30.1 | 29.9 | 30.4 |
| Rotherham | 12 | - | 28.9 | 28.6 | 29.2 |
| Stoke-on-Trent | 7 | - | 27.7 | 27.4 | 28.0 |
| St. Helens | 9 | - | 26.2 | 25.9 | 26.5 |
| Knowsley | 8 | - | 26.2 | 25.9 | 26.5 |
| Gateshead | 4 | - | 25.7 | 25.4 | 26.0 |
| Sunderland | - | - | 25.7 | 25.4 | 26.0 |
| South Tyneside | 1 | - | 25.7 | 25.4 | 26.0 |
| North Tyneside | 3 | - | 25.7 | 25.4 | 26.0 |
| Wakefield | 15 | - | 24.9 | 24.7 | 25.2 |
| North East Lincolnshire | 10 | - | 24.8 | 24.4 | 25.1 |
| Plymouth | 2 | - | 19.8 | 19.6 | 20.1 |
| Halton | 13 | - | 9.4 | 9.2 | 9.6 |

*Source: Office for National Statistics (ONS)*

Victims

The 6382 DVA incidents reported to Northumbria Police in 2016/17 involved 3,869 victims, 2966 (77%) of which were female and 901 (23%) male. There were 1510 repeat victims during 2016/17, representing 39% of all victims.

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

Seasonal distribution of DVA incidents

Temporal analysis by Northumbria police indicates that the highest levels of incidents of domestic abuse are reported on the weekend. During 2013-14 period 35.8% of domestic abuse was reported over Saturday-Sunday with the highest levels on Sunday (19%). The lowest levels were experienced between Tuesday–Friday. This pattern was the same across the previous 3 years of data and across both family member incidents and partner/ex-partner incidents.

Levels are highest during the summer months, especially in July and August. Levels then decrease and are low during September- November before increasing again over December and January. These patterns are to be expected, these periods coincide during parts of the year when above average levels of socialising takes place – the summer months (and often

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sporting events) and over Christmas/New Year period. These also coincide with higher levels of alcohol consumption.

The lowest levels of reporting take place within the early hours of the day between 05:00 and 07:00. From this point onwards levels steadily increase and peak between 23:00 and 01:00. After this point levels then quickly decrease to the 05:00 low point.

Geographical distribution of DVA incidents

Figure 10 illustrates the distribution of reported DVA incidents across the city, proportional to population size, by Lower Super Output Areas (LSOA). 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). Blue represents the lowest rates of DVA per capita, with, green, yellow and orange representing increasing rates, up to the highest rates, shown in red. The map shows the highest rates of reported DVA were found in pockets around Hendon, Pallion, Southwick, and Washington South wards.

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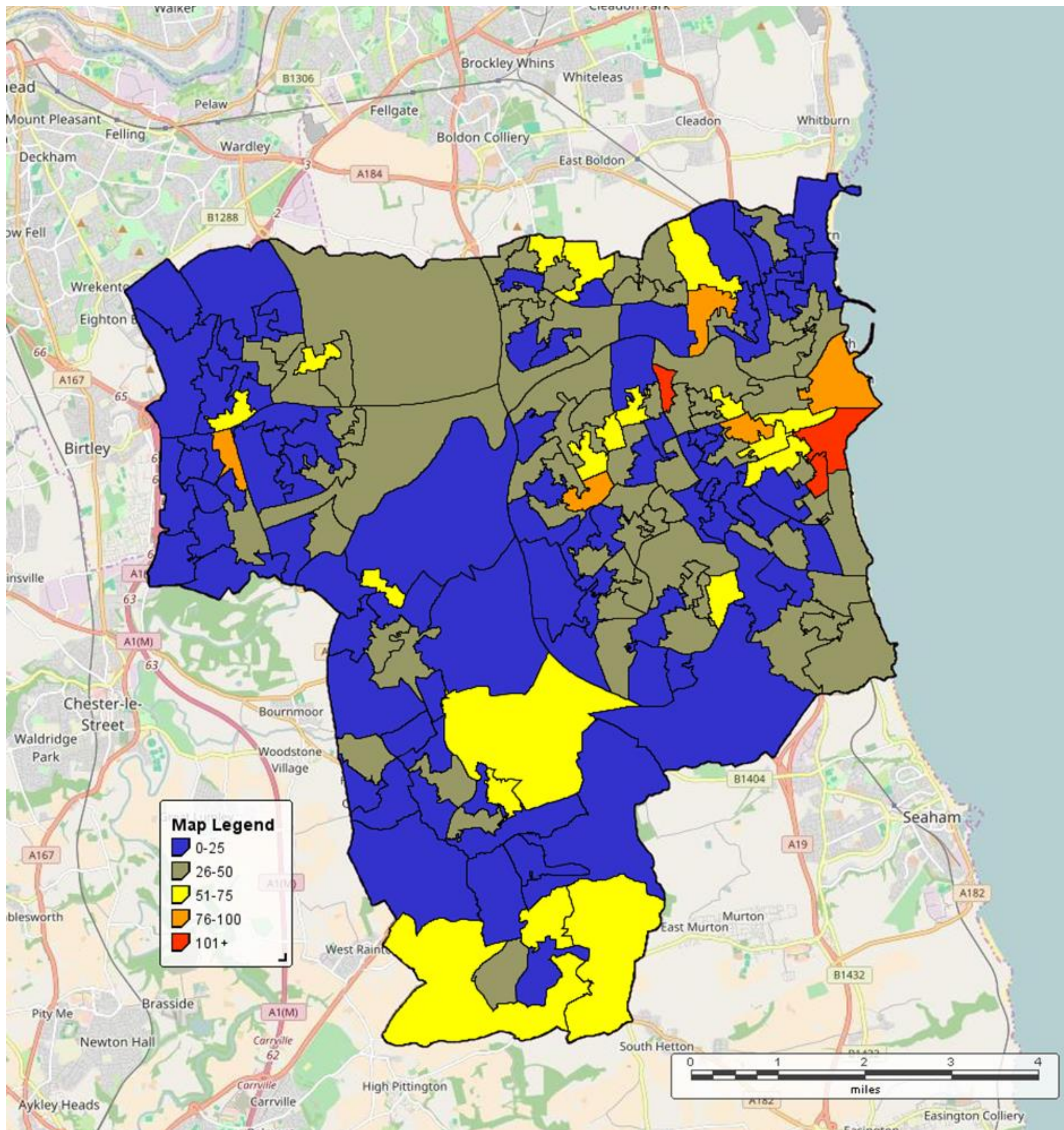
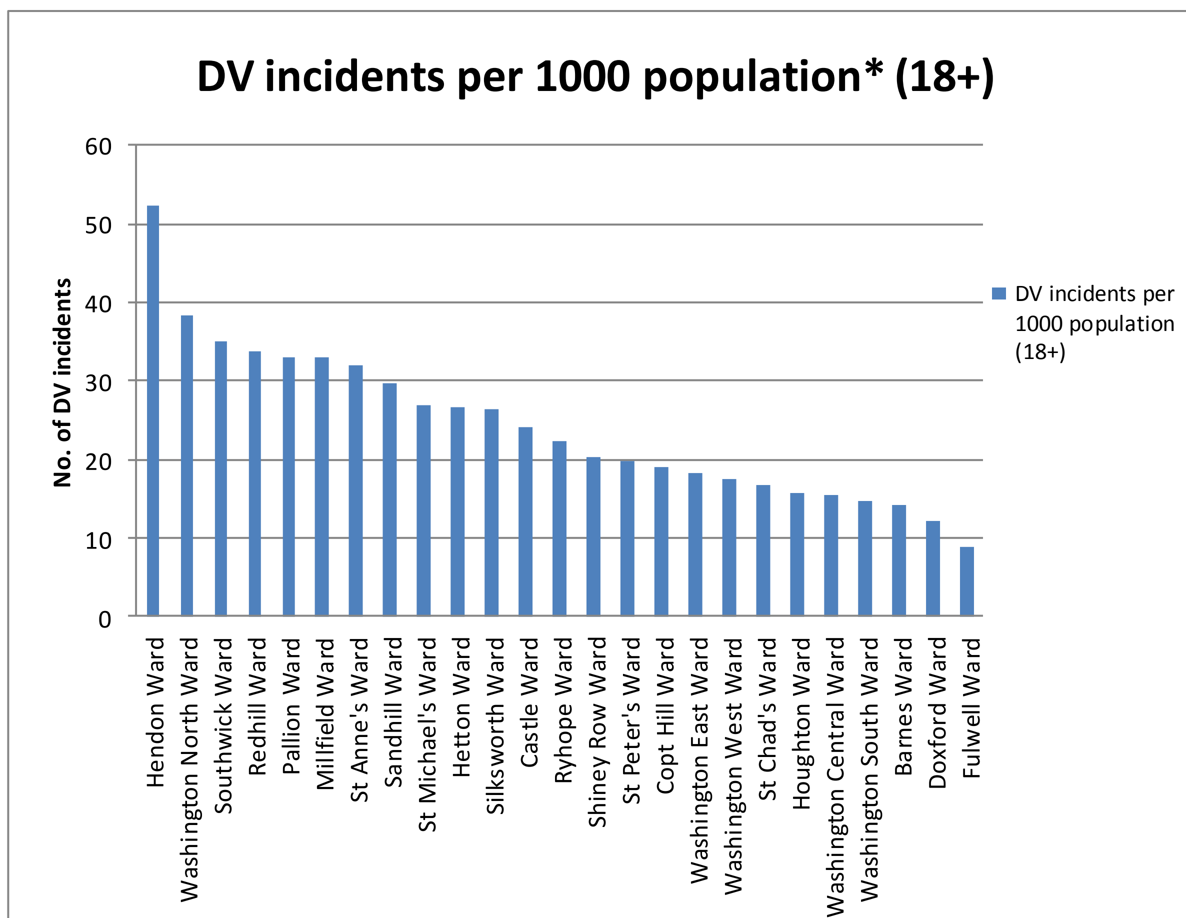
**Figure 10 Map showing the geographical distribution of reported DVA incidents in Sunderland January- December 2016**




Analysing this in terms of incidents per 1,000 population (at ward level, and using 2016/17 data), the distribution of reported DVA incidents (2016/17) across the city was inequitable, ranging from a peak of 52.24 per 1000 population in Hendon ward to a low of 8.9 per 1,000 population in Fulwell ward. Figure 13 shows the number and rate per 1,000 population of reported DVA incidents in each ward of the city in 2016/17.

**Figure 11** **Reported DV incidents across the city in 2016/17**[2]




*Adult population based on mid-2015 ward population estimates, published by the Office for National Statistics.

## Geographical distribution of DVA crimes

As with incidents, there was marked variation in the prevalence of DVA crimes across the city. Figure 12 illustrates this variation by ward, as well as showing the trend in number of DVA crimes for each ward over the previous year.

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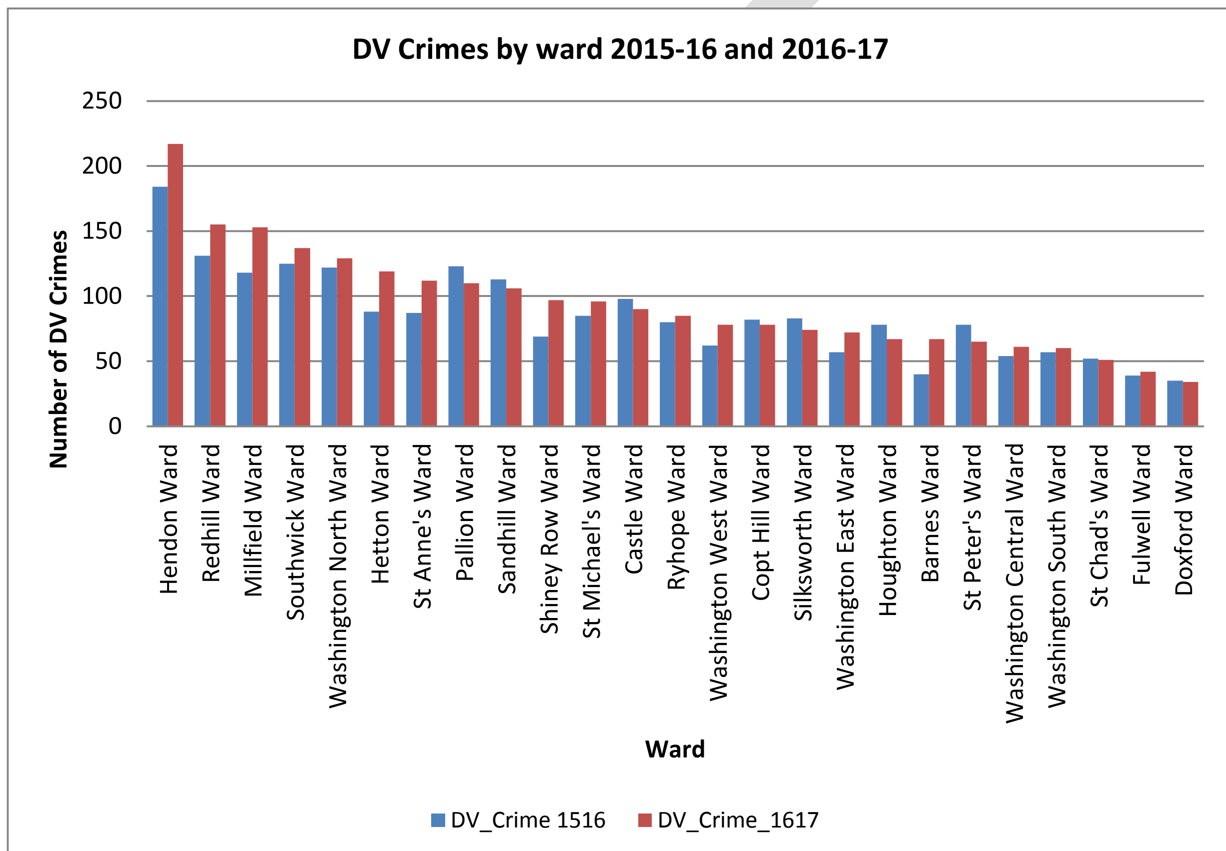
[2] It is important to note that the total number of DV incidents included in the dataset provided from iBase differs from that provided directly by Northumbria Police. The report from police computer included a total of 6804 DV incidents in 2016. The data from the police computer is based on recorded DV incidents, where a "domestic abuse flag" is recorded 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. The data in Figure 13 is taken from DV incidents with a "domestic abuse flag".

The data show a marked inequality in the number of reported DVA crimes experienced by ward, and in trends in numbers of DVA crimes over the last two years. There have been decreases from the previous year for DVA crimes in some wards including Pallion, Sandhill, Houghton and St Peters. In many wards there have been increases over the previous year, such as Hendon, Redhill, Millfield, Hetton, St. Anne's, Shiney Row and Barnes. 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 12 Variation and trends over time in numbers of DV crimes by ward**




<u>Association with deprivation</u>

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) The 2013 DV HNA reported a highly statistically significant correlation between the rate of reported DVA incidents and deprivation at LSOA level (Sunderland City Council, 2013). It found a clear trend that LSOAs with higher deprivation scores tend to experience higher rates of reported DVA incidents.

While these analyses suggest that DVA incidence is significantly higher in more deprived areas, it is important to note that this refers only to *reported* DVA incidence. There is conflicting opinion as to whether DVA 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 Department of Health publication described a strong socioeconomic gradient for violence, likely to be attributable to a clustering of risk factors for violence in deprived communities. (Department of Health, 2012) It should however be noted that DVA incidents were reported in every ward of the City in 2016/17, so although some areas have higher reported rates than others, DVA is a citywide issue in Sunderland.

Women living in households in the 20% most deprived areas of the England were more likely to be victims of domestic abuse (9.1%) than women in other areas (5.6% for the 20% least deprived areas and 6.7% in other areas). The prevalence of domestic abuse for men was not statistically different between these three area types. (Penhale and Porritt, 2010)

**Local data: Multi Agency Risk Assessment Conference (MARAC)**

MARAC is recommended by the Home Office as best practice for addressing high risk cases of DVA. DVA 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 DVA. (HM Government 2010a) The MARAC process is a multi-agency approach which enables the identification and management of high risk DVA cases through information sharing by a number of agencies and organisations to assess the needs of high-risk victims, enabling action planning to reduce risk. The MARAC aims to ensure that agencies work together to minimise risk to those at the most serious risk of harm or death. Northumbria Police and partner agencies undertake risk assessment of DVA 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. MARAC data from SafeLives for the 12 month period to 30 June 2017 shows that there were 605 high risk victims considered at MARAC.

Collated information on MARAC activity levels are presented below:



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**Table 2: Sunderland MARAC activity levels 12 months to 30th June 2017**

| 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 |
|---|---|---|---|---|---|---|
| 605 | 33 | 1044 | 2 | 0.8 | 1.3 | 3.5 |

Sunderland MARAC data from SafeLives for 12 months to 30th June 2017 show that there have been 605 victims referred to MARAC (with 1044 children) and many of these victims have additional vulnerabilities such as alcohol misuse, drug misuse, mental ill health, learning disabilities, physical disabilities etc. The Independent Domestic Violence Advisor (IDVA) service supports the majority of these victims but has significant capacity issues. It is recommended there should be around 470 high risk victims for a population size of Sunderland with 5 IDVAs supporting these victims. Currently there are 605 high risk victims referred to MARAC in the 12 months to June 2017 and based on the actual volume of high risk cases Sunderland should have 6.5 IDVAs but only currently has 4 x FTE IDVAs (3 of these are part of the commissioned specialist domestic abuse service and includes the manager and the hospital IDVA; the other IDVA is funded by the service provider to help manage the workload).

MARAC has discussed a very small proportion of cases where the victim was male (3.5%), or from the LGBT community (0.8%), again suggesting that these groups may be under-represented 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). 2% of MARAC cases were from the BME community.(Table 2) Those from BME communities appear to be under-represented in the MARAC data, though to a lesser extent than the other groups described above. In 2016-17 there was a drop in the number of BME victims reporting to the Police in Sunderland (-24% or 26 fewer victims) which had taken the proportion of victims who are BME from 2.9% down to 2.2%. The April-Sept 2017-18 data have shown a continued fall (-10% or 5 fewer victims) and the proportion of BME victims is now only 1.8%.

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Repeat victimisation levels in Sunderland are around 33% and within the national SafeLives recommended levels of 28%-40% (Sunderland City Council, 2015)

Change that Lasts

Sunderland is one of 3 national Change That Lasts (CTL) pilots. Women's Aid England, in partnership with Welsh Women's Aid, has developed the Change that Lasts model. Current provision and partnerships are often funded with a focus on short term risk reduction. Risk assessment is increasingly the main gateway to support with the management of risk as the main criterion of success. Understanding of risk is limited to homicide and serious injury and fails to take into account other factors such as the risk of homelessness and financial insecurity. It also does not account for the resources and resilience that survivors bring to their situation. The unintended consequences of this approach are that survivors are being held responsible for reducing the risks posed by the perpetrator and that risk is being managed in the absence of considering the survivor's other needs.

CTL has the ultimate aims of reducing the number of women and children living with abuse and the long term costs associated with abuse to survivors, services and society. The model is underpinned by a strengths-based, needs-led, trauma informed approach for supporting domestic abuse survivors and their children to build resilience and foster independence. CTL recognises risk as a safety need, but also takes into account the wider array of needs and resources survivors have. It places survivors at the heart of the model and builds upon good practice already established in local areas to codify and evidence what we know works. Crucially, CTL is cost effective as it builds on existing structures and opportunities to respond to domestic abuse.

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Change that Lasts is made up of three main interventions, which together, ensure that survivors can access help wherever they disclose abuse

1. The ask me scheme

One of the key principles of CTL is that every point of interaction with a survivor is an opportunity for intervention. It should not be missed, and should never add to the enormous barriers that survivors already face. In response to this, we are piloting a scheme that will

widen the opportunities there are for survivors to access help within their communities. Ask me will work with the local community to change the way it acts and think about abuse by creating spaces where people who have experienced abuse can feel safe to access vital information and be directed to the help that they need the first time around.  Women's Aid will work with local services to train and support people to become an ask me ambassador and help establish their organisation as an ask me site by putting up posters and leaflets and sharing their learning with their colleagues. Ambassadors will also sign a pledge to 'pay it forwards' by talking to others in their personal networks to help raise awareness about coercive control and domestic abuse.

2. The trusted professional

Survivors have paid testament to the importance of a trusted relationship with an individual professional in facilitating change for them. The trusted professional intervention is aimed at public and voluntary sector services, such as substance misuse, mental health and children's services, that do not deliver a specialist domestic abuse response but are likely to have an established relationship with survivors through their work. In Sunderland the focus will be on a cohort of those working in housing, early help and mental health. The aim of the intervention is to increase the confidence levels and skills of staff to enable them to provide a more holistic and helpful response to the survivors they are in contact with. Building on the trusting relationship already established with survivors, the trusted professional will receive training on how to recognise the signs of abuse so that domestic abuse is not missed and is included as a support need in case management. Trusted professionals will also receive assessment and support planning tools to enable them to provide a safe and needs led response within the limitations of their role.

3. Expert Support Services – a trauma informed approach

Dedicated domestic abuse services provide the level of expertise that is crucial to facilitating long term and meaningful change for survivors. They are often engaged with survivors for a longer period than other agencies and are most likely to come into contact with the survivors with the most complex needs. The third element provides delivery a framework for the core dedicated domestic abuse services to enhance their support for survivors and strengthen their capacity to deal with complex issues in accessing safety and recovery from the traumatic impacts of abuse. This intervention builds upon the emerging evidence from a small scale pilot delivered by My Sisters Place where a trauma informed approach was shown to achieve significant positive benefits for the service users involved. Women's Aid will take the learning from this pilot, developing and testing a framework and the resources that will enable providers to effectively support survivors with additional and complex needs.

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Essentially this response refocuses on the approach developed by the VAWG sector and provides the framework to evidence the positive impact of this upon survivors. Women's Aid will provide the resources, and training, along with assessment, support planning and evaluation tools, which correspond to their case management and outcomes system On Track.

*Local data: Sunderland Safeguarding Children Board (SSCB)*

Data from 2011/12 from the SSCB indicated that, on average, Children's Social Care received approximately 5,000 referrals related to DVA per year. Data on the proportion of referrals to children's social care in Sunderland which were related to DVA are available for the previous three complete financial years (Table 3). 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 showed that approximately one third of all referrals to Children's Social Care in Sunderland were related to DVA. Recent data has not been obtained as DVA has been captured within a more generic title of neglect, but a new system *Liquid Logic* should enable Together for Children to provide more detailed analysis in the future.

**Table 3 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% |

During 2015/16, domestic violence was identified as a factor in 547 (26%) referrals out of the 2115 referrals to social care that went on to assessment (where one or more factors were identified). (Department for Education, 2016)

Table 4 shows the proportion of families becoming subject to a child protection plan (CPP) which were related to DVA over the same time period. Again, there is annual fluctuation,

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however the data show that just under half of all families becoming subject to a CPP in Sunderland were related to DV in 2011/12.

**Table 4 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% |

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## Protected Characteristics and Risk Factors

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

Independent risk factors for DVA victimisation can also include drug or alcohol use, long-term illness or disability, household income, housing tenure and occupation (2009/10 BCS). It is important to note that association does not necessarily imply a causal relationship with DVA. (Smith, 2011)

### Age

Data from the previous DVA HNA showed that, while 20-24 year olds report the highest rates, DVA can and does occur at all ages.

### Children

An estimated 130,000 children in the UK live in households with high-risk domestic abuse; that is, where there is a significant risk of harm or death. 6% of all children are estimated to be exposed to severe domestic abuse between adults in their homes at some point in childhood. Thousands more live with other levels of domestic abuse every single day (SafeLives, 2014). Exposure to DVA in childhood has been associated with an increased risk of involvement in violence in later life. Children who witness DVA in the home have

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been shown to be at an increased risk of both suffering and perpetrating DVA as adults, as well as increased risk of involvement in youth violence. (Department of Health, 2012)

The psychological impact of living with domestic abuse is no smaller than the impact of being physically abused. Children are affected by overhearing violent incidents; the survivors and children are often degraded and belittled by the perpetrator. There may be parental drug/alcohol misuse/mental health issues, the destruction of property or belongings and other family members may be being hurt or intimidated and there may be abuse of siblings. Children may be forced to participate in the abuse or degradation; be made to watch physical or sexual assault or rape; feel responsible for protecting their parent or siblings; deal with the aftermath of seeing injuries and distress; witness the arrest of the parent and deal with issues of shame or embarrassment of neighbours observing incidents; being deprived of family and social contacts which reduces the likelihood of disclosure; and attempted suicide or even death of a parent.

Domestic abuse impacts negatively on children such as their emotional and physical wellbeing, their behaviour and attendance at school, feelings of blame, social adjustment and so on. They might experience: anxiety, restlessness, nightmares or sleep disruptions, eating disorders, headaches or chronic fatigue; distraction as well as difficulties with thinking, learning, concentrating, or processing information; re-living violence through play; fear of being alone or difficulty separating from parents; physical aggression; inappropriate social responses to others, bullying or peer victimization; or a diminished ability to trust others. Around 9 out of 10 children are in the same or the next room when domestic abuse incidents happen between their parents, and over 40% of these children will try and intervene to protect their family. In Sunderland, around 55% of child protection plans have domestic violence as the most prevalent issue in the families (Ref: Julie Smith, Domestic Abuse impact protected characteristics). The psychological impact of living with domestic abuse is no smaller than the impact of being physically abused. Children are affected by overhearing violent incidents; the victims and children are often degraded and belittled by the perpetrator. There may be parental drug/alcohol misuse/mental health issues, the destruction of property or belongings and other family members may be being hurt or intimidated and there may be abuse of siblings.

SafeLives (previously CAADA) have done extensive research on the impacts of domestic abuse on children and young people (SafeLives, 2014). This research (based on a national dataset from domestic abuse services) found a major overlap between domestic abuse and direct harm of children. Almost two thirds (62%) of the children who were exposed to

domestic abuse were also directly harmed. These children's families were vulnerable in multiple ways with the data showing a clear co-occurrence between the 'toxic trio' risk factors of domestic abuse, substance misuse (alcohol and/or drugs) and parental mental ill health. Nearly a third of mothers (31%) and a third of fathers (32%) in these families experiencing domestic abuse disclosed either mental health problems, substance misuse, or both. Children were suffering multiple physical and mental health consequences as a result of exposure to domestic abuse. Amongst other effects, over half (52%) had behavioural problems, over a third (39%) had difficulties adjusting at school and nearly two thirds (60%) felt responsible or to blame for negative events.

Data extracted from 2016/17 shows 41% of police reported DV incidents in Sunderland involved children (Northumbria Police, 2017). 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 2,618 incidents reported in 2016/17 involved children, therefore the most conservative estimate would indicate that at least 2,618 children were involved, though the actual number is likely to be considerably higher.

**Older people**

Domestic abuse can affect older victims in different ways to young victims. For some, it can be 'domestic abuse grown old' where it started earlier in life and persists into old age. Some older people enter into abusive relationships late in life, where the perpetrator is a new spouse or intimate partner. For others, late onset domestic abuse can begin in old age. There may have been a strained relationship or emotional abuse earlier that has got worse as the partners aged (Ref: Julie Smith, Domestic Abuse impact protected characteristics). In 2016-17 there were 3,869 victims (6382 incidents) and of these there were 340 victims aged 55+ which is only 8.8% of all victims (Northumbria Police, 2017). However, Sunderland's female populations aged +55 years is 47,778 (mid-2016 estimates) and given that 1 in 4 women are expected to experience domestic abuse at some point in their lives, those reporting abuse to the police are still a very small minority. There were 224 victims aged over 55 years who reported their abuse to the Police in Sunderland April-Sept (a +22.4% rise). This means that the proportion of all victims aged 55 or over is 9.1% and is at its highest levels in Sunderland and likely to be as a result of the local awareness raising that continues to be done around abuse in older relationships (Police data April to September 2017).



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Barriers to reporting can be both service-based barriers (e.g. staff failing to recognise signs/symptoms as domestic abuse); and the victims' own personal barriers (e.g. caring responsibilities where victims of domestic abuse may be being cared for by their partner or they may be their partner's carer. They may have to care for adult disabled children or may feel their abusers are emotionally dependent on them, and/or feel responsible for them; older victims typically demonstrate feelings of stigma and shame; generational beliefs with older victims often having more traditional attitudes towards marriage and gender roles; prolonged trauma and psychological damage; and many older victims have become financially dependent on their abuser etc.). ((Ref: Julie Smith, Domestic Abuse impact protected characteristics, Penhale and Porritt, 2010)

**Disability**

Research into disabled women's experiences has found that the effect of being both disabled and a woman places disabled women at significant and higher risk than women in the general population (LGA and ADASS Adult safeguarding and domestic abuse: A guide to support practitioners and managers). Women's Aid has identified that disabled victims of domestic abuse on average contact services 12 times (compared to an average of 5 times) before their needs around the domestic abuse are met. (ref Julie Smith, Domestic Abuse impact protected characteristics)

The data in Table 2 shows that 1.3% of victims in MARAC cases have a registered disability. 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) The estimated prevalence of physical disability in people aged 16-64 in Sunderland in 2012 was 11.5%, and the QOF prevalence of learning disability in 2013/14 Sunderland was 0.6% (Public Health England, 2017).

**Gender identity**

An equality impact assessment (HM Government 2011b) reported that experience of DVA varied according to sexual orientation and gender identity, with bisexual and transgender people more likely to experience DVA than lesbians and gay men. No comparison was made between these groups and the heterosexual population.

**Marriage/civil partnership**

Findings from the ONS report on intimate personal violence and partner abuse (ONS, 2016) reported that women who were separated had the highest prevalence of any domestic abuse in the last year (19.8%) compared with other marital status groups (such as married/civil partnered 3.6%) or cohabiting (6.6%)). Married /civil partnered men were less likely to experience any domestic abuse (2.4%) compared with all other marital status groups. The percentage of widowed women who were a victim of domestic abuse in the last year was higher in the year ending March 2015 than in previous years, however, this is based on a small number of respondents, therefore it is too early to draw any conclusions on whether this is a real increase in the prevalence for this demographic group

**Pregnancy/maternity**

It has been estimated that around one third of cases of DVA 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) A woman who is experiencing domestic abuse may have particular difficulties using antenatal care services: for example, the perpetrator of the abuse may try to prevent her from attending appointments. The woman may be afraid that disclosure of the abuse to a healthcare professional will worsen her situation, or anxious about the reaction of the healthcare professional. NICE guideline CG110 recommends training healthcare professionals in the identification and care of women who experience domestic abuse through routine enquiry in maternity and midwifery services (NICE, 2011).

**Race**

BME victims tend to require longer term support and are often at significantly high risk. Many of these victims have no recourse to public funds, complicated visa and immigration issues or other complex needs connected to FGM, forced marriage and honour based abuse (where there can be multiple perpetrators). There are high levels of under reporting to the police and they can often be identified sooner through health routes as opposed to criminal justice routes as they are often less likely to contact the police (SafeLives, 2016). BME victims tend to require longer term support and are often at significant high risk. Many of these victims have no recourse to public funds, complicated visa and immigration issues or

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other complex needs connected to FGM, forced marriage and honour based abuse. There are high levels of under reporting to the police and they can often be identified sooner through health routes as opposed to criminal justice routes as they are often less likely to contact the police (SafeLives, 2016; Julie Smith paper on Domestic Abuse impact protected characteristics).

The vast majority of reported DVA 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 (Northumbria Police, 2017). Census estimates indicate that approximately 5.2% of the Sunderland population are from the BME community. (Office for National Statistics, 2012e). In 2016-17 there was a drop in the number of BME victims reporting to the Police in Sunderland (-24% or 26 fewer victims) which had taken the proportion of victims who are BME from 2.9% down to 2.2%. The April-Sept 2017-18 data have shown a continued fall (-10% or 5 fewer victims) and the proportion of BME victims is now only 1.8%.

**Religion/belief**

The BCS found that ethnicity was not independently associated with risk of DVA, however some specific forms of DVA, such as forced marriage, so-called ‘honour’ based violence (HBV) and female genital mutilation, are disproportionately distributed by race or religion/belief. (HM Government 2010a).

Northumbria Police recorded less than 5 HBV incidents in Sunderland between April to September 2017. Nationally there were 11,744 recorded incidences by the police between 2010 and 2014. 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. (Cowen, 2003, HM Government 2011b)

The Forced Marriage Unit (FMU) which is a joint Foreign and Commonwealth Office and Home Office unit was set up in January 2005 to lead on the Government’s forced marriage policy, outreach and casework. It operates both inside the UK, where support is provided to any individual, and overseas, where consular assistance is provided to British nationals, including dual nationals.

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The FMU operates a public helpline to provide advice and support to victims of forced marriage as well as to professionals dealing with cases. The assistance provided ranges from simple safety advice, through to aiding a victim to prevent their unwanted spouse moving to the UK (‘reluctant sponsor’ cases), and, in extreme circumstances, to rescues of victims held against their will overseas.

The FMU undertake an extensive outreach and training programme of around 100 events a year, targeting both professionals and potential victims. The FMU also carry out media campaigns, such as 2015’s ‘right to choose’ campaign, where the FMU commissioned a short film to raise awareness amongst young people at risk of being forced into marriage, as well as potential perpetrators.

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) Data from HSCIC (Health and Social Care Information Centre, now NHS Digital) for 2015/16 showed there were 70 newly recorded cases of FGM in the North East and Cumbria. No data is listed for Sunderland, which indicates that between 0-4 cases may have been recorded (numbers under 5 are not disclosed due to confidentiality).

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.

There are no accurate statistics on forced marriage in the UK. There are statistics available from the Forced Marriage Unit (FMU) which provide information on the extent of the problem. The latest statistics by the FMU in 2015 (as of 8 March 2016) state that the FMU gave advice or support in 1200 cases with 80% involving female victims and 57% of cases involving South-Asian communities.

**Sex**

Women are more likely to be victims of domestic abuse than men. The CSEW indicates that in 2015/16, 6.2% 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 (8.1%) in women compared to men (4.3%). Based on mid 2016 population estimates, this equates to approximately 1.4 million female and 720,000 male victims aged 16 to 59 reporting having suffered DV within the last year in England and Wales.

In addition, DVA 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.

Capped data from CSEW masks the frequency and severity of DVA for female victims and women are more likely to experience more frequent and more severe abuse and men are more likely to experience one off incidents of DVA.

**Sexual orientation**

Data from SafeLives showed that just 1.3% of victim cases accessing support identified as LGBT. Of the cases discussed at MARAC in 2012/13 only 0.8% were noted to involve a LGBT victim. Informed guidance on this subject would suggest that MARAC and domestic abuse services in urban areas should expect a proportionate representation of 10%, suggesting that domestic abuse amongst LGBT men and women is heavily under reported (SafeLives, 2015). This is consistent with research evidence which shows under-representation of LGBT victims at MARAC at both national and regional level. (Donovan, 2010) Research demonstrates that LGB and/or T people can be reluctant to turn to mainstream services because of fears of homophobia or of being ‘outed’ or of an inappropriate response. They may be fearful of leaving because the abuser has threatened to ‘out’ them if they do leave. Research also highlights that because domestic abuse is often seen as something which heterosexual gendered women experience, some LGB and/or T people may not actually realise that what they are experiencing is domestic abuse. (Julie Smith, Domestic Abuse impact protected characteristics)

DVA amongst gay men has been shown to be associated with mental and sexual health problems and drug and alcohol abuse. (Bacchus et al, 2016)



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In 2013, just over one in ten DV incidents occurred in same sex relationships (667; 11%) (Northumbria Police, 2013).

### Alcohol

Over the last year, there has been an increase in both DVA crimes and alcohol related DVA related crimes. In Sunderland, data from Northumbria Police shows that there has been a 24.2% increase in alcohol-related DV crimes during 2016/17, although the proportion of the total number of DV crimes which are alcohol-related has fallen from 45.6% in 2015/16 to 39.3% in 2016/17 with the most current data showing the proportion being 28.7% in April-Sept 2017 (Table 5 below).

**Table 5 Number and proportion of alcohol related DV crimes**

| | Total DV crimes | Alcohol related | Proportion of DVA crimes that are alcohol-related |
|---|---|---|---|
| **2014/15** | 1468 | 732 | 49.9% |
| **2015/16** | 2265 | 1035 | 45.6% |
| **2016/17** | 3272 | 1285 | 39.3% |
| **April-Sept 2017** | 2549 | 732 | 28.7% |

### Substance Misuse

A study on intimate personal violence and partner abuse reported that victims were more likely to report that the offender was under the influence of alcohol (17%) rather than illicit drugs (10%) (ONS, 2016). Female victims were more likely than male victims to perceive that the offender was under the influence of drugs (12% compared with 3%). However, caution should be taken when making inferences about the relationship between alcohol consumption, illicit drug taking and partner abuse victimisation. The victim's alcohol consumption and illicit drug use may affect or be affected by their experience of partner abuse e.g. some victims may use substances as a coping mechanism as a result of the trauma experienced.

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**Mental Health**

A recent systematic review has shown that the prevalence of DVA 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 found that risk of DVA 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 DVA therefore care should be taken when interpreting the numerical risk estimates quoted. Nonetheless, the association between DVA and mental illness means that those working with individuals with mental illness should be aware of the vulnerability for DVA to be present, and vice versa.

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## *Evidence review*

### Health impacts of domestic violence

The well documented health impacts of DVA have been quantified in a report based on the Crime Survey for England and Wales (CSEW) and summarised in a Department of Health publication. (Department of Health, 2012) Data from the CSEW indicates that approximately one in four (27%) victims of DVA 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, DVA can also impact on health related behaviours, such as drug and alcohol misuse. (Department of Health, 2012) A study exploring the lives of sex workers in Tyne and Wear identified particularly high rates of DVA, as well as mental health problems and 'chaotic lifestyles' among sex workers. (PEER Research Team, 2013) These observations highlight the potential for the accumulation of risk factors in vulnerable groups, as well as emphasising the impact the DVA 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, DVA can result in homicide or suicide. It has been reported that on average there are two DVA homicides per week in England and Wales, and around 500 suicides per year occur in women who have experienced DVA. In the case of suicides, over one third had visited a hospital on the day they committed suicide. DVA is believed to be a factor in approximately one third of all female suicides. (Walby, 2004)

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

- The physical injuries sustained by substantial numbers of DVA victims likely contribute to the high levels of demand for emergency care in Sunderland; reducing this is a key priority of the CCG.
- Links to mental health are particularly significant. Sunderland has the highest prevalence of depression and anxiety in the region at 17.8% of respondents aged 18

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and over. This was the second lowest level when compared with statistical neighbours (GP Patient Survey, NHS England, cited on Public Health England 2017)

- Alcohol related hospital admissions in Sunderland are particularly high and reducing these is a further priority area for the city.

The SafeLives report *In plain sight: Effective help for children exposed to domestic abuse* (2014) reported that:

1. There is a major overlap between direct harm to children and domestic abuse: 62% of children exposed to domestic abuse in the research were also directly harmed
2. Children are suffering multiple physical and mental health consequences as a result of exposure to domestic abuse.
3. A quarter of the children exhibit abuse behaviours, mostly once their exposure to domestic abuse has ended
4. Only half of these children were previously known to children's social care, but 80% were known to at least one public agency.

The SafeLives report recommended that to ensure children's safety, provide linked specialist domestic abuse services for the child and the parents. Their evidence shows that these specialist children's services (e.g. children's IDVAs or children's DA specialist workers) give young people a voice and improve their safety, recovery, health and wellbeing. They meet the Munro Review's call to provide early help for all children at risk, and the requirements of the statutory guidance 'Working together to safeguard children' to place the child's needs and wishes at the heart of the service they receive. They also have the potential to alleviate pressure on children's social care and Child and Adolescent Mental Health Services (CAMHS), freeing them up to manage the highest-risk cases. They can also bring cost savings to health and criminal justice services in the long term by supporting children to move on from their experiences. Their evidence shows that stopping domestic abuse is a crucial first step in achieving safety for children. They recommend that domestic abuse services for parents should be commissioned in parallel with services for children. They recommend that every child living with domestic abuse should have someone to support them in their own right, using whichever local model works best (e.g. a children's worker in a domestic abuse service, dedicated therapeutic service etc.) and that they should exist alongside commissioned domestic abuse services that support victims and perpetrators to ensure services for children and parents are linked together in a whole family response). SafeLives state that as a minimum the domestic abuse services for children must offer all of the following:

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- Practical age-appropriate help for the child with safety planning.
- Therapeutic support to help the child with feelings of blame and guilt, healthy relationships, abusive behaviour and how to resolve conflict.
- Other relevant interventions around the child based on their risk and need.

**Financial costs of domestic violence**

A study published in 2009 estimated the total cost of DV in England and Wales in 2008 to be around £15.7 billion, of which £1.7 billion were health care costs. The costs of domestic abuse to Sunderland were estimated to be £79.6m per annum in 2013. (Domestic Violence Health Needs Assessment). It should be noted that these estimates were based on inflation and gross domestic product in 2008; therefore the true cost may be markedly different. Applying an uplift to this cost to reflect the overall population increase in Sunderland (276,080 in 2013 and 277,962 in 2016) would suggest a new crude estimate of costs of around £80.4m per annum.

Table 6 below provides an overview of the estimated costs across service sectors. (Walby 2009)

**Table 6 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** |

In terms of health care (both physical and mental health), GPs and hospitals are the major costs included (Walby, 2009). Physical injuries account for most of the NHS costs (Walby, 2004). Overall, the study estimated that around 3% of the England and Wales NHS expenditure in 2001 was due to the physical injuries associated with domestic violence (covering hospital and ambulance services, GP and prescription health care services). However, there is an important element of mental health care (12.6% of the 2001 costs) in that it leads to increased use of health services e.g. costs associated with depression, anxiety, post-traumatic stress disorder; attempted and completed suicide.

The cost of DVA is similar to other public health priorities, such as smoking, obesity and alcohol misuse. Table 7 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 7 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 DVA. (Department of Health, 2011) A tool produced by the Department for Education estimated the average cost of responding to one DVA 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 DVA has been partly attributed to investment in public services to prevent and better respond to DVA. (Department of Health, 2011). Key findings from a review of the evidence base for what works in DVA interventions are set out below.

A 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)

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

Between 2007 and 2009 an evaluation of IDVA services was conducted by Howarth (2009) in the UK to understand the process of delivering IDVA services and the outcomes that may

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be achieved for victims. The evaluation looked at 2,567 victims (and over 3600 children) at the point of referral and then at the closure of the case or after 4 months of engagement as an interim marker of case progress .

By engaging with supporting interventions, victims of domestic violence can either experience a cessation, reduction, or no change in their domestic violence. The evaluation found that IDVA is extremely effective in terms of cessation and reduction of domestic violence . The high effectiveness of IDVA is likely explained by the types of support interventions IDVAs help victims access. Therefore, it is important to recognise the effectiveness of providing IDVA is not due to IDVAs time alone but also due to the support interventions received. That is, the effectiveness represents a combined effect of both IDVAs time and support interventions that the IDVAs help the victim to access.

National Institute for Health and Care Excellence (NICE) Guidance 2014 includes results of an economic modelling study of the use of IDVA services . Two key economic benefits associated with reducing domestic violence are:

1. Quality of life gain from reduced domestic violence; and
2. Cost savings associated with reduced domestic violence

Overall, the IDVA service intervention was found to be cost saving (that is, it both saves resources and improves quality of life) compared with no intervention. The overall message is that the cost of domestic violence and abuse is so significant that even marginally effective interventions are cost effective in achieving cessation in domestic violence and therefore represent efficient use of public resources. Full details can be found in the economic analysis of interventions to reduce the incidence and harm of domestic violence and abuse, and in http://guidance.nice.org.uk/PH50/SupportingEvidence.

Moreover, the benefit associated with preventing and reducing of domestic violence is wider than those captured in the economic modelling undertaken for this study; the economic model is limited to an analysis of specific health.

**What works: evidence of effective interventions**

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.

There is no core outcome set for DVA and therefore evaluations of interventions often report a variety of indicators, and use a variety of measures and tools, many of which are not validated. This can be a challenge when identifying evidence of "what works". A review of current service provision and gaps has been undertaken outwith this paper. Evidence around interventions to mitigate DVA for this paper has been obtained from a rapid review of available literature (Appendix 1).

Key findings are:

Primary prevention:

- A multi-agency approach to DVA is needed which should incorporate elements of prevention and management, whilst addressing the wider impact of DVA on the individual and their families.(SafeLives, 2016) (NICE, 2017)
- School-based interventions and support for families through health visiting, midwives and family nurse partnership, can promote healthy relationships (Wood, 2010) (Department of Health, 2012)
- Regulation of alcohol sales at a community level, for example through increasing prices (associated with reduction in intimate partner violence) (Wood, 2010) (Department of Health, 2012)
- Community interventions, including multiagency partnership working in areas such as tackling alcohol related DVA, and data sharing. (Department of Health, 2012)
- Changing social norms, through approaches such as mass media campaigns, aiming to shift stigma from victims to perpetrators. (Department of Health, 2012)
- Publish a directory of local and national services (NICE 2017)
- Consult with women, men and young people who have experienced domestic violence and abuse as part of a joint strategic needs assessment, including those from hard-to-reach communities (NICE 2017)

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Secondary prevention:

- Identify and train key contacts responsible for advising on the safe sharing of domestic violence and abuse-related information (NICE 2017)
- Routine enquiry about DVA in health care setting by trained health care professionals can be successful in increasing disclosure (Wood, 2010), e.g. the IRIS programme[3] (Feder, 2011) (Department of Health, 2012) (SafeLives, 2015, 2016). Sunderland is piloting routine enquiry with 12 GP practices between 2017-19.
- Commission specialist services e.g.:
    - Children's outcomes significantly improve across all key measures after support from specialist children's services (SafeLives, 2014 and 2016)
    - Across local authority boundaries where there is not enough local need to justify setting them up within a particular local authority area. (This could include services to help prevent forced marriages, to help men, or lesbian, gay, bisexual or trans people affected by domestic violence, or for people subjected to 'honour' violence or stalking.) (NICE 2017)

Tertiary prevention:

- Victim advocacy, including case management, connection to legal services and information, and on a system-wide level, home visitation and health worker outreach can reduce a woman's risk of further victimisation. (Ellsberg, M, 2015) Advocacy services can reduce some forms of physical abuse in the medium, but not long, term (Wood, 2010)
- Substance misuse treatment among offenders (successful in reducing repeat offending; beyond the scope of this HNA) (Wood, 2010)
- Develop referral pathways that aim to meet the health and social care needs of all those affected by domestic violence and abuse, including people with protected characteristics and those who face particular barriers trying to access domestic violence and abuse support services. (NICE 2017)
- Commission specialist services e.g.:
    - Children's outcomes significantly improve across all key measures after support from specialist children's services (SafeLives, 2014 and 2016)

[3] 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.

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- Across local authority boundaries where there is not enough local need to justify setting them up within a particular local authority area. (This could include services to help prevent forced marriages, to help men, or lesbian, gay, bisexual or trans people affected by domestic violence, or for people subjected to 'honour' violence or stalking). (NICE 2017)
- Services include advocacy, advice, floating support, outreach support, refuges and provision of tailored interventions for victims and their children. They also include housing workers, independent domestic violence advisers and multi-agency risk assessment conferences for those at high risk. Services should be tailored to the level of risk and specific needs of people experiencing domestic violence or abuse. (NICE guideline, PH50)

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## *RECOMMENDATIONS*

- Recommendations from the 2013 DV HNA should be reviewed and impact assessed, and compliance against NICE pathways should be assessed
- A review of service provision and demand should accompany this HNA.
- Further work on BME, LGBT, travelling community and other minority groups could be undertaken to identify their needs and experiences of accessing services
- A review of children's data where this was not available should be undertaken
- Unlike many other areas of good practice, Sunderland does not have any Children's IDVA (CHIDVA) provision, specialist DVA workers for children or specialist workers providing therapeutic support, counselling and play therapy to offer short term emotional support to children and young people who are affected by domestic violence. Such services have been found to have a significant impact on the health and wellbeing of children. (Sunderland City Council, 2015) This is an area for further work.
- Use this HNA to inform the cross partnership DVA proposal around the formation of a cross-partnership time limited project group focused on understanding the prevalence and impact of domestic abuse on children, adults and their families , the strategies and plans in place to reduce the level and impact, identify areas/services for improvement and improve outcomes for those affected.
- Review the current approach taken in Sunderland to stop people offending (nationally less than 1% of DVA perpetrators receive a specialist intervention), break the cycle of abuse and provide ways out of difficult circumstances that achieve sustainable and lasting change

## Appendix 1: Table of findings from Rapid Literature Review on DV

| Author | Findings |
|---|---|
| Wood, 2010 | A review of the evidence for prevention of intimate partner violence identified five successful or promising interventions:<br>• School-based education programmes that promote healthy relationships (successful in reducing violence toward current partners)<br>• 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)<br>• Regulation of alcohol sales at a community level, for example through increasing prices (associated with reduction in intimate partner violence)<br>• 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)<br>• Substance misuse treatment among offenders (successful in reducing repeat offending; beyond the scope of this HNA) |
| Department of Health, 2012 | This paper identified a range of violence prevention initiatives in which health services should have a leading role:<br>• Supporting parents and families by developing parenting skills and strengthening family relationships (midwives, health visiting and family nurse partnership).<br>• 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).<br>• 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).<br>• Community interventions, including multiagency partnership working in areas such as tackling alcohol related DV, and data sharing.<br>• Changing social norms, through approaches such as mass media campaigns, aiming to shift stigma from victims to perpetrators.<br>• 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).<br>• IRIS is highlighted by the Department of Health as an evidence-based method of providing DV training to health professionals in primary care settings. |
| Feder, 2011 | IRIS has been shown in a randomised controlled trial to improve identification and referral of DV victims |
| SafeLives, 2014 | *In plain sight: Effective help for children exposed to domestic abuse* (2014) reported that: Children's outcomes significantly improve across all key measures after support from specialist children's services. Data shows a relationship between cessation of domestic abuse and cessation of direct harm to children. |
| SafeLives, 2015 | Getting it Right First Time looked at how to identify every family where domestic abuse takes place as quickly as possible. Cutting the time it takes to find and help victims and their families is critical to stop murder, serious injury, and enduring harm. Programmes in GP surgeries and advice agencies have shown that it is possible to significantly increase identification. These programmes may also reach a group of victims and families who are different to – and in some cases, more vulnerable than – those identified by other routes. Every area should have enough capacity to respond to every identified victim and family living with abuse. |

| | |
|---|---|
| SafeLives, 2016 | The SafeLives publication *A Cry for Health – Why we must invest in domestic abuse services in hospitals* explored the impact of co-location IDVA services in hospitals. It also examined the evidence base to highlight the benefits of stronger links between the health sector and domestic abuse service through innovative models.<br>There must be clear referral pathways to specialist domestic abuse provision with the training and focus to reassure victims and support them |
| (Ellsberg, M, 2015) | A study published in the Lancet into the evidence base for prevention of violence against women and girls found victim advocacy, including case management, connection to legal services and information, and on a system-wide level, home visitation and health worker outreach can reduce a woman's risk of further victimisation. |
| NICE, 2017 | NICE has published a domestic violence and abuse interactive pathway along with associated recommendations for commissioners. Full information, pathway and recommendations are available at: https://pathways.nice.org.uk/pathways/domestic-violence-and-abuse.<br><br>A summary of recommendations is below:<br><br>Plan services;<br>• Assess the need for DV services as part of the joint strategic needs assessment. This includes consulting with women, men and young people who have experienced domestic violence and abuse as part of this assessment, including those from hard-to-reach communities.<br>• Local commissioners of domestic violence and abuse services and related services should undertake a comprehensive mapping exercise to identify all local services and partnerships that work in domestic violence and abuse. (For example, this could include: ambulance services, housing, the police, health, criminal justice, education, probation, safeguarding and social care services. It could also include other specialist statutory, community and voluntary services, such as drug and alcohol services.) Map services against the Home Office-endorsed Coordinated Community Response Model and identify any gaps.<br>• Commissioners should develop referral pathways that aim to meet the health and social care needs of all those affected by domestic violence and abuse. This includes people with protected characteristics and those who face particular barriers trying to access domestic violence and abuse support services.<br>• Regional and national commissioners (see above) should work with local commissioners to provide specialist services across local authority boundaries where there is not enough local need to justify setting them up within a particular local authority area. (This could include services to help prevent forced marriages, to help men, or lesbian, gay, bisexual or trans people affected by domestic violence, or for people subjected to 'honour' violence or stalking.)<br>• Strategic partnerships should consider publishing a directory of local and national services.<br>Work in partnership to prevent DV;<br>Identify and train key contacts responsible for advising on the safe sharing of domestic violence and abuse-related information;<br>Remove obstacles to people disclosing DV: including displaying information and contact numbers in waiting rooms, in a range of languages and formats including braille and audio versions, and ensure there are private areas for disclosure of DV;<br>Help people who find it difficult to access services. |
| NICE Guidance 2014 | The National Institute for Health and Care Excellence (NICE) Guidance 2014 includes results of an economic modelling study of the use of IDVA services. Two key economic benefits associated with reducing domestic violence are:<br><br>1. Quality of life gain from reduced domestic violence; and<br>2. Cost savings associated with reduced domestic violence |

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|---|---|
| | Overall, the IDVA service intervention was found to be cost saving (that is, it both saves resources and improves quality of life) compared with no intervention. The overall message is that the cost of domestic violence and abuse is so significant that even marginally effective interventions are cost effective in achieving cessation in domestic violence and therefore represent efficient use of public resources. Full details can be found in the economic analysis of interventions to reduce the incidence and harm of domestic violence and abuse. As well as in http://guidance.nice.org.uk/PH50/SupportingEvidence |

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