Croydon Joint Strategic Needs Assessment (JSNA) 2013/14

Key-Topic 3

Domestic Violence and Abuse

Lead author

Daniel MacIntyre, Health Improvement Principal, Croydon Council

Co-authors

Ian Archer-Wright

Sharon Boakye

Antony Botting

Dawn Cox

Paula Doherty

Sarah Exall

Carl Parker

Ellen Schwartz

CROYDON
www.croydon.gov.uk

Note on data cut off period

The data in this chapter were the most recent published data as at December 2013. Readers should note that more up-to-date data may have been subsequently published, and are advised to refer to the source shown under figures or listed in the appendices for the chapter for the latest information.

Table of Contents

1 Executive summary

Domestic violence and abuse is an international, national and local issue. British Crime Survey (BCS) data showed 7.3% of all women and 5.0% of men experienced domestic violence and abuse in 2011/2012. In Croydon from July 2011 to June 2012 there were just fewer than 6,000 allegations of domestic abuse, with around 1,900 of these being allegations of violence of a serious nature, including grievous and actual bodily harm, rape and harassment. However, there is almost certainly a very large underreporting as to the actual extent of domestic violence and abuse in the borough.

Domestic violence and abuse are complex issues that require sensitive handling by professionals in many fields including health, social care, legal, criminal justice and housing. Most of this violence and abuse is perpetrated by men on women and girls, although men can also experience domestic violence and abuse, and it can occur in same-sex relationships. Children and young people can experience domestic violence and abuse when they are exposed to it within their families and within their own intimate relationships. Young people may also perpetrate domestic violence and abuse in their own intimate relationships.

Following the launch of the Home Office strategy to tackle violence against women and girls (VAWG) in March 2010, domestic violence and its consequences for individuals and society has become a government priority. Domestic violence has become a priority issue in Croydon due to an increase in the number of allegations and offences in the borough, and the occurrence of two domestic homicides and the resulting domestic homicide reviews.

The 2013 Home Office definition of domestic violence and abuse covers psychological, physical, sexual, financial and emotional abuse and as such, covers behaviours and consequences not all of which are inherently violent or criminal offences. The new definition includes so called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage.

Domestic violence and abuse has a devastating impact on the lives of those who experience it, their families and friends, and the wider society. Victims of domestic violence and abuse are more likely to be repeat victims than victims of other crimes, and domestic violence and abuse is likely to become more frequent and more serious the longer it continues. Risk factors and risks associated with domestic violence and abuse include: female gender, rape and sexual violence, previous assault, stalking, child abuse, pregnancy, separation, discrimination, isolation, immigration, age, sexuality, relationship inequality, poverty and social exclusion, increased risk of abuse, serious injury or death of children and young people, mental ill-health, alcohol and substance misuse and homelessness.

When the Domestic Violence and Abuse Joint Strategic Needs Assessment (JSNA) was commissioned in 2013, a local Domestic Violence Strategy was already in place and a Domestic Abuse and Sexual Violence Group (DASV) chaired by Croydon Council's Chief Executive took charge of strategic developments to reduce DASV in Croydon. During the development of this chapter, the DASV developed a draft action plan involving all major local partners. (Appendix 8.4 Domestic Abuse and Sexual Violence action plan 2014/15**)**

Emerging findings from the JSNA informed further development of the draft action plan, provided an update on available evidence and local data for benchmarking domestic violence and abuse in Croydon.

Using BCS data, it is estimated that the prevalence of domestic violence and abuse in Croydon is likely that around 13,700 women and 8,800 men have experienced at least one incident of domestic violence and abuse during 2011/2012. It is also likely that during the same period around 12,600 women experienced four or more incidents of domestic violence and abuse (with a mean average of 20 incidents) and just fewer than 1,000 men experienced four or more incidents (with a mean average of 7 incidents). However during the 12 month period from July 2011 to June 2012, there were 5,960 recorded allegations of domestic violence and abuse. A single person can be involved in more than one allegation. This indicates massive underreporting of domestic violence and abuse in Croydon.

In terms of violent crime in Croydon, between 2011/2012 and 2012/2013 there was an 8.4% increase in domestic violence allegations in Croydon and a 4.0% increase in offences. Croydon has the largest number of domestic violence offences by volume in London ranking 19th out of 32 London boroughs for the rate per 1000 population. At 7.0 per 1,000 population, Croydon's domestic violence rate is higher than the average for similar Crime and Disorder Reduction Partnership (CDRP) boroughs (5.7 per 1000 population) and for London as a whole (6.4 per 1,000 population). However, the increase in offences at 4.0% is less than the CDRP borough average (5.5%) and London's percentage increase of 6.0%.

While in the short term there has been an increase, over the long term domestic violence and abuse offences have remained fairly constant. Between 2004–2013 there was an average of 2502 recorded domestic violence offences per year with higher numbers of offences in 2005 (2963), 2008 (2639) and 2009 (2657) compared with 2506 in 2013. This is supported by BCS data which shows that nationally domestic violence and abuse prevalence remained fairly constant between 2008/2009 and 2011/2012.

Data on 'honour' based violence; FGM and forced marriage are not currently being systematically collected in Croydon, although these may be common within a number of local communities.

The majority of recorded victims of domestic violence and abuse in Croydon are

women aged 21-30 years (586 allegations) and women aged 31-40 years (426 allegations). For those aged 21-30 years, 31-40 years and 41-50 years, most victims and accused belong to the same age band. For victims under 21 years of age, most accused are between 21-30 years old but for victims aged 51 years and above, the perpetrators tended to be younger.

A small number of recorded allegations could be considered elder abuse. The best estimate based on national research prevalence rates and 2011 census figures, is that 1,154 Croydon residents aged 61 years and above experience elder abuse.

There are very poor data on domestic violence and abuse within lesbian, gay, bisexual and transgender (LGBT) communities.

An association between ethnicity and domestic violence allegations in Croydon cannot be demonstrated.

However, two domestic homicide reviews in Croydon have resulted in detailed recommendations which will have a significant impact on local organisations and services that engage with domestic violence, as well as related partnerships, policies, strategies, pathways and procedures. The local group leading on this is the Domestic Abuse and Sexual Violence (DASV) Group, made up of Chief Executives from partner agencies, the third sector and the community. This group produced the Domestic Violence Strategy and an Action Plan, which includes the recommendations from the two Domestic Violence Homicide reviews. The Safer Croydon Board will hold the responsibility to ensure the recommendations from both cases are taken forward. At the time of this JSNA (September 2014), the recommendations were still awaiting Home Office approval.

An emerging theme in Croydon's reviews and at a national level is the need to develop the response to domestic violence and abuse within healthcare services, including general practice, urgent care and the emergency services.

A mapping exercise identified a significant number of organisations and services in Croydon that specifically address domestic violence and abuse, together with a large number of organisations in the borough working with at-risk populations. This is a significant community asset that should be systematically supported and developed.

The Family Justice Centre and its associated services, including Multi Agency Risk Assessment Conferences (MARACs) and Independent Domestic Violence Advisors (IDVAs), are key components of domestic violence services in Croydon, but locally there are currently limited resources allocated to preventative domestic violence and abuse service.

In February 2014, the National Institute of Health and Care Excellence (NICE) issued Public Health guidance on 'Domestic violence and abuse: identification and prevention'. This was supported by an extensive review of the evidence for the effectiveness of interventions to prevent, identify and respond to domestic violence in

healthcare settings. Given the nature of domestic violence and abuse, robust evidence is often difficult to produce. However, there are a number of interventions with good evidence to support their implementation.

For example, evidence shows that media campaigns have the potential to raise awareness of domestic violence and services available. There is moderate evidence that screening in health and care settings can improve identification, and advocacy is seen as a promising approach. There is also moderate evidence supporting counselling and other therapeutic interventions both for people who have experienced domestic violence and their perpetrators, and moderate to strong evidence that therapeutic interventions involving both mother and child are also effective.

There are gaps in evidence on Female Genital Mutilation (FGM), 'honour'-based violence or forced marriage, interventions to prevent elder abuse, lesbian, gay, bisexual and transgender experiences of domestic violence and abuse, the differences in outcomes of interventions for women and men, dating violence and intimate partner violence among adolescents, tailored approaches for women facing different levels of risk and whole-family interventions in response to domestic violence.

NICE recommendations focus on service strategy and planning, identification and support for those at risk of domestic violence and abuse, and training for staff involved with victims and perpetrators.

2 Introduction

2.1 Background

Domestic and sexual violence is an international, national and local widespread problem affecting women, men, and children from all walks of life regardless of ethnicity, sexuality and socio-economic status. It can have devastating consequences in terms of health and wellbeing for the individuals, their families and the wider society.

Domestic violence has become a priority issue in Croydon due to a perceived increase in the number of allegations and offences in the borough and also due to the occurrence of two domestic homicides and the resulting homicide reviews.

This Joint Strategic Needs Assessment (JSNA) into Domestic Violence (DV) was commissioned in 2013 despite the existence of a local Domestic Violence Strategy and in parallel to the formation of a Domestic Abuse and Sexual Violence Group (DASV) chaired by Croydon Council's Chief Executive. During the development of this JSNA chapter, the DASV began a major review of Croydon's strategy to reduce Domestic Abuse and developed a draft action plan involving all major local partners. (Appendix 8.4 Domestic Abuse and Sexual Violence action plan 2014/15)

This chapter reviews the current evidence of effectiveness of interventions and prevention in relation to domestic abuse and sexual violence. National and local data provide an overview of the prevalence and trends of domestic violence and abuse in Croydon to enable benchmarking of Croydon's efforts against domestic violence and abuse. To improve understanding of the domestic violence from those affected and about acceptable service provision, the views of members of the community and partnership organisations have been included in addition to a mapping of services currently available for victims and perpetrators of domestic violence and abuse in Croydon.

Findings and conclusions will inform the ongoing strategy development as well as the commissioning of services for the prevention and response to domestic violence and abuse in Croydon.

2.2 Why is Domestic and Sexual Violence an issue?

Following the launch of the Home Office Strategy to tackle violence against women and girls (VAWG) in March 2010[1], there has been renewed attention at a national level on domestic violence and its consequences for individuals and society.

[1] Call to end Violence against Women and Girls 2010 Home Office

Domestic violence and abuse is an international, national and local issue. Globally it is estimated that up to six out of every ten women experience physical and/or sexual violence in their lifetime[2].

The BCS[3] showed 7.3% of all women and 5.0% of men experienced domestic violence and abuse in 2011/2012. In 2012 in England & Wales, around 1.2 million women suffered domestic abuse, over 400,000 women were sexually assaulted, 70,000 women were raped and thousands more were stalked. One in five women (aged 16 – 59 years) has experienced some form of sexual violence since the age of 16.[4] Fewer than one in four people who suffer abuse at the hands of their partner, and only around one in ten women who experience serious sexual assault, report it to the police. These crimes are often hidden with the victims suffering in silence.[5]

Using the BCS data[6] it is possible to estimate the prevalence of domestic violence and abuse in Croydon. It is likely that around 13,700 women and 8,800 men experienced at least one incident of domestic abuse during 2011/2012, It is also likely that during the same period, around 12,600 women experienced four or more incidents of domestic abuse (mean average of 20 incidents) and just fewer than 1,000 men experienced four or more incidents (mean average of seven incidents). However, in Croydon, during the 12 month period from July 2011 to June 2012, there were just under 6,000 allegations of domestic violence and abuse, of which around 1,800 were allegations of violence of a serious nature, including grievous and actual bodily harm, rape and harassment.[7] Whilst a single person can be involved in more than one allegation, there is almost certainly underreporting as to the actual extent of domestic violence and abuse in the borough.

It has been estimated that the annual cost of domestic violence and abuse for Croydon is £100 million.[8] Daily, local individuals and families experience the direct and indirect effects of domestic violence and abuse, the impact on individuals' livelihoods, health, and the ability to parent their children.

Domestic violence and abuse are complex issues that require sensitive handling by professionals in many fields which include health, social care, legal, criminal justice and housing. Most of this violence and abuse is perpetrated by men on women and girls, although men also experience domestic violence and abuse, and it occurs in same sex relationships. Children and young people can experience domestic

[2] WHO Multi-country Study on Women's Health and Domestic Violence against Women WHO, 2005
[3] Focus on Violent Crime and Sexual Offences, 2011/12 Statistical Bulletin 2013 ONS
[4] An overview of Sexual Offending in England and Wales. Ministry of Justice, Home Office & The Office for National Statistics 2013
[5] Call to end Violence against Women and Girls 2010 Home Office
[6] Focus on Violent Crime and Sexual Offences , 2011/12 Statistical Bulletin 2013 ONS
[7] Metropolitan Police data
[8] Croydon Domestic Abuse and Sexual Violence Strategy 2012-2015

violence and abuse when they are exposed to it within their families and within their own intimate relationships.[9]

Young people may also perpetrate domestic violence and abuse in their own intimate relationships and of increasing concern but anecdotally reported as a common problem, is child-to-parent violence, also referred to as parent abuse. This can be in the form of physical and mental abuse.[10]

Whilst evidence suggests that boys are more likely to be physically abusive than girls, aggressive behaviour by girls is increasing and mothers are more frequently the victims.[11]

Increasing evidence indicates that there are distinct links between domestic and sexual violence with inequalities, mental ill-health, health and wellbeing, homelessness, alcohol and substance misuse, child poverty, and children in care.[12] [13] [14]

2.3 Defining Domestic Violence[15]

Domestic violence and abuse is any incident or pattern of incidents of controlling, coercive, 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. The abuse can encompass, but is not limited to psychological, physical sexual, financial and emotional abuse.

In 2013 the definition of domestic violence was widened to include 16-17 year olds and whilst not a legal definition, the wording changed to reflect coercive control, and includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and victims are not confined to one gender or ethnic group. This new definition recognises that 16-17 year olds can also be victims of domestic violence and abuse.

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

[9] Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively 2014 NICE Public Health Guidance 50
[10] The Enemy Within. 4Children. 2012
[11] Break4change Youth Justice Board 2009
[12] No health without mental health: a cross cutting, a cross-government mental health outcomes DH 2011
strategy for people of all ages
[13] Reducing demand, restricting supply, building recovery: supporting people to live a drug free life DH 2010
[14] The government's alcohol strategy 2012
[15] https://www.gov.uk/domestic-violence-and-abuse

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 the victim.[16]

Domestic violence is a learned intentional behaviour and perpetrators choose this behaviour to get what they want and gain control frequently avoiding taking responsibility for their behaviour, by blaming their violence on someone or something else, denying it took place at all or minimising their behaviour.[17]

These behaviours whilst not inherently violent or criminal offences may include:

Psychological and emotional violence which includes harassment; destructive criticism; threats; verbal abuse; isolation; destroying possessions; humiliation and degradation and a range of other abusive behaviours. [18]

Physical violence which may include punching; slapping; hitting; biting; pinching; kicking; pulling hair out; pushing; shoving; burning or strangling.[19]

Sexual violence within a domestic violence context (perpetrated by current or former partners and/or family members) includes rape, sexual assault, sexual abuse and exploitation. The majority of rape and sexual assault takes place within this context but is often poorly recognised. In addition there is an association between the existence of physical violence in adult relationships and child sexual abuse within the family.[20]

Financial abuse is one of the most prominent forms of control tactics involving three distinct but overlapping factors, all of which can have a negative impact on a survivor's economic wellbeing. These include the perpetrator using male privilege to exploit existing economic disadvantage; causing survivors to incur financial costs as a result of domestic violence, and using economic abuse to deliberately threaten their economic security.[21]

Female Genital Mutilation (FGM), also known as female circumcision or female genital cutting, involves procedures that include partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or other non-medical reasons. Medically this is unnecessary, extremely painful and depending on the degree of mutilation, has serious short and long term health consequences both physically and psychologically. The origins of FGM are complex but it generally derives from beliefs that it is a religious requirement or a necessary

[16] Information for Local Areas on the change to the Definition of Domestic Violence and abuse 2013 Home Office
[17] www.womensaid.org.uk accessed 07.03.2014
[18] www.womensaid.org.uk accessed 07.03.2014
[19] www.womensaid.org.uk accessed 07.03.2014
[20] WHO Multi-country Study on Women's Health and Domestic Violence against Women WHO 2005
[21] www.womensaid.org.uk accessed 07.03.2014

rite of passage to womanhood, that it ensures cleanliness or better marriage prospects, prevents promiscuity and excessive clitoral growth, preserves virginity and enhances male sexuality. It also relates to tradition, power inequalities and the compliance of women.

When mutilation is performed ranges from a few days old to adolescence, before marriage and occasionally on pregnant women and widows.[22]

FGM is illegal in the United Kingdom (UK) either to perform or arrange for a girl to be taken abroad to have it performed. However, it is estimated that over 20,000 girls under the age of 15 years are at risk of FGM in the UK each year, and 66,000 women in the UK are living with the consequences of FGM. However, due to the hidden nature of this crime the full extent is unknown.[23]

The largest communities in the United Kingdom where women are at risk of FGM are those with backgrounds from Kenya, Nigeria, Ghana, Uganda, Somalia, Tanzania, Sierra Leone, Egypt, Ethiopia and Sudan. The countries with the highest rates of prevalence are Djibouti (98%), Egypt (97%), Somalia (97%), Mali (91.6%), Sierra Leone (90%), North Sudan (90%), Eritrea (88.7%), Ethiopia (79.9%), Gambia (79%) and Burkina Faso (76.6%).[24]

Forced Marriage

In the UK, forced marriage is recognised as a form of violence against women and men, domestic /child abuse and a serious abuse of human rights. A forced marriage is where one or both people do not (or in cases of people with learning disabilities, cannot) consent to the marriage and pressure or abuse is used. This can be in the form of physical (including threats, actual physical violence and sexual violence) or emotional and psychological, financial, sexual and emotional pressure.

There is a clear distinction between forced marriages and an arranged marriage. In an arranged marriage, the families of both spouses take a leading role in arranging the marriage but the choice whether or not to accept the arrangement remains with the prospective spouses.

Forced marriages affect people across culture, class and religion and happen worldwide tending to originate from Asia.[25]

In 2012, the Forced Marriage Unit (FMU) received 1485 reports of possible forced marriages; however the true scale of forced marriage is unknown.

[22] A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales. Dorkenoo E et al. 2007. DH
[23] http://www.nhs.uk/conditions/female-genital-mutilation/Pages/Introduction.aspx
[24] A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales. Dorkenoo E et al. 2007. DH
[25] The Right to Choose: multi-agency statutory guidance 2013 Foreign and Commonwealth office

Honour crime or honour based violence

Honour crime or honour- based violence consists of a variety of crimes of violence (mainly but not exclusively against women), including assault, imprisonment and murder where the person is being punished by their family or their community. They are being punished for actually, or allegedly, undermining what the family or community believes to be the correct code of behaviour. Not conforming to this code of behaviour brings shame or dishonour on the family.[26]

Honour- based violence can exist in any culture or community where males are in position to establish and enforce women's conduct but males can also become victims when a relationship has been deemed as inappropriate.[27]

2.4 The Financial Cost of the Problem

In 2004, Professor Sylvia Walby[28] looked at the rate of domestic violence, the use of services, the costs of those services, lost economic output, and the human cost of pain and suffering to estimate the cost of domestic violence to the state and society. For the purposes of the report, domestic violence was considered to comprise of physical violence, sexual violence and threatening behaviour, including stalking between intimate partners.

In her updated report of 2009[29], Professor Walby estimated that in England and Wales, domestic violence costs almost £6 billion annually: £4 billion in service use and £2 million in lost economic activity. In total, 3% of NHS expenditure was believed to be due to physical injuries associated with domestic violence. An additional £10 billion was thought to be incurred in human and emotional costs. This figure was based on surveys which estimated the monetary value of the pain and suffering endured as a result of road traffic accidents. These values were then applied to similar levels of physical injury as a result of different forms of domestic violence.

Walby's report was built on by Trust for London and the Henry Smith Charity[30], who used the work to break down the costs incurred within each local authority area. This breakdown estimates that annually, Croydon incurs £37.4 million in tangible costs, and a further £64.5 million in human and emotional costs (Table 1). These costs are incurred by health and social care services, criminal justice services, local government, local employers, and individuals themselves.

[26] The Right to Choose: multi-agency statutory guidance 2013 Foreign and Commonwealth office
[27] http://www.domesticviolencelondon.nhs.uk/1-what-is-domestic-violence-/17-honour-based-violence.html accessed 07.03.2014
[28] Walby S. (2004) The Cost of Domestic Violence. London
[29] Walby S. (2009) The Cost of Domestic Violence. Lancaster
[30] Trust for London and the Henry Smith Charity (2011) Costs of domestic violence per local area. Available online at: http://www.avaproject.org.uk/media/60461/costs%20of%20dv%20by%20local%20authority.pdf Accessed 19th February 2014

Table 1: the estimated cost of domestic violence in Croydon based on 2009 population estimate of people aged 16-59 years

	Cost (£millions)
Physical and mental health care costs	11.2
Criminal justice costs	8.2
Social services costs	1.8
Housing and refuges	1.3
Civil legal services	2.5
Lost economic output	12.4
Total costs (not including human and emotional costs)	37.4
Human and emotional costs (not included in total)	64.5

Source: Trust for London and the Henry Smith Charity (2011)

It is likely that the costing described above is a significant underestimate of the economic impact of domestic violence for a number of reasons:

- domestic violence is widely acknowledged to cause more mental trauma compared to the road traffic accidents on which the human cost is based, even for similar levels of physical injury;
- no account was taken of lost economic output due to the mental effects of domestic violence;
- no account was taken of the likely significant long-term effect on children exposed to violence in the home;
- no economic impact resulting from support from family, friends and wider society was taken into account;
- only violence between intimate partners was included, while violence among other family members was excluded;
- the local figure is only based on people aged 16 – 59 years, while elder abuse is excluded.

2.5 Risk Factors

Domestic violence and abuse has a devastating impact on the lives of those who experience it, their families and friends, and wider society.[31] Victims of domestic violence and abuse are more likely to be repeat victims than other victims of crime, and domestic violence and abuse is likely to become more frequent and more serious the longer it continues. Long-term consequences include post-traumatic

[31] Cross government action plan on Sexual Violence and Abuse DH 2007

stress disorder, anxiety and panic attacks, depression, social phobia, substance abuse, obesity, eating disorders, self-harm and suicide.

Research in the UK in the last ten years has identified significant risk factors associated with domestic violence; in terms of it starting, escalating and resulting in homicide.

Gender

While both men and women may experience incidents of interpersonal violence, gender is a significant risk factor[32] with women more likely than men to experience interpersonal violence, especially sexual violence, and to experience severe and/or repeated, often life-threatening, incidents of violence and abuse. Women under the age of 30 years are at a greater risk than those over the age of 40 years, with coercive control a key indicator of domestic homicide.

However, when female to male violence is serious and risk of injury is high, female perpetrators are more likely to use weapons but this may be in self-defence.[33]

Rape and sexual violence

Sexual violence is any unwanted sexual act or activity. There are many different kinds of sexual violence, including but not restricted to: rape, sexual assault, child sexual abuse, sexual harassment, rape within marriage / relationships, forced marriage, so-called honour-based violence, female genital mutilation, trafficking, sexual exploitation, and ritual abuse. Sexual violence can happen to anybody and be perpetrated by a complete stranger, or by someone known and even trusted, such as a friend, colleague, family member, partner or ex-partner.[34]

Those who are sexually assaulted are subjected to more serious injury, and those who report a domestic sexual assault tend to have a history of domestic violence whether or not it has been reported previously.

Rape is associated with the most severe cases of domestic violence, and is a risk factor for domestic homicide.

From 2011 to 2012, 211 cases of rape and 271 other sexual offences were reported in Croydon, but according to the BCS, 24% of women had suffered some form of sexual violence since the age of 16. Research also shows that around 10,000 women are sexually assaulted and 2,000 women are raped every week. However, statistics are unlikely to reveal the full extent of sexual violence perpetrated against women because of the small number of survivors willing to report. It is well documented that the offence of rape is under-reported due to what has been referred

[32] British Crime Survey Walaby and Allen 2004
[33] http://www.respect.uk.net accessed 08.03.2014
[34] http://www.rapecrisis.org.uk/rapeampsexualviolence2.php accessed 07.03.2014

to as a "culture of scepticism" that sometimes meets survivors of sexual violence when they report rape, and the lack of organisations to support them.

Human Trafficking

A victim of human trafficking is someone who has been recruited or moved into a situation of exploitation by deception or coercion. Domestic violence and abuse is fundamentally linked to human trafficking where it relates to abuse of the victim for the purposes of sexual exploitation and domestic servitude amongst others. Human trafficking (modern day slavery) is a severe infringement on the human rights of the victim where through the exploitation of the victim's position of vulnerability, the trafficker secures compliance possibly benefitting financially from the victim's suffering.[35]

Previous assault

Previous physical domestic assault is the simplest, most robust risk marker of subsequent domestic assault. 35% of households have a second incident within five weeks of the first, and minor violence is a predictor of escalation to major violence.[36]

Stalking

Stalking is defined as a repeated and persistent unwanted communications and /or approaches that produce fear in the victim. Stalkers are more likely to be violent if they have had an intimate relationship with the victim. Furthermore, stalking and physical assault are significantly associated with murder and attempted murder.[37]

Child abuse

There is evidence of co-occurrence of domestic violence and child abuse in the same family. Child abuse can be seen as an indicator of domestic violence and abuse in the family and vice versa.[38]

Pregnancy

Domestic abuse during pregnancy has serious consequences for maternal and infant health. Evidence also suggests that around 30% of domestic violence and abuse starts or worsens during pregnancy and is higher in the immediate months following the birth of the baby.[39]

Separation

Women who are in the process of separating or who have separated from their partner are at much higher risk of domestic violence and abuse than women in any

[35] Victims of Human Trafficking – guidance for frontline staff. Home Office 2013
[36] Reducing Domestic Violence What works? Walaby S & A Myall University of Leeds 2000
[37] http://www.dashriskchecklist.co.uk accessed 07.03.2014
[38] http://www.dashriskchecklist.co.uk accessed 07.03.2014

[39] http://www.dashriskchecklist.co.uk accessed 07.03.2014

other marital status. Victims trying to leave relationships or after leaving a violent partner are at greatest risk of being murdered, and many incidents happen as a result of child contact or disputes over residence.[40]

Disability and isolation

There is an increased risk of domestic violence and abuse for women with a disability or additional support needs. Women isolated from friends, family, colleagues or community networks, or who live in rural or isolated communities are more vulnerable to escalating violence as a result of their isolation. There is no evidence to suggest that women from some ethnic or cultural communities are any more at risk than others, but cultural factors may result in additional risks including: extended family members as perpetrators; isolation due to language issues; fear of repercussions from the family and wider community; inappropriate responses and racism from mainstream agencies.[41]

Immigration

There are large numbers of women who experience domestic violence and abuse who have 'no recourse to public funds' because of their immigration status and therefore do not have access to statutory services or safe housing. Some women's immigration status may be secure but their abuser may exploit their lack of knowledge about immigration systems.[42]

Age

Women under the age of 30 years are at considerably greater risk than those over the age of 40 years.[43] However, in the elderly there is increased vulnerability which increases the risk of abuse. Factors leading to elder abuse can include: social isolation, poor quality long term relationships, patterns of family violence, dependency, alcohol, drug and mental health problems. Identification is difficult because of the victim's reluctance to disclose. This may be due to a range of factors including: denial, shame, the hope that it will not happen again, guilt and practicalities.

Sexuality

Every individual's experience of domestic violence and abuse will be unique. However, lesbian, gay, bisexual and transgender (LGBT) individuals are likely to face additional concerns around homophobia and gender discrimination, not being recognised as victims, believed or taken seriously. LGBT individuals are less likely to report domestic violence with the threat of 'outing'.[44]

---

[40] www.womensaid.org.uk accessed 07.03.2014
[41] Making the links disabled women and domestic violence Final Report. Hague, G et al. 2007
[42] Commissioning domestic violence services – a quick guide. Women's Aid 2009
[43] British Crime Survey, Walby & Allen, 2004
[44] http://www.domesticviolencelondon.nhs.uk accessed 07.03.2014

Relationship inequality

Marital dependency and lack of economic resources increases the risk of violence where women are unemployed or housewives, compared to egalitarian partnerships.[45]

Poverty and social exclusion

There is an associated risk between poverty, people living in poor and financially insecure households and domestic violence and abuse. Domestic violence and abuse can lead to poverty by making it more difficult for the victim to maintain employment or possibly increasing ill health. In addition, unemployment and lack of money may make it harder for a victim to leave a violent partner. However, domestic violence is not confined to those who are poor. It is also seen in families who are financially secure.[46]

Children and Young People

Children and young people are at an increased risk of abuse, serious injury, or death if they are exposed to domestic violence and abuse, but there are also long term consequences of witnessing domestic violence. Children may be placed into care or placed in potentially unsafe contact arrangements on separation. Witnessing domestic violence and abuse may result in subsequent substance abuse, depression, trauma symptoms, self-harm or suicide attempts.[47]

Domestic violence and abuse in teenage relationships is very common with girls reporting greater incidence rates of teen relationship abuse, experience of more severe abuse more frequently, and more negative impacts on their welfare, compared with boys.[48]

Mental Health

The experience of abuse can have major long-term effects for mental wellbeing with depression, severe anxiety, panic attacks and post-traumatic stress disorder being the most common consequences of abuse.[49]

Domestic violence often results in self-harm and attempted suicide; one third of women attending emergency departments for self-harm were domestic violence survivors; abused women are five times more likely to attempt suicide, and one third

[45] British Crime Survey, Walby & Allen, 2004
[46] Reducing domestic violence.. what works? Assessing and managing the risk of domestic violence Walby,S and Myhill A. 2000
[47] Every Child Matters. Research and practice briefings: children and families. 2006 Department for Education and Skills.
[48] Barter C. et al. 2009. Partner exploitation and violence in teenage intimate relationships. NSPCC
[49] The impact of abuse and neglect on the health and mental health of children and young people. Anne Lazenbatt NSPCC Reader in Childhood Studies, Queen's University Belfast February 2010

of all female suicide attempts can be attributed to current or past experience of domestic violence.[50]

Alcohol and substance misuse

Alcohol and drugs do not cause or excuse domestic violence, but when alcohol and drugs are combined with domestic violence, the risks to women and children are increased. These include increased severity of abuse by perpetrators and increased risks of dependency on substances as a coping mechanism by survivors from the pain, fear, isolation and guilt that are associated with violence.[51] Women experiencing domestic violence are 15 times more likely to misuse alcohol and nine times more likely to misuse drugs than non-abused women.[52] Those who access drug and alcohol services often have current or past experience of domestic violence.

Domestic Violence and Homelessness

Re-housing victims of domestic violence is a mainstream activity of every local authority housing service.[53] Between April 2009 and June 2009, 1500 households were accepted as homeless and in priority need of re-housing by councils in England because of violence by a partner. This represented 14 per cent of the total applications and was the second largest category after parents were no longer able to accommodate family members.

Survivors of domestic violence need housing related support either to make it possible for them to remain safely in their own homes, or to support them if they are forced to move to alternative accommodation. Some women who escape domestic violence face homelessness or destitution, and many are forced to remain in temporary accommodation for long periods of time while they seek re-housing.[54]

[50] http://www.womensaid.org.uk/domestic-violence accessed 07.03.2014
[51] Guidance for domestic abuse and alcohol and drug services in Lanarkshire. Lanarkshire ADP. 2011
[52] Why mothers die 1997-1999: Report from the Confidential Enquiries into Maternal Deaths in the United Kingdom 2001 London: RCOG Press.

[53] Communities and Local Government Department 2009. Statutory Homelessness: 2nd quarter April – June 2009. England
[54] Meeting the needs of households at risk of domestic violence in England; the role of accommodation and housing-related support. November 2010 Department for Communities and Local Government

3 Data

Domestic Violence Criminal Justice Glossary

Allegation – a report of a crime to the police made either by a victim or by a witness. This will be given an initial classification – e.g. Common Assault, which may be later upgraded or downgraded to a more or less serious offence. Allegation data can include date, time and location information.

Arrest – following an allegation of a crime a person may be arrested. Not all crime allegations lead to an arrest, but in domestic violence, due to the nature of the crime and the victim's knowledge of the perpetrator, higher rates of arrests can be expected.

Offence – once the allegation has been confirmed it becomes an offence and is stripped of all attributes relating to date, time and location. These are the data that are reported to the Home Office and used for inter-borough comparison. A proportion of offence figure undergo re-classification into different offence categories.

3.1 Croydon Prevalence

At a national level, the most reliable estimates of the extent of domestic violence and abuse come from the British Crime Survey (BCS). The BCS asks people about their experience as victims and picks up more crime than the official police figures, as not all crimes are reported to the police, and not all those reported are recorded. Given that there are no statistically significant regional variations in domestic violence rates, extrapolation from this national data can be used to determine local prevalence. In the UK in 2011/2012, 7.3% of women (1.2 million) and 5.0% of men (800,000) reported having experienced domestic abuse[55]. Using 2011 Census data it can be estimated that:

- **13,666 women and 8,810 men experienced domestic violence and abuse in Croydon during 2011/2012.**

Of all the respondents recording experience of domestic violence and abuse, 89% of women experienced four or more repeat incidents (with a mean average of 20 incidents per victim) compared to 11% of men (with a mean average of 7 incidents per victim) meaning that:

- **12,163 women and 969 men experienced four or more incidents of domestic violence and abuse in Croydon during 2011/2012.**

[55] http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/focus-on-violent-crime/stb-focus-on--violent-crime-and-sexual-offences-2011-12.html

However:

- **From April 2011 to March 2012, there were only 5,960 recorded allegations of domestic violence and abuse. A single person can be involved in more than one allegation so the number of victims this represents is likely to be even smaller.**

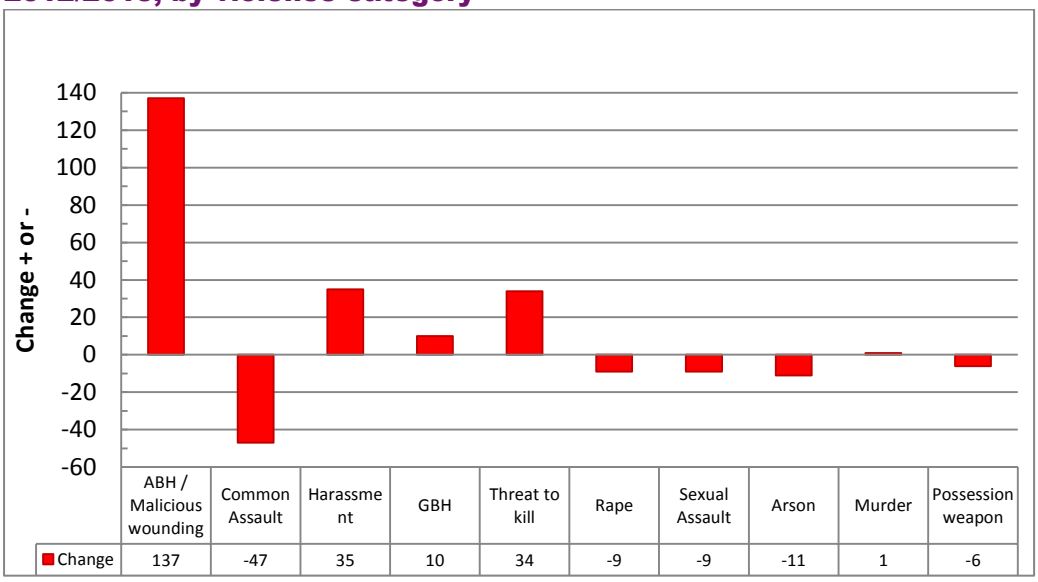
Table 2 shows that while the proportion of female and male victims has remained similar in terms of allegations of domestic violence from 2011/2012 to 2012/2013, there has been an 8.4% increase (159 additional allegations) recorded during this time period.

Figure 1 shows that most of this is due to an additional 137 allegations of actual bodily harm (ABH) / malicious wounding. However, during this period there were 47 fewer allegations of common assault, potentially pointing to a partial change in recording rather than simply a change in the nature of incidents.

Table 2: Number of domestic violence allegations for 2011/2012 and 2012/2013 by victim's gender, and degree of change

	Allegations (n)	Female victims (n)	Female victims (%)	Male victims (n)	Male victims (%)
2011/12	1,889	1,584	84	305	16
2012/13	2,048	1,683	82	365	18
Change	159 (+8.4%)	+99	-2%	+60	+2%

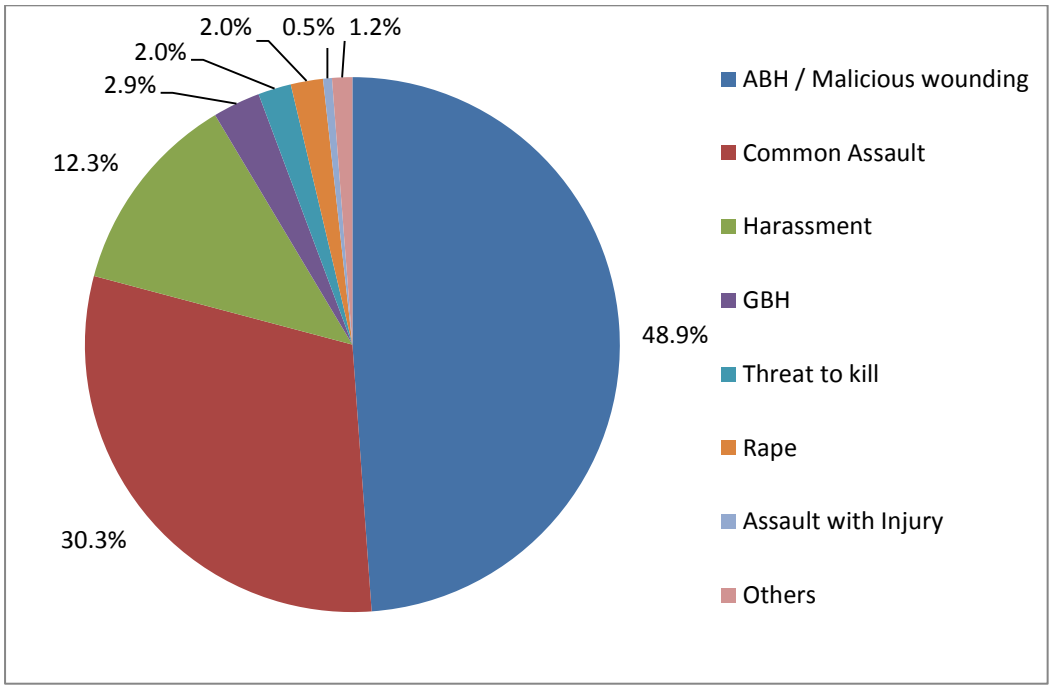
Figure 1: Change in number of domestic violence allegations from 2011/2012 to 2012/2013, by violence category



Source: Police Crime Report Information System (CRIS)

Figure 2 shows that the majority of domestic violence allegations relate to 'ABH / malicious wounding', 'common assault' and to a lesser extent 'harassment'. All of the categories with a significant number of allegations have around a 4:1 or greater female to male victim ratio except for grievous bodily harm (GBH), which has a ratio of 3:2 (although this category includes only a relatively small number of cases, meaning that such comparisons may not be reliable).

Figure 2: Domestic violence allegations by category 2012/13



Source: Police Crime Report Information System (CRIS)

3.2 Female Genital Mutilation

Data on Female Genital Mutilation (FGM) is not captured by police domestic violence data. A 2007 report by the Foundation for Women's Health Research and Development (FORWARD)[56] on the prevalence of FGM (that is, women living with mutilation) in England and Wales based on 2001 census data estimated that there were 65,790 women, or 0.1% of the total population, with FGM in 2001. The 2011 census found that the percentage of Croydon residents born outside the UK was much higher than the national average, at 29.6%, with 44.9% of residents belonging to Black and Minority Ethnic (BME) communities. Given that many of the communities living within Croydon are known to have high FGM prevalence rates, the current percentage of women with FGM in Croydon is almost certainly likely to be higher than the 0.1% estimate.

[56] http://www.forwarduk.org.uk/key-issues/fgm/research

Table 3 shows the FORWARD report's estimated numbers and proportion of women with FGM giving birth in Croydon.

Table 3: Estimated percentage of women resident in Croydon giving birth with FGM 2001 - 2004

Year	Number	Percentage
2001	106	2.43
2002	121	2.79
2003	132	2.91
2004	148	3.08

In 2012/13, 4,180 women gave birth at Croydon University Hospital. Croydon Healthcare Services do not collect data on FGM or on women with FGM who give birth, although the NSPCC FGM helpline notes that this is the practice at other midwifery departments in the country (personal communication).

However, as part of the UK government's commitment to ending the practice of FGM, from September 2014[57], all acute hospitals will be required to report data to the Department of Health:

- If the patient has had FGM
- If there is a family history of FGM
- If an FGM related procedure has been carried out on women

3.3 Forced Marriage

The Home Office and Foreign and Commonwealth Office Forced Marriage Unit (FMU) only provides data at a regional level. Between January and December 2012 the FMU gave advice or support related to a possible forced marriage in 1485 cases. Of these cases 21% were from the London region and 66% of the cases involved people from countries within South Asia.

3.4 Comparative Data and Trends

Comparative data are based on offences rather than allegations of domestic violence. Croydon reported 2,342 domestic violence offences in 2011/2012 and 2,436 in 2012/2013: an increase of 4.0% (Table 4). Croydon has the largest number of domestic violence offences of any of the London boroughs, but it is important to note that Croydon is also the capital's most populous borough. The domestic

[57] https://www.gov.uk/government/news/new-government-measures-to-end-fgm

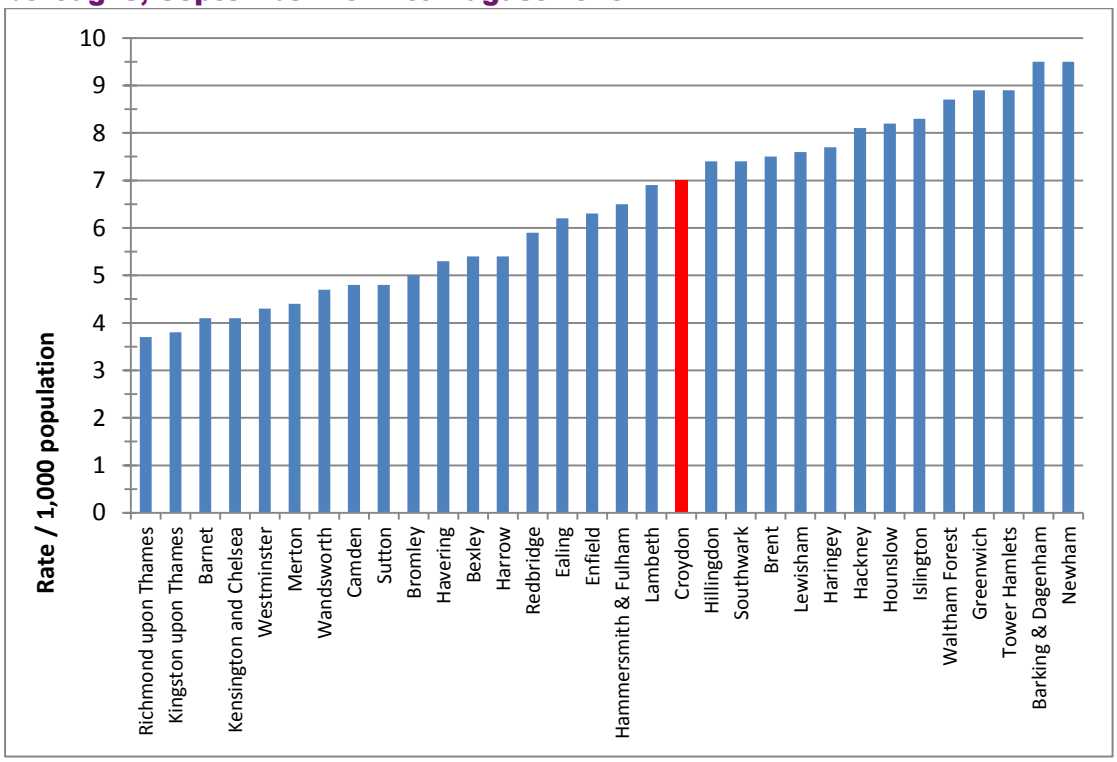
violence rate for Croydon is 7.0 offences per 1,000 population compared to 5.7 per 1000 population for similar Crime and Disorder Reduction Partnership (CDRP) boroughs and 6.4 per 1000 population for London as a whole. The recent 4.0% increase in offences is less than the 5.5% increase in similar CDRP boroughs and the 6.0% increase in London over the same period. In 2012/2013 Croydon ranked 19th out of the 32 London boroughs in terms of rates of domestic violence offences (Figure 3).

Table 4: Domestic violence offences for Croydon, Crime Reduction Partnership Boroughs and London, shown as number, volume and percentage change, and rate per 1,000 population, from September 2011- August 2013

Borough	September 2011 to August 2012	September 2012 to August 2013	Volume change	% change	Rate / 1,000 population
Croydon	2,342	2,436	+94	4.0%	7.0
'CDRP' borough average	1, 348	1,422	+74	5.5%	5.7
London	47,518	50,386	+2,868	6.0%	6.4

Source: Metropolitan Police Management Information System (MetMis)

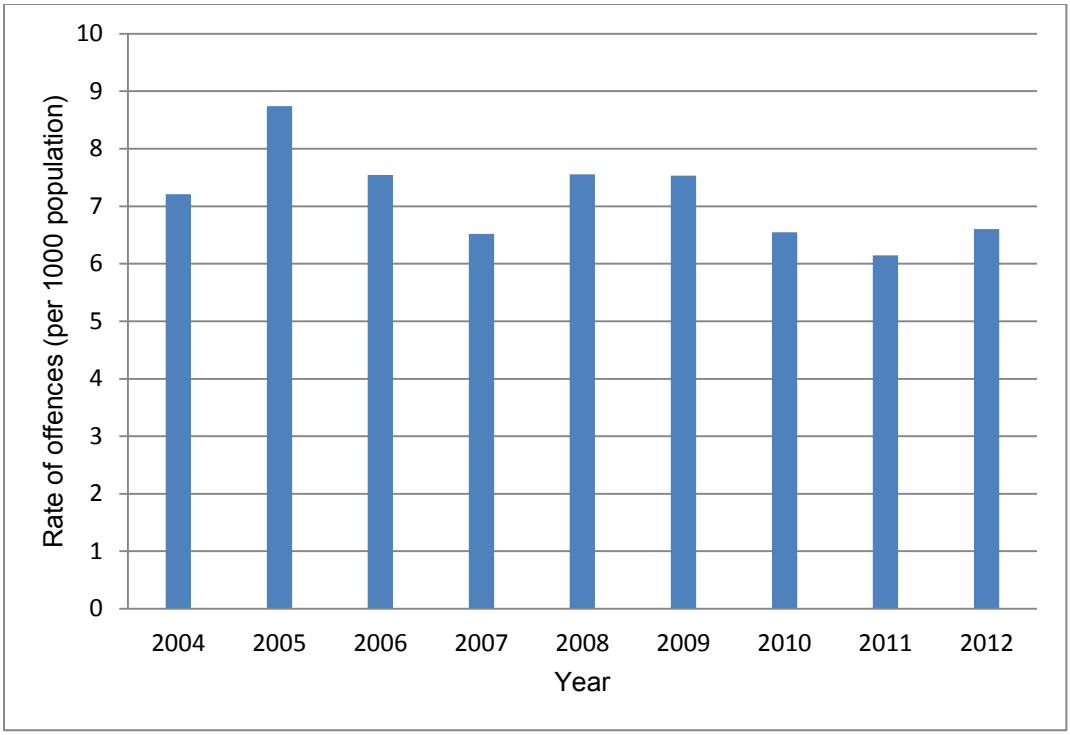
Figure 3: Rate of domestic violence offences per 1,000 population for all London boroughs, September 2012 to August 2013



Source: Metropolitan Police Management Information System (MetMis)

In Croydon, while there has been a short term increase in domestic violence offences, in the long term the number of offences has remained steady. Ten year data show an average of 2502 offences per year, with higher numbers of offences in 2005 (2963), 2008 (2639) and 2009 (2657) compared with the 2506 offences in 2013. Figure 4 shows the rate of domestic offences per 1000 population 2004 – 2012.

Figure 4: Rate of domestic violence offences per 1000 residents in Croydon, 2004-2012



Sources: 1) Mid-2001 to Mid-2012 Population Estimates: Components of Population change for local authorities in the United Kingdom: usual residents. ONS, 2013. Accessed 24/01/14; 2) Metropolitan Police

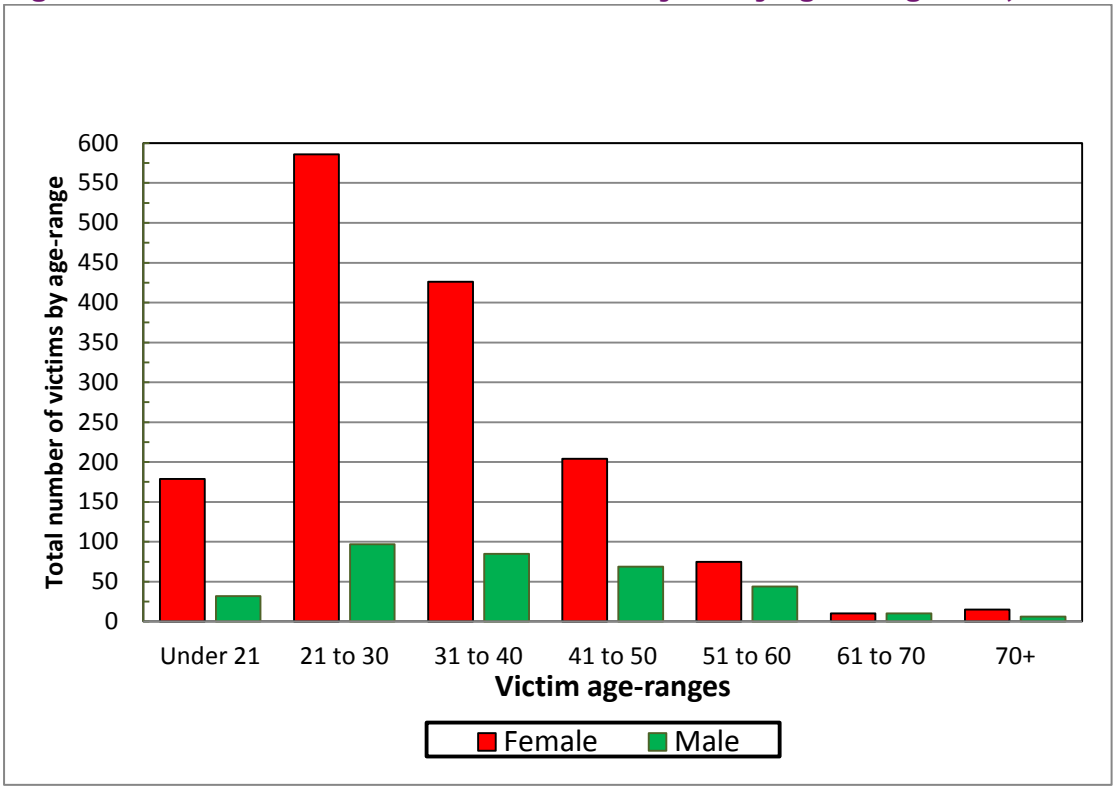
There has been little change in the rate of domestic violence in Croydon and nationally this is similar to the findings of the Crime Survey for England and Wales 2011/2012 who suggest very little change in the rate of self-reported domestic violence from 2008/2009.

3.5 Victims and Perpetrators

3.5.1 Age and gender

In 2012/2013, the majority of victims of domestic violence in Croydon were women aged 21-30 (586 allegations), and women aged 31-40 (426 allegations) (Figure 5).

Figure 5: Victims of domestic violence in Croydon by age and gender, 2012/2013



Source: Police Crime Report Information System (CRIS)

For victims of DV aged 21-30 years, 31-40 years and 41-50 years the majority of perpetrators are in the same age range, whilst for victims under 21 years, nearly a half of the perpetrators are aged between 21 and 30 years and for victims aged 51+ years, the perpetrators tend to be younger[58].

There are a small number of reported instances of domestic violence allegations that could be considered elder abuse as the victim is aged 61 or above. The UK Study of Abuse and Neglect of Older People[59] indicated that 2.6% of people aged 66 and over, living in private households, reported that they had experienced mistreatment involving a family member, close friend or care worker (i.e. those in a traditional position of trust) during the past year. This would amount to 1154 Croydon residents aged 65+ based on 2011 census figures. However, it is worth noting that abuse and neglect perpetrated by a care worker would not be defined as domestic abuse under the current Home Office definition[60].

[58] Police Crime Report Information System (CRIS)
[59] https://www.warwickshire.gov.uk/Web/corporate/wccweb.nsf/Links/6EA919F805F3B54180257885002E4C6B/$file/Full+Report_UK+Study+of+Abuse+and+Neglect+of+Older+People+v2.pdf
[60] https://www.gov.uk/domestic-violence-and-abuse

3.5.2 Ethnicity

The 2011 census found that the largest ethnic group in Croydon was White, followed by Black, Asian and Mixed groups (Table 4).

Table 4: Ethnicity of Croydon residents 2011

Ethnicity	%
White	55.1
Black	20.2
Asian	16.4
Mixed	6.6
Other	1.8

Source: ONS 2012

Self-reported ethnicity as recorded in the census does not always correspond to the police identity code (IC)[61], which is based on an individual's visual appearance as perceived by the police officer. However for the purposes of comparison here, IC1 and IC2 will be considered as White, IC3 as Black, IC4 as Asian, and IC5 and IC6 as Other. The census category "Mixed" (reflecting 6.6% of Croydon residents) has no direct IC equivalent.

Categorisation of domestic violence victims and perpetrators by IC code shows a similar pattern to the census profile for all groups except 'Black'. The proportion of victims and accused described by IC codes as Black is nearly double what would be expected (Table 5).

[61] http://www.listpoint.co.uk/CodeList/details/EthnicAppearance6PointCodeClass/3.1/1

Table 5: Male and female victim and accused IC code by number and percentage 2012/2013

IC Code	Ethnicity	Female victim (n)	Female victim (%)	Male victim (n)	Male victim (%)	Female accused (n)	Female accused (%)	Male accused (n)	Male accused (%)
1	White: North European	831	50.2	178	50.1	43	48.9	277	43.1
2	White: South European	51	3.1	18	5.1%	6	6.8	32	5.0
3	Black	572	34.5	116	32.7	31	35.2	243	37.9
4	Asian	185	11.2	41	11.5	6	61.8	74	11.5
5	Other: includes: Chinese, Japanese or South East Asian	9	0.5	1	0.3	1	1.1	4	0.6
6	Other includes: Arab / North African	8	0.5	1	0.3	1	1.1	12	1.9
Total		1656		355		642		88	

Source: Police Crime Report Information System (CRIS)

3.5.3 Sexuality

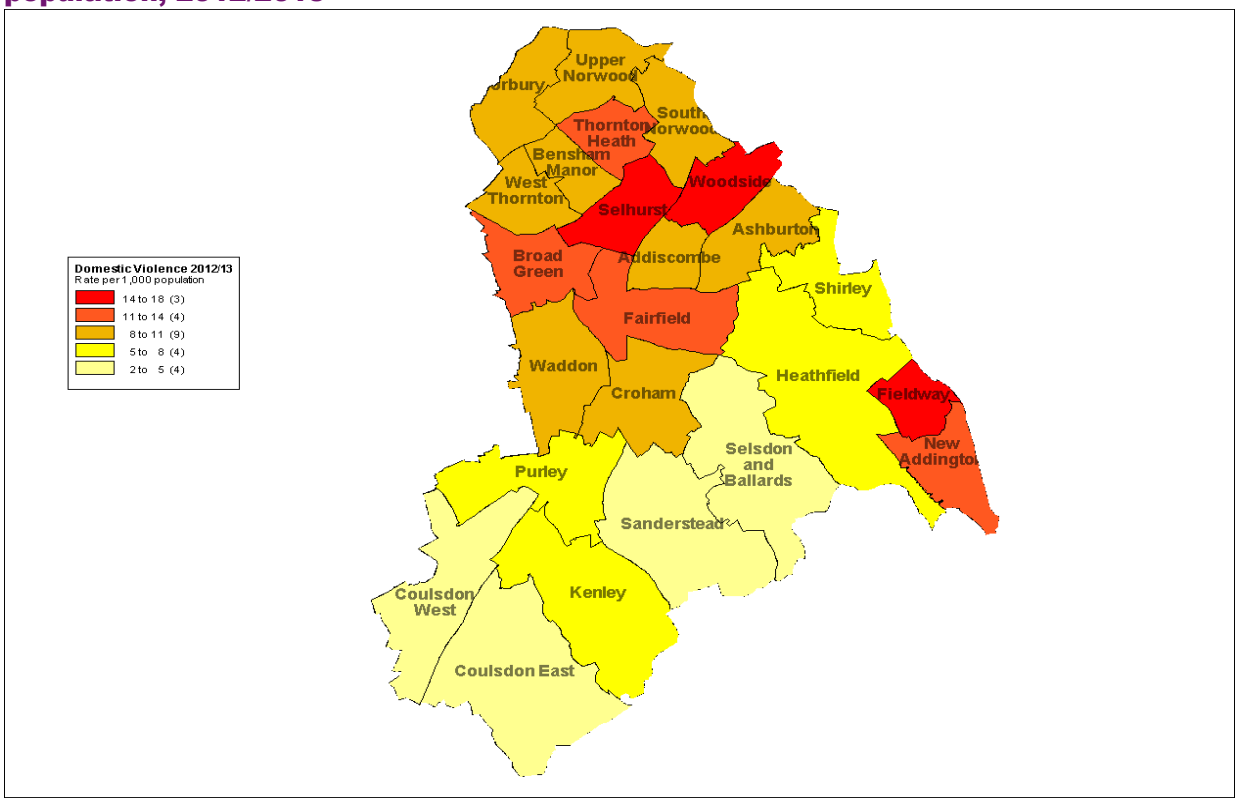
There is no self-reported data on sexuality and domestic violence available for Croydon, and it is only possible to make very rough estimates of recorded same sex domestic violence prevalence from data on the accused and victim gender. In 2012/2013 there were 67 allegations of domestic violence in which the victim and the accused were of the same sex. These comprised of 9% of all allegations where genders of both victims and accused were recorded. The Greater London Authority (GLA) has estimated the lesbian-gay-bisexual (LGB) population of London as being around 10%, suggesting that the risk of domestic abuse within same sex relationships in Croydon may be broadly similar to the risk within heterosexual

relationships. However, it must be noted that these data include violence between same sex family members, in addition to intimate same sex partners.

3.6 Domestic violence location

Rates of domestic violence in Croydon are higher in the more deprived areas in the north of the borough, and in Fieldway and New Addington than in the less deprived south of the borough (Figure 6).

Figure 6: Rates of alleged domestic violence per 1,000 residents by ward population, 2012/2013



Source: Police Crime Report Information System (CRIS)

Croydon wards with the highest (Selhurst) and lowest (Selsdon and Ballards) rates of DV have retained these positions over time. The wards showing notable increases in numbers of allegations are Fieldway (+60), Woodside (+ 57), Norbury (+56) and Ashburton (+46). The only wards recording a reduction in DV numbers are South Norwood (-11) and Purley (-10).

4 Evidence Review

4.1 NICE evidence review

In 2013, NICE commissioned the British Columbia Centre for Excellence in Women's Health to review of the evidence[62] surrounding the topic and a full summary is presented in appendix 8.1.

The review aimed to investigate "interventions to identify, prevent, reduce and respond to domestic violence between family members or between people who are (or who have been) intimate partners"[62] and focused on five areas:

1. Prevention
2. Identifying and intervening to prevent domestic violence
3. Responding to domestic violence
4. Interventions for children exposed to domestic violence
5. Partnership approaches to domestic violence

A large number of gaps were identified in the evidence, where no or very little research existed. However, some significant findings were uncovered, and included:

- the use of screening tools, antenatal screening, and that cueing (providing information about a patient prior to a clinical encounter) improves identification of domestic violence
- moderate evidence of improvements in domestic violence outcomes within advocacy, skills-building, counselling and brief interventions, therapy, individual interventions for abusers, short duration group interventions measuring attitudinal, psychological and interpersonal outcomes, and couples' interventions including substance use treatment.
- where children are exposed to domestic violence, interventions aimed at both mothers and children together appear to have the most positive impact on outcomes
- Partnerships to address domestic violence were effective at increasing referrals, reducing further violence, and supporting victims of domestic violence.

4.1.1 Interventions in educational and youth service settings

Another NICE evidence review[63] investigated interventions focusing on health literacy and personal skills in relation to alcohol, sex and relationships for primary school aged children. The review found moderate evidence that such interventions improved children's knowledge, communication skills, behaviours, academic

[62] British Columbia Centre of Excellence for Women's Health (on behalf of NICE) (2013) Review of Interventions to Identify, Prevent, Reduce and Respond to Domestic Violence. Available online at: http://www.nice.org.uk/nicemedia/live/12116/64791/64791.pdf . [Accessed online on 10th February 2014]
[63] http://www.nice.org.uk/guidance/gid-phg0/resources/pshe-evidence-review-primary-education2

performance and attachment to school. However, there is no evidence that incorporating domestic or dating violence lessons into PSHE is effective, despite this being recommended. School-based education programmes promoting healthy relationships can be effective in reducing violence towards current dating partners but evidence relating to their application in the UK is limited. A review specifically examining school-based dating violence prevention programmes in the US provides promising results. In contrast, a UK school based education study found that adolescents receiving interventions had improved knowledge of partner violence but little change in attitude.

4.1.2 Interventions to prevent FGM

One systematic review was located assessing the effectiveness of interventions to prevent FGM[64]. The research was reviewed on the effectiveness of interventions carried out in various countries within Africa, and factors related to the continuation or discontinuation of the practice of FGM. There was weak evidence for a positive effect of some education and communication interventions on the prevalence of FGM, and on knowledge, belief and attitudes towards it. Contextual factors cited by supporters of FGM within the studies were tradition, religion, and the aim of reducing women's sexual desire. This was closely linked to the ideas that FGM enhanced the morality of women and girls and the likelihood that they would marry. The main factors cited by those expressing negative opinions of the practice were the risk of harm and medical complications, and the reduction of sexual satisfaction.

4.2 National Context

Various guidelines and policies have been produced at a national level to support commissioners, practitioners and other strategic partners in providing services for domestic violence.

4.2.1 NICE guidance

In February 2014, NICE guidance on domestic violence was released[65] developed on the basis of the NICE evidence review. A full summary is presented in Appendix 8.2. The guidance covers:

1. Commissioning – planning services
2. Local partnerships to prevent domestic violence and abuse.
3. Commissioning: develop an integrated strategy
4. Commissioning: establish an integrated care pathway

[64] Effectiveness of Interventions Designed to Prevent Female Genital Mutilation/Cutting: A Systematic Review Berg R. and Denison E. 2009
[65] NICE (2014) Public Health Guidance PH 50, issued Feb 2014, Domestic Violence and Abuse: how social care, health services and those they work with can identify, prevent and reduce domestic violence and abuse. Available online at: http://guidance.nice.org.uk/PH50

5. Services: create an environment for disclosing domestic violence and abuse
6. Services: tailor support
7. Information sharing
8. Asking about domestic violence and abuse
9. Equality and diversity: overcoming barriers to accessing services
10. Identifying domestic violence and abuse: children and young people
11. Specialist domestic violence and abuse services for children and young people
12. Advocacy
13. Mental health interventions
14. Commissioning programmes for people who perpetrate domestic violence and abuse
15. Training to support different roles
16. Training: integration of training and a referral pathway into general practice
17. Training: pre-qualifying and continuing professional development for health and social care professionals

4.2.2 Other national and regional guidance

A range of other national guidance is available which is specifically relevant to domestic violence and abuse. Given the cross-cutting nature of domestic violence and abuse, national strategies in wider areas such as mental health, substance abuse and alcohol, also have a bearing on domestic violence.

4.2.2.1 Call to end violence against women and girls[66]

This document is the current coalition government's national strategy guiding action on domestic violence in the UK.

The accompanying action plan has been updated twice, most recently in March 2013. This continues to progress the original themes but places additional emphasis on: integrating policies to counter violence against women and girls into wider government reforms, providing more support to women and girls, a strengthened whole pathway approach to the criminal justice system and developing stronger outcome measures.

4.2.2.2 The way forward: taking action to end violence against women and girls, final strategy, 2010-13[67]

The Greater London Authority (GLA) strategy, alongside the national strategy described above, provides a framework for a greater emphasis on tackling all forms of violence against women and girls.

[66] Call to End Violence Against Women and Girls. HM Government 2010
[67] The Way Forward: taking action to end violence against women and girls (VAWG) Final Strategy 2010 – 2013. Greater London Authority. March 2010

4.2.2.3 Protecting adults at risk: London multi-agency policy and procedures to protect adults from abuse[68]

This policy was developed with input from all London councils and contains detailed guidance on both the policies and procedures relating to safeguarding adults at risk, covering all seven stages of the Safeguarding Adults process – raising an alert, making a referral, strategy discussion or meeting, making an investigation, case conference and protection plan, reviewing the protection plan and closing the process. The document makes extensive reference to the different types of domestic violence and abuse. Key considerations that should be taken into account when dealing with both the perpetrator and the victim include areas such as: consent and information sharing / withholding, advocacy, risk assessment and management, mental capacity and gathering intelligence on the alleged perpetrator. It recommends the use of Co-ordinated Action Against Domestic Abuse (CAADA), Domestic Abuse, Stalking and 'Honour'-based Violence (DASH) Risk Identification Checklists (RICs) and referrals to Multi Agency Risk Assessment Conferences (MARACs), meetings where information is shared on the highest risk domestic abuse cases between representatives of all relevant agencies, as well as referring to specialist domestic violence services.

4.2.2.4 Working Together: A guide to inter-agency working to safeguard and promote the welfare of children[69]

This is the national statutory guidance on safeguarding and promoting the welfare of children. The guidance states that local agencies need to have effective ways in place to identify emerging problems and potential unmet needs and this includes being in a family circumstance presenting challenges for the child, such as domestic violence. Local areas should have a range of services in place to address the assessed needs early, including specific local early help services which will typically include help for problems relating to domestic violence, drugs and alcohol. It notes that police officers, and other police employees such as Police Community Support Officers, are well placed to identify early when a child's welfare is at risk and when a child may need protection from harm and this can include attending domestic violence incidents.

4.2.2.5 Coordinated Action Against Domestic Abuse[70]

Coordinated Action Against Domestic Abuse (CAADA**)** is a national charity supporting effective multi-agency responses to domestic abuse. They have developed a quality accreditation programme for Independent Domestic Violence Advisors (IDVAs) called Leading Lights. Leading Lights Accreditation centres around seven principles: safety, risk, diversity, dynamics of domestic abuse, independence,

[68] Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse. Social Care Institute for Excellence with the Pan London Adult Safeguarding Editorial Board 2011
[69] http://www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children
[70] http://www.caada.org.uk/

accountability to stakeholders and respect. The quality standards are grouped in four domains: governance, human resources, multi-agency working and service. provision. CAADA have also produced a domestic violence Risk Identification Checklist (RIC) with accompanying guidance.

4.2.2.6 Female genital mutilation: multi-agency practice guidelines[71]

These guidelines note that as it is unlikely that any single agency will be able to meet the multiple needs of someone affected by FGM, guidance is needed for a multi-agency response. This includes NHS staff and other health professionals, police officers, children's social care workers, and teachers and other educational professionals. The guidelines cover: professionals being alert to the range of potential indicators for FGM; the need to share information with social care or the police; and using the relevant existing statutory procedures. It outlines the requirements needed for different professional groups. Healthcare professionals need to be familiar with the relevant clinical guidance. Criminal investigations should follow police forces' standard operating procedures and those for child protection investigations. Children's social care professionals should work in accordance with statutory safeguarding guidelines. Educational establishments should aim to create an 'open environment' where students feel comfortable and safe to discuss the problems they are facing. The document outlines the importance of the role of the Local Safeguarding Children Board in raising awareness, training professionals in FGM related issues and of a 'bottom-up', community-led approach to the abandonment of FGM.

4.2.2.7 Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage[72]

These guidelines note that a multi-agency response is required for this issue. They cover problems with family counselling, mediation, arbitration and reconciliation; the importance of information sharing; suitable venues for interviews; future contact and meetings, personal safety advice and devising a strategy for leaving home, missing persons and young people who run away, confidentiality and record keeping. There is specific guidance for healthcare professionals, police officers, adult and children social care and local authority housing.

71 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216669/dh_124588.pdf

72 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/35530/forced-marriage-guidelines09.pdf

4.2.2.8 Crown Prosecution Service policy for prosecuting cases of domestic violence[73]

The Crown Prosecution Service (CPS) policy notes that cases involving domestic violence can be difficult to prosecute, and because of their nature require particularly sensitive and careful handling, especially with regard to victim care and support. Support and accurate up-to-date information needs to be provided to the victim throughout the life of the case, and there should be liaison where possible with IDVAs, Witness Care Units (WCUs) and voluntary sector support organisations. In some parts of England and Wales, domestic violence cases will be heard in specialist domestic violence courts (SDVCs). Domestic violence cases being heard in any court should be clustered on a particular day or fast tracked, should have specially trained magistrates and prosecutors and have separate entrances, exits and waiting areas so that victims do not come into contact with defendants.

4.1.3 Public Health Outcomes Framework[74]

Nationally, domestic violence and abuse is seen as a vital public health issue and this is reflected by its inclusion as an indicator in the Wider Determinants section of the Public Health Outcomes Framework (PHOF). The indicators relate to domestic abuse and violent crime which includes sexual violence. Data are collected and compared between regions.

4.1.4 Early Intervention Foundation review on domestic violence and abuse[75]

The Early Intervention Foundation (EIF) has been established to tackle the causes of problems for children and young people, including domestic violence and abuse. In their recent publication the EIF reviews the effectiveness of existing services aimed at the prevention of domestic violence and proposes a number of recommendations aimed at both national and local government, as well as a range of local agencies.

- Embedding of domestic violence prevention into local strategies on crime prevention and health and wellbeing, and children and young people.
- Measuring the impact of prevention programmes at national and local level
- Specific recommendations on how to embed early intervention programmes into schools and the workforce

Croydon is among the 20 Early Intervention Pioneering Places across the country where the EIF support local authorities, the police and crime commissioners to embed early intervention programmes locally.

[73] http://www.cps.gov.uk/publications/prosecution/domestic/domv_guidance.html
[74] DH (2013) Public Health Outcomes Framework. London: Crown Copyright
[75] Early Intervention Foundation review on domestic violence and abuse, February 2014 , accessible on http://www.eif.org.uk/publications/

4.3 Local Context

4.3.1 Croydon Domestic Violence Strategy 2013-16

In 2011 Croydon Council and its partners reviewed its work on domestic violence in the light of the Coalition Government's strategic vision.

This resulted in the Croydon Domestic Violence Strategy 2013-16 which aimed to refocus work to reduce domestic abuse and sexual violence to early intervention and prevention. It was based on four principles known as "the four P's":

- prevention
- protection
- provision
- partnership

In light of the draft action plan developed by Croydon's Domestic Abuse and Sexual Violence group a major revision of the strategy is taking place that takes into account the recommendations generated from the domestic homicide reviews, the JSNA chapter, NICE and other national guidance.

4.3.2 Safer Croydon Partnership

Responsibility for Croydon's Domestic Violence Strategy sits with the Safer Croydon Partnership, Croydon's Community Safety Partnership. The Safer Croydon Partnership Board is responsible for all matters relating to crime, disorder and safeguarding across the borough. This group provides strategic leadership and makes decisions regarding resources, performance management and future developments. The Cabinet Member for Community Safety is the Chair of the Board. Other members include those at a level senior enough to ensure decisions are made and resources made available from:

- Police
- Metropolitan Police Authority
- Croydon Council
- Croydon Clinical Commissioning Group (CCG)
- Probation Service
- NHS South West London
- London Fire Brigade
- Voluntary and Community Sector partners
- Members of the business community
- Crown Prosecution Service
- Courts

4.3.3 Domestic Abuse and Sexual Violence Group

This group has historically been responsible for oversight of delivery of the domestic violence strategy. In 2013 a new Domestic Abuse and Sexual Violence Group was formed and is chaired by the Chief Executive of Croydon Council. Informed by emerging data and evidence from this JSNA chapter and the recommendations from the Homicide Reviews, the group developed a draft action plan to address domestic violence in Croydon in all four areas, prevention, protection, provision and partnership and with actions assigned to all major partner organisations. (Appendix 8.4 Domestic Abuse and Sexual Violence action plan 2014/15)

4.3.4 Domestic Homicide Reviews

There is a legal obligation for local areas to undertake multi-agency reviews following a domestic homicide. Two reviews commenced in Croydon in March 2013. At the time of writing in January 2014, draft final reports have been circulated to review members, but these have not been signed off by Safer Croydon Partnership or the Home Office. The stated purpose of these reviews is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result
- Apply those lessons to service responses. This includes making changes to policies and procedures as appropriate
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

The following agencies participated in the Croydon reviews:

- Metropolitan Police – Croydon Borough and Critical Incident Advisory Team
- Croydon Council – Public Realm and Safety
- Croydon Council – Social Care and Family Support
- Croydon Council – Public Health
- Croydon Council – Adult Social Services and Housing
- Croydon Council – Safeguarding and Looked After Children Service
- Croydon Clinical Commissioning Group
- Croydon Health Services NHS Trust
- London Probation Trust
- South London & Maudsley NHS Foundation Trust
- Croydon Council Family Justice Centre

- London Ambulance Service NHS Trust
- Standing Together Against Domestic Violence

Agencies were asked to give chronological accounts of their contact with the victims prior to their death. Each agency's report covered the following:

- A chronology of interaction with the victim and/or their family
- What was done or agreed
- Whether internal procedures were followed
- Conclusions and recommendations from the agency's point of view.

The review panel concluded that agency and partnership policies or practice were not causal factors for these homicides, but felt that improvement in the local response to those in the victim's circumstances would reduce the likelihood of such a death occurring in the future. This development should be mediated and driven through the local community safety partnership.

The panel noted that since October 2012 there have been a significant number of positive and innovative developments to Croydon's coordinated response to domestic violence. However, there was a significant gap between Croydon's strategic vision and operational practice. This included little evidence of internal agency policies and procedures and the need for a comprehensive Croydon domestic violence protocol, policy and pathway. It also noted that there was a greater possibility of ineffective safeguarding in cases where children were not involved.

The reviews made a number of specific recommendations aimed at the different agencies that participated in the review. General recommendations included the need for greater engagement from local health organisations in the borough's domestic violence partnerships – Croydon CCG, Public Health Croydon, Croydon Healthcare Services (particularly urgent and emergency care services) - and also the need for a borough multi-agency domestic violence training programme which should specifically address diversity issues.

The Home Office[76] (2013) outlined some of the common themes that have emerged from Domestic Homicide Reviews across the country. They include:

- Gaps in awareness as to what constitutes domestic violence and abuse – that it only means physical violence, does not include financial or emotional abuse and does not take into account power and control.
- A number of reports identified the need for improved training and awareness on domestic violence and abuse for GPs and healthcare professionals

[76] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2013

- The importance of a consistent approach to risk identification, assessment and management for all professionals was identified in a number of reports
- Many of the reports highlighted the importance of sharing information about risk of domestic violence or abuse between agencies, and described cases where knowledge was not shared, even where it was lawful to do so.
- In a number of cases the victim and/or the perpetrator had complex needs which could include domestic violence and abuse, sexual abuse, alcohol, substance misuse and mental health illness. In some cases the domestic violence and abuse was not identified because agencies were focusing on addressing these other issues.
- Inadequate information sharing between agencies was also identified in some cases where a perpetrator is released on bail or from prison.

4.3.5 Best Practice and Horizon Scanning

Two areas were assessed in terms of best practice and horizon scanning – NHS responses to domestic violence and abuse and the increasing use of technology and social media to perpetrate domestic violence and abuse.

The Bristol Royal Infirmary (BRI) Emergency Department IDVA service

As the city's main hospital, the BRI's A&E unit sees between 190 and 200 patients each day. Having a specialist IDVA team based within this department ensures that victims are not only more readily identified, but that they are also offered a full care package: from immediate medical assistance and IDVA support, to alcohol/substance misuse services and psychiatric care, where appropriate. The majority of the service's referrals come from the Minor Injury Unit, with patients typically arriving at the hospital 24-28 hours after an incident has taken place. The service is available 9am – 5pm, seven days a week, including bank holidays, with Sundays being the busiest day for referrals.

Cyberstalking Protection Guide

Most stalking now includes a ‘cyber’ or technology aspect, either by stalkers who stalk offline assisting their activities with some form of technology as a tool, or by cyberstalking where the perpetrator uses technology but does not stalk the person in the offline world.[77] Technology can include mobile phones, social networks, computers and emails or geolocation tracking. “Digital stalking, a guide to technology risks for victims,” by Jennifer Perry (v2 – 11/2012) is an 87 page book published jointly by Network for Surviving Stalking and Women’s Aid Federation of England. It is free to download at www.womensaid.org.uk.

[77] https//www.gov.uk/government/publications/definition-of-domesticviolence-and-abuse-guide-for-local-areas

The book provides information on all aspects of cyberstalking protection and includes information on: warning signs, key actions, gathering evidence of stalking, password security, creating new email accounts, sharing information, Facebook and other social networks, mobile / smartphone security and support.

5 Consultation: what do local people say

Four in-depth interviews were conducted by an independent researcher with victims of domestic violence and abuse accessing the Family Justice Centre (FJC) in Croydon.

Participants were provided with background information on the purpose of the research and some background information on domestic violence.

Interviews were structured around the following broad questions:

1. Can you tell me about what you have experienced that made you use these services?
2. What help and support is available for people who have experienced domestic violence in Croydon?
3. What support or services would you like to see in Croydon to help prevent domestic abuse from taking place?
4. If you were to give one message to the people in Croydon who set up services, what would it be?

Themes emerging from the analysis of interviews were:

1. Reasons for accessing services
    - A mixture of emotional, physical and in some cases sexual abuse was experienced by all participants

2. Help and support available in Croydon
    - All participants felt ill-informed in the face of a situation involving domestic violence
    - All participants had been referred to the FJC, mostly by the police
    - The police had been helpful by referring to the FJC
    - Housing department, supported housing
    - Women's refuges are available but access is difficult for people with mental health problems

3. Support victims would like to see
    - Services like the FJC, which they value greatly and would have liked to be signposted or referred to earlier
    - Services offering open access, without long waiting lists
    - An immediate response from services to a person seeking help around domestic violence
    - A proactive approach from services following up on a person who has requested help

- One lead person or agency co-ordinating the different strands of support they were given
- Training of staff in services dealing with victims of domestic violence, particularly the police, housing departments and social workers
- Support for victims of domestic violence who have mental health problems
- Access to services for carers of victims with particular needs
- Long term housing opportunities for victims of domestic violence

4. Reasons for not accessing services or delaying making contact
    - Participants did not feel they could change their situation
    - Participants did not know where to find support
    - Fear of reprisals from perpetrator
    - Fear of losing children if the police or social services were involved
    - Fear of conflicting with cultural norms

Direct quotes from participants:

"*I'd like to see more places like the Family Justice Centre.*"

"*But I had the Family Justice Centre, cos I wouldn't have been able to do it otherwise.*"

"*Just having an open door to say anytime you're ready…*"

"*I was quite naïve and expected to be chased up, but I never heard anything.*" (victim on difficulties with referral to FJC)

"*Why did they wait for 45 call outs* (by the police)*? You know, why didn't social services step in earlier?" "…and you don't know about the other probably a hundred times, you know, non call outs…*" (victim on number of calls made to police before referral to FJC occurred)

"*It's like sometimes I feel like my voice is not being heard.* (on contact with social workers)"

6 SERVICE REVIEW: what is currently available in Croydon?

6.1 Croydon Domestic Violence Service Mapping

A mapping exercise was undertaken in November 2013 to generate a comprehensive list of national, regional and local services available to victims and perpetrators of domestic violence in Croydon (Appendix 8.3).

6.2 Family Justice Centre

Croydon Council's Family Justice Centre (FJC), located in central Croydon, offers a multi-disciplinary and multi-agency approach to services for victims of domestic abuse and sexual violence (DASV), and their children. The centre aims to provide a safe environment where victims and their children can get all their services in one place. The Family Justice Centre provides:

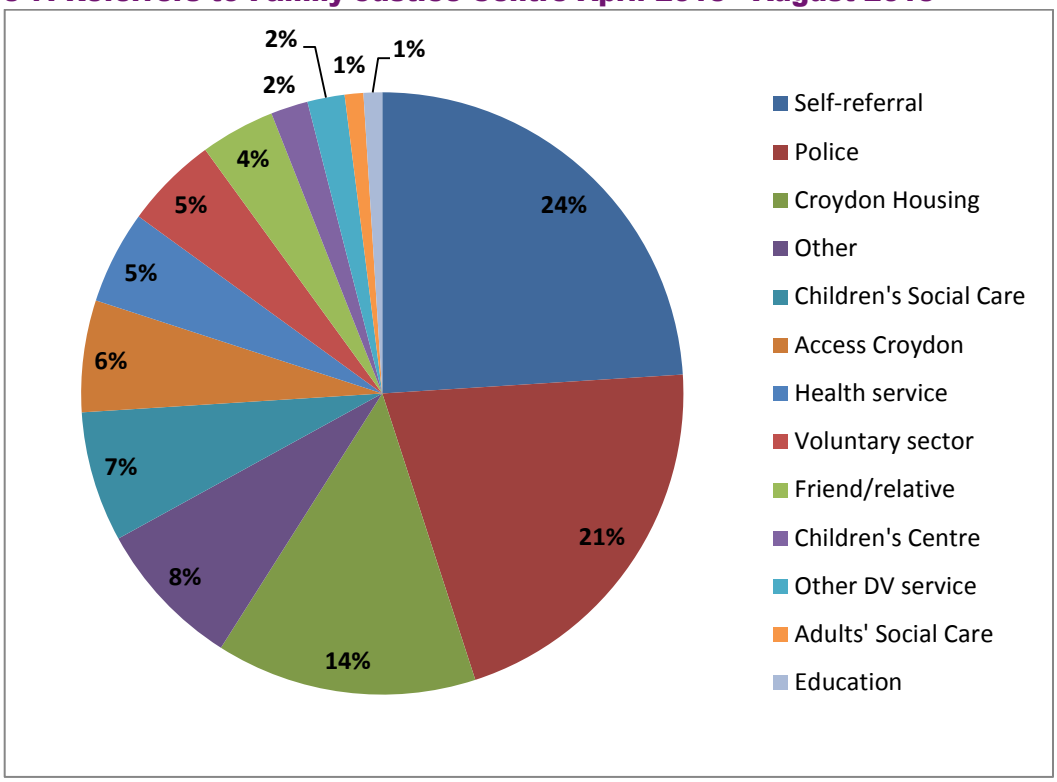
- an holistic assessment of need and risk
- advice and support on all aspects of DASV
- legal advice and support to obtain injunctions
- support and advice to access safe emergency accommodation
- support to access specialist services and advice, including issues surrounding recourse to public funding, rape and sexual abuse, and support for children
- drop-in and appointment services
- a domestic abuse helpline for survivors and practitioners

The majority of the service users at the FJC are self-referrals, followed by police referrals and then Croydon housing referrals (Figure 7). The category 'Other domestic violence service' includes referrals from out of borough domestic violence services, refuges and the national domestic violence helpline. The category 'Health Service' includes referrals from GPs, hospitals, health visitors and mental health services. 'Education' includes referrals from primary and secondary schools as well as colleges. The category 'Other' is for referrals from drugs services, probation, registered social landlords and other Croydon Council services.

The most common form of abuse reported by users of FJC is 'Stalking /Harassment' followed by 'Verbal Abuse' and then 'Physical Abuse' and 'Emotional / Psychological Abuse' (Figure 8).

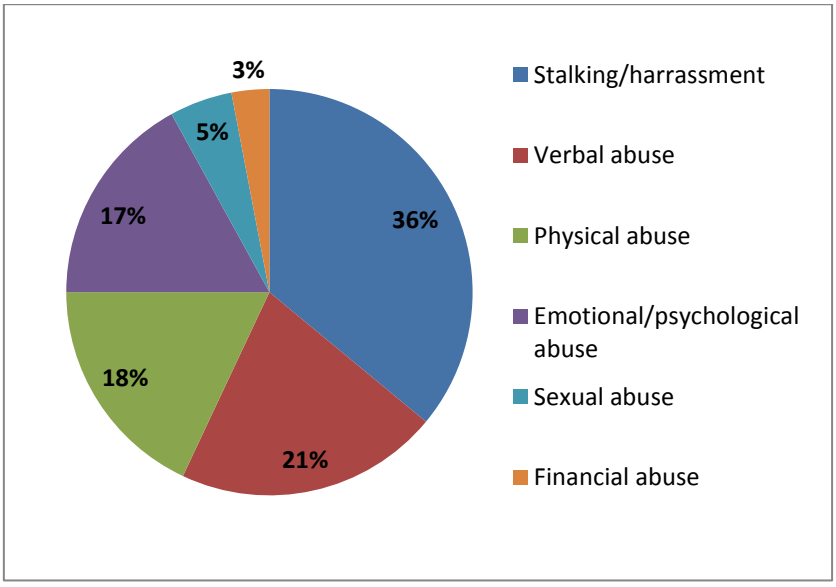
The most common service offered to users of the FJC is 'General Advice' followed by 'Housing Referral' and then 'Legal Advice' and 'Other Referral' (Figure 9). The main types of 'Other Referral' are for 'Therapy', 'Family Engagement Partnership', 'Victim Support' and 'Women and Girls Network' (Figure 10).

Figure 7: Referrers to Family Justice Centre April 2013 - August 2013



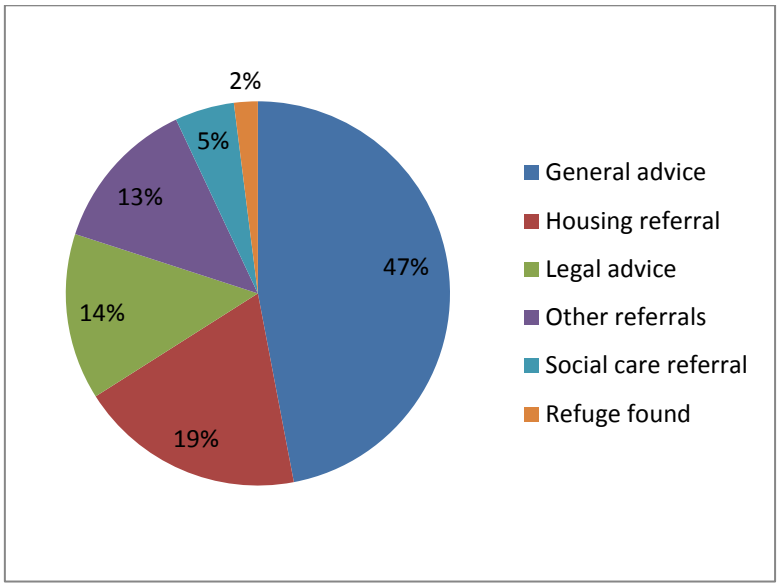
Source: Croydon Family Justice Centre, 2013

Figure 8: Type of abuse reported at the Family Justice Centre April 2013 - August 2013



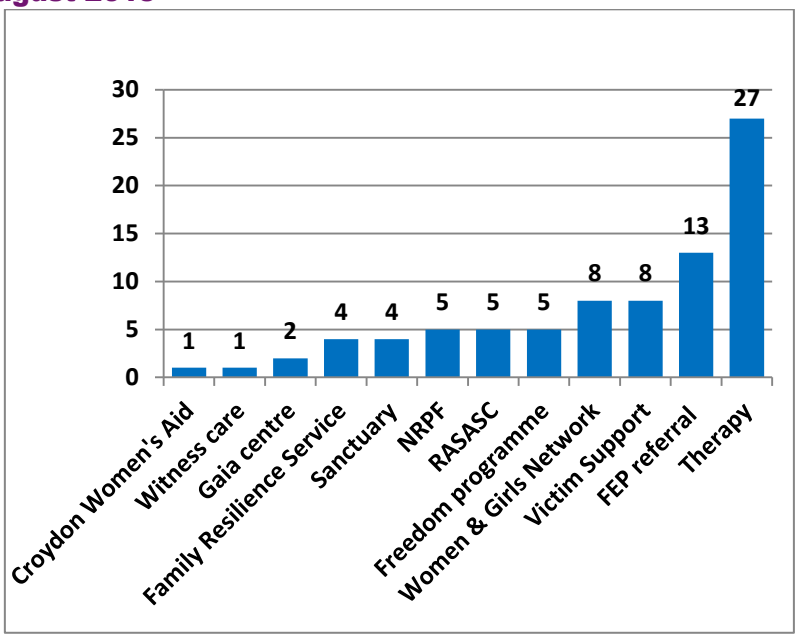
Source: Croydon Family Justice Centre, 2013

Figure 9: Type of service offered to service users at Family Justice Centre April 2013 - August 2013



Source: Croydon Family Justice Centre, 2013

Figure 10: Other referrals made by Family Justice Centre April 2013 - August 2013



Source: Croydon Family Justice Centre, 2013

6.3 Multi-Agency Risk Assessment Conferences and Independent Domestic Violence Advisors

A key aspect of domestic violence partnership work is the Multi-Agency Risk Assessment Conference (MARAC). MARACs are regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. There are currently over 260 MARACs operating across England, Wales and Northern Ireland.

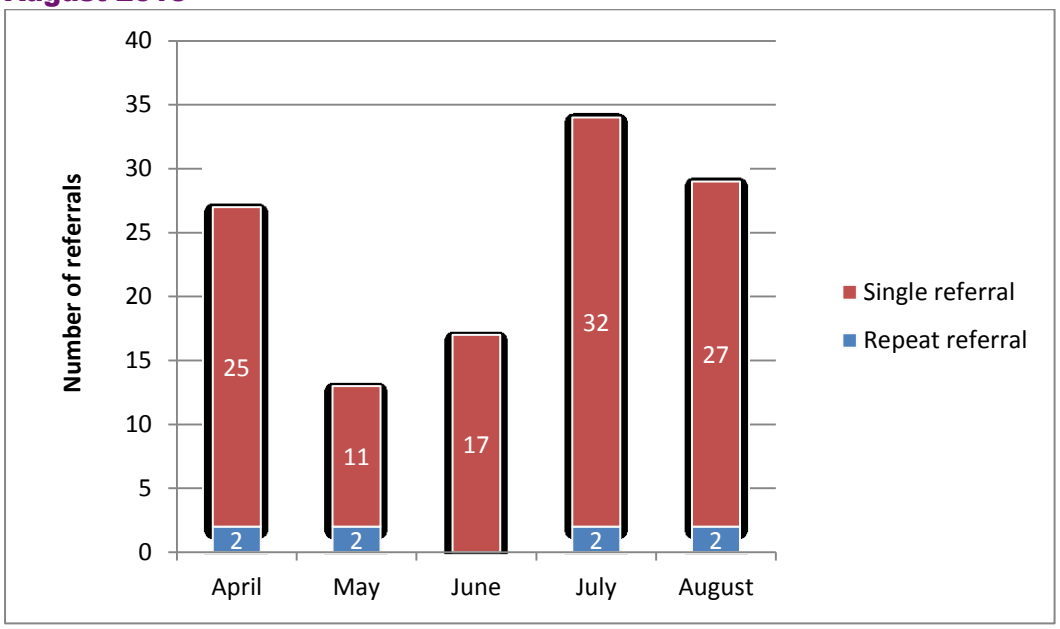
By bringing all agencies together at a MARAC, sharing relevant and proportionate information, and ensuring that whenever possible the voice of the victim is represented by an Independent Domestic Violence Advisor (IDVA), a risk focused, co-ordinated safety plan can be drawn up to support the victim.

An IDVA is a named professional case worker for domestic abuse victims whose primary purpose is to address the safety of 'high risk' victims and their children. IDVAs are a victim's main point of contact with services. They normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop coordinated safety plans.

IDVAs are proactive in implementing safety plans, which include practical steps to protect victims and their children, as well as longer-term solutions. These plans will include actions from the MARAC as well as sanctions and remedies available through the criminal and civil courts, housing options and services available through other organisations. IDVAs offer independent support and work over the short- to medium-term to put victims on the path to long-term safety.

The number of monthly referrals to MARAC between April 2013 and August 2013 averaged 24 (Figure 12).

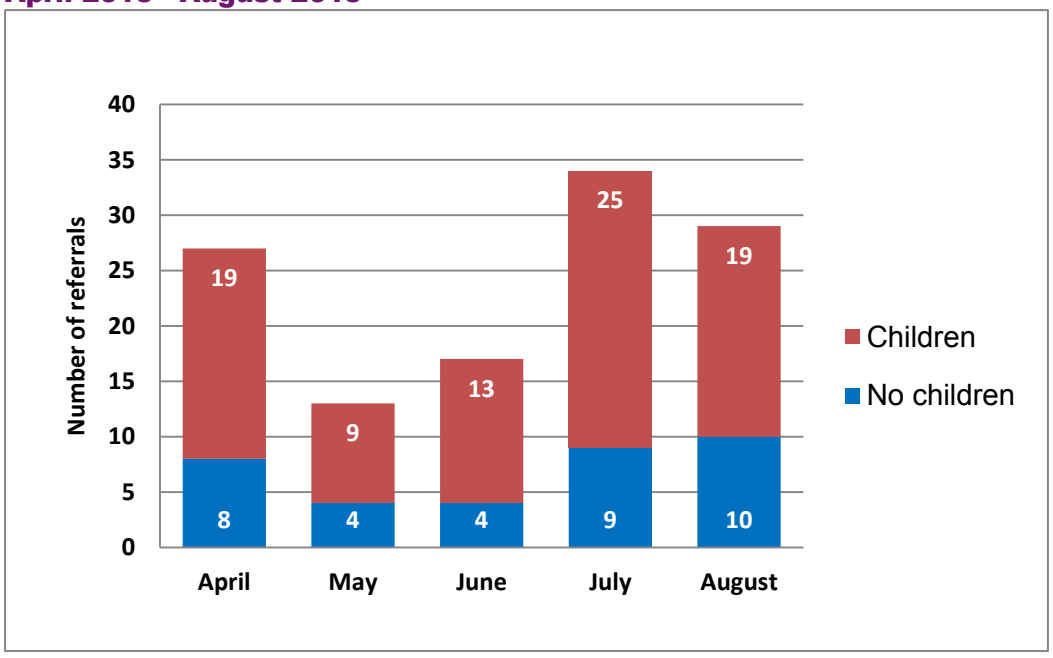
Figure 11: Number of single and repeat referrals to Croydon MARAC April 2013 - August 2013



Source: MARAC Croydon 2013

Figure 12 shows that the majority of referrals to Croydon MARAC involve children.

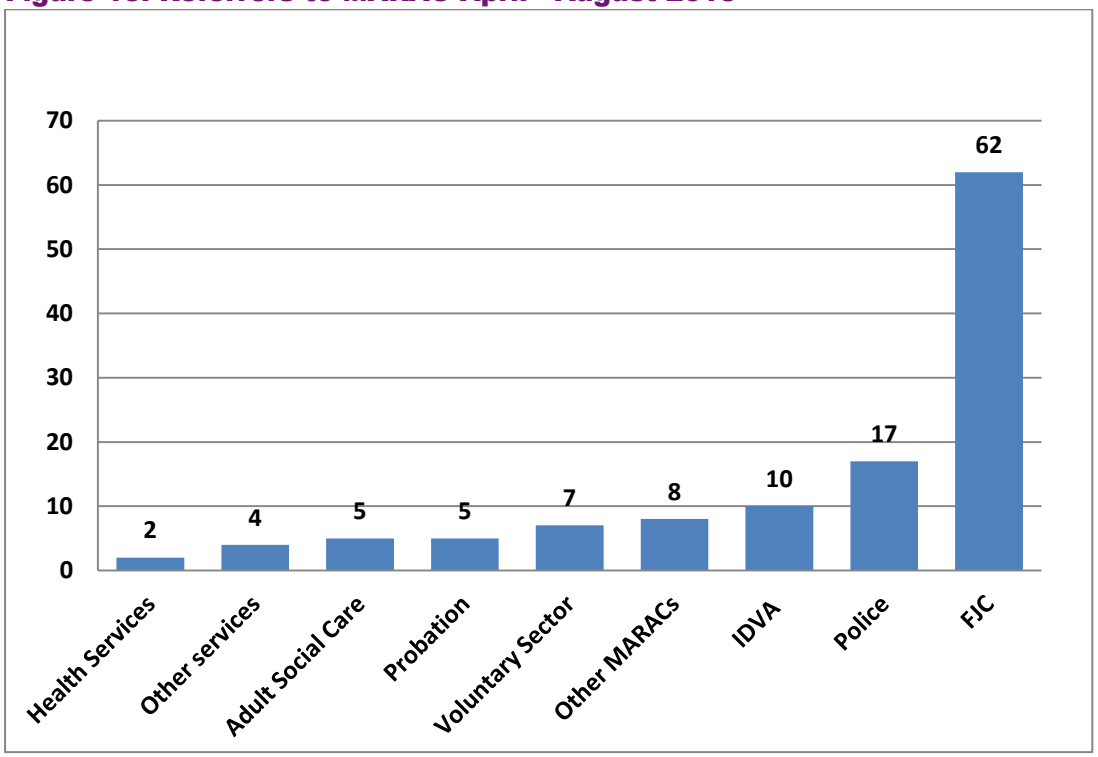
Figure 12: Number of referrals to Croydon MARAC April 2013 - August 2013



Source: MARAC Croydon 2013

Most referrals to MARAC come from the Family Justice Centre, followed by Police, Independent Domestic Violence Advisors (IDVAs), Other MARACs and the Voluntary Sector (Figure 13).

Figure 13: Referrers to MARAC April - August 2013



Source: MARAC Croydon 2013

7 Conclusions

When the Domestic Violence JSNA was commissioned in 2013, a local Domestic Violence Strategy was already in place and a Domestic Abuse and Sexual Violence Group (DASV) chaired by Croydon Council's Chief Executive took charge of strategic developments to reduce DV in Croydon. During the development of this chapter, the DASV developed a draft action plan involving all major local partners. (Appendix 8.4 Domestic Abuse and Sexual Violence action plan 2014/15) Emerging findings from this chapter informed the development of the action plan, provided an update on available evidence and local data for benchmarking of domestic violence and abuse in Croydon.

The conclusions emerging from the JSNA have therefore already been taken forward and incorporated into the action plan or implemented by partner organisations.

1. Domestic Abuse and Sexual Violence Group (DASV) to have a named lead from every key local partner agency. These individuals will act as the DASV champion and be responsible for ensuring that the DASV action plan is high profile and there is progress on actions identified within their organisation.

2. The DASV strategic lead will develop a quality assurance framework that directly informs integrated commissioning and can be used by partners to inform quality standards of non-commissioned services.

3. Ensure the DASV features in all services commissioned by the Local Authority Integrated Commissioning Unit.

4. Safer Croydon Partnership and Domestic Abuse and Sexual Violence Group to continue to oversee implementation of Croydon's Domestic Homicide Review recommendations and ensure that the local action plan reflects the recommendations.

5. Safer Croydon Partnership and Domestic Abuse and Sexual Violence Group to assess and take account of NICE domestic violence and abuse guidance and continue to update DASV strategy and action plan in the light of best available evidence.

6. The DASV is a key element in all safeguarding training and designated leads for safeguarding are made aware of their responsibilities concerning DASV.

7. Croydon Clinical Commissioning Group to set up a Health Services Working Group reporting to Domestic Abuse and Sexual Violence Group with membership including Croydon CCG, Public Health Croydon, Croydon Healthcare Services (including urgent and emergency care services and Midwifery Departments), Croydon DAAT and SLaM, to ensure coordinated health service response to domestic violence and abuse.

8. Safer Croydon Partnership to decide strategic approach and governance arrangements relating to Female Genital Mutilation, Forced Marriage and 'honour' based violence. This should include data collection.

9. Domestic Abuse and Sexual Violence Executive Group to be developed as part of the broader DASV strategy having responsibility to oversee the DASV strategy and action plan. The group will develop and implement measures to prevent and reduce DASV including prevention and early intervention, targeting children, young people and families.

10. Training and communications to highlight that the vast majority of domestic violence and abuse involves coercive and controlling relationships rather than criminal acts of physical violence, and that safeguarding adults and children is a key consideration when DASV features.

11. Training and communications to explore the use of technology and social media to increase access to support services aimed at reducing incidents of DASV.

12. Explore the needs of distinct and hidden communities with local partners to further assess the needs in relation to elder abuse, the needs of Croydon's LGBT communities and other communities who face barriers in reporting. Ensure that services are gender sensitive.

13. Systematic engagement with the wide range of non-specialist voluntary and community sector organisations working with groups at risk of experiencing domestic violence and abuse through a Domestic Violence forum.

14. Reduce repeat incidents of DASV by 20% by 2016 which can be evidenced through partnership monitoring and data.

15. Increase reporting of DASV, improve the interventions available to support reporting, and improve the accessibility of the "help offer".

16. Public Health Croydon to carry out regular reviews of the evidence around effective interventions.

8 APPENDICES

8.1 NICE evidence review summary

This summary has been taken directly from the NICE evidence review[62].

Q1: Prevention of Domestic Violence

A total of 14 articles were identified on interventions for preventing domestic violence, informing four evidence statements related to: prevention approaches for young people; media campaigns; interventions implemented in health settings; and interventions in community settings for at-risk women.

Summary of findings

The majority of prevention approaches for young people were secondary prevention approaches, aimed at preventing violence among diverse sub-groups identified as high risk for IPV. Primary prevention programs that were school based and not linked with health, social care, or specialized domestic violence services were outside of the scope of this review. While there is limited evidence on primary prevention programs for young people, there is modest evidence that prevention programs that target young people at risk for partner violence may improve knowledge, attitudinal (towards violence and gender roles) and interpersonal outcomes. Programmes tended to focus on attitudinal changes, yet some studies conducted with young people at high risk of abuse also measured and reported modest reductions in violent behaviours.

Inconsistent evidence was found on the impact of media campaigns for improved recall, hypothetical bystander actions, awareness of available resources, calls to hotlines, and knowledge and perceptions of domestic violence. Some studies reported improvements while others lacked reach to the intended audience, suggesting that media campaigns have the potential to raise awareness of domestic violence and services but may be hindered by issues with implementation.

Only weak evidence was available for prevention interventions implemented in health care settings. Only two studies were located, both delivered in emergency departments, which demonstrated improvements in exposure to domestic violence materials, or changes in knowledge and attitudes related to domestic violence. Further research is required to examine prevention interventions within or linked to health settings, and also to explore behavioural change following an intervention.

Finally, there was weak evidence related to prevention programs implemented in community settings for high-risk women, which included: women with learning disabilities and low income single African American mothers. While evidence was limited to two studies, findings suggest that engaging high risk groups may require tailored and innovative approaches to programme delivery.

Discussion

Overall, studies were primarily of moderate quality, with only one high quality study. Methodological limitations included the non-experimental nature of studies and lack of follow up beyond the end of the intervention. More robust studies are required to determine effective approaches to preventing domestic violence among these groups.

While studies did not address all groups within the scope of our review (particularly 'honour based violence' and elder abuse prevention), the included studies did address diverse sub-populations of women and men or girls and boys, including: African American male adolescents, Hispanic youth, adolescent mothers and couples, women with learning disabilities, low income single African American mothers, as well as media campaigns with African Americans or within rural contexts. The range of diversity in these studies may reflect efforts to prevent domestic violence among vulnerable sub-populations.

The contextual literature recommends the development of further tailored, community based approaches to violence prevention, along with interventions that address multiple levels of prevention. The need for longitudinal research to examine the effect of prevention programming on behaviour change has also been noted.

Q2: Identification of Domestic Violence

A total of 28 articles addressed the nature of the interventions and approaches used in health and social care settings for identifying domestic violence, informing six evidence statements on: screening/ identification tools, screening formats, enhancing identification through additional protocols such as provider cueing, provider education that supports identification and intervention, organizational level supports for identification, and identification of violence with pregnant/ postpartum women.

Summary of findings

Moderate evidence revealed that the length of the tool used, the types of questions asked (e.g. frequency of abuse vs. yes/ no question) and screening tool used (tools captured by these studies include: WAST, CAS2, PVS, HITS) resulted in differences in identification (rates, types of violence and groups identified). However, the screening tools that were compared varied greatly between studies, so it is not possible to determine which particular tool or tools are most effective.

Moderate evidence also suggests that screening format (computer-assisted, face-to-face, self-reported) impacts the disclosure of IPV, forms of violence reported, or may improve awareness of abuse. Again, it is not possible to determine which specific format is most effective due to variability between studies in which the formats were compared. However, some moderately rated studies reported that women were

more likely to disclose IPV in a self-report compared to a face-to-face format, while one poorly rated study reported the opposite.

Cueing refers to providing information about a patient prior to a clinical encounter that will "cue" or propel the provider to investigate issues of domestic violence. There is moderate evidence that cueing improves discussion, disclosure and referrals to services provided for domestic violence among some populations. All studies reported improvements in rates of identification and disclosure, with some differences noted between samples being compared (e.g. urban versus suburban participants).

The evidence on the effectiveness of provider education interventions for improving screening practices or clinical enquiry is inconsistent. Interventions were typically aimed at increasing health care providers' ability to raise the issue, screen for or detect domestic violence among their patients. Some studies reported an increase in awareness, screening and documentation of domestic violence, while in other studies, improvements were modest or limited.

There is weak evidence that the implementation of policy or organizational changes to screening for domestic violence improves screening rates, referral rates and/or provider ability or comfort to screen. Only two studies examined this form of intervention. Both reported improvements in screening practices following the implementation of new procedures.

There is moderate evidence that universal screening or routine enquiry for domestic violence in pregnancy, when supported by staff training and organizational support, improves screening practices and documentation of domestic violence. Studies reported modest to substantial improvements screening rates in clinical settings, and improvements in women's privacy during screening and documentation of abuse during home visitation.

Discussion

Overall, the majority of studies were before and after studies and lacked follow-up. The majority of studies also focused on abuse of women by a male partner. Very few studies examined the impact of identification interventions or approaches for diverse sub-populations of women or screening for perpetrators, children who witness violence, 'honour' based violence, and elders. The majority of studies also focused on the identification of domestic violence in emergency department, antenatal care, or primary care settings. There is a lack of research examining the identification of domestic violence in social care settings, or evaluating integrated approaches to identification across various health and social care settings.

While interventions and approaches examined reveal some modest improvements in rates of identification or practices and knowledge related to the identification of domestic violence, there appear to be significant challenges in achieving

identification, referral and support goals. Although few studies examined interventions beyond the point of identification, some studies reported low rates of follow-up with women who had been identified as at risk. Further research is required to examine and address the barriers providers face in identifying and responding to domestic violence. Furthermore, interventions are required that include a post-identification intervention and measure health outcomes for participants. However, screening and routine enquiry interventions during pregnancy and postpartum appear to result in greater improvements in providers' inquiry or screening for domestic violence. Perhaps the improvements are due to the relatively sustained and ongoing nature of the patient-provider relationship during pregnancy/ postpartum.

Q3: Responses to Domestic Violence

A total of 76 articles were identified on interventions and approaches used in health and social care settings for: responding to violence among victims (33) [other than elders and couples, which are reported in the following section], perpetrators of violence (33), elders (3) and couples (7). These informed 12 evidence statements on: advocacy interventions, skill-building interventions, counselling and brief interventions, and therapy interventions for victims; and individual interventions for abusers, short duration (16 weeks or less) group interventions measuring recidivism/ abuse outcomes, short duration group interventions measuring attitudinal, psychological and interpersonal outcomes, long duration (over 16 weeks) group interventions measuring recidivism/ abuse outcomes, long duration group interventions measuring attitudinal, interpersonal and psychological outcomes; couple interventions including substance use treatment and couples interventions not including substance use treatment; and interventions addressing elder abuse.

Summary of findings

Interventions for Victims of Domestic Violence

Advocacy interventions are those that inform, guide and help victims of domestic violence to access a range of services and support, and ensure that their rights and entitlements are achieved. There is moderate evidence that advocacy services may improve women's access to community resources, reduce rates of IPV, improve safety, decrease depression, reduce various stressors, and improve parenting stress and children's well-being. While the majority of studies received a moderate quality rating, all studies reported improvements for women, suggesting that this may be a promising approach for responding to domestic violence. Additional evidence for advocacy approaches will be included in the partnership section.

There is moderate evidence that skill building (teaching, training, experiential or group learning) on a range of topics with victims of partner violence has positive effects on victims' coping, well-being, decision-making abilities, safety, and reduces coercive and violent behaviour. While all studies reported improvements,

interventions varied widely focusing on building skills such as: coping skills, safety planning and conflict resolution skills, knowledge of reproductive coercion and harm reduction in a reproductive context, decision-making and danger-assessment skills, economic education, and sleep training.

Counselling/ brief interventions promote a range of outcomes, such as reducing depression and increasing empowerment among those who have experienced domestic violence, through interventions based on brief educational, cognitive-behavioural, and motivational interviewing approaches. There is moderate evidence that counselling interventions may improve: PTSD symptoms, depression, anxiety, self-esteem, stress management, independence, support, re-occurrence of violence, birth outcomes for pregnant women, motivational level, readiness to change, and/ or forgiveness. Diverse groups of women were included in these studies, such as: pregnant African American women, pregnant and postpartum women, women in shelters, Hispanic immigrant women and rural women. While the majority of interventions reported improvements on the various outcomes measured, some reported only modest improvements or improvements on some but not all measures.

Therapeutic interventions promote improvement in mental health impacts of violence, through more intensive treatments than counselling interventions such as group therapy. There is moderate evidence that therapy interventions may be effective for improving various PTSD symptoms, depression, trauma symptoms, psychological and social outcomes, parenting/ family-related outcomes and in some cases may reduce likelihood of future IPV or re-abuse. Several studies were conducted with low-income women, and the majority of women captured in these interventions were Caucasian. All studies reported improvements on the various outcomes measured. Some studies that compared interventions reported differences in the type and level of effect.

Interventions for Perpetrators of Domestic Violence

Several studies on interventions for batterers included female batterers/ abusers, although the majority addressed interventions for male batterers. Studies varied in whether participants were court mandated, non-mandated or both.

There is moderate evidence that individual interventions for abusers may improve aggressive feelings towards partners, attitudinal change, understandings of violence and accountability, or short-term help seeking. Some interventions also reported improvements in violent behaviours or recidivism, while others demonstrated no effect. The types of individual interventions employed varied, including: case management, an individual level intervention combined with community outreach services, solution focused therapy, educational interventions, and motivational interviewing. Overall, interventions appeared to have a greater effect on attitudinal outcomes than recidivism/ violence outcomes (which when measured, improved in some but not all studies).

Short duration group approaches (16 weeks or less) included: family of origin group therapy, a solution and goal focused group treatment programme, CBT, unstructured supportive group therapy, group counselling, and group sessions based on the Duluth model. There is inconsistent evidence that these interventions reduce recidivism/ abuse outcomes. Multiple studies reported a reduction in recidivism or other abuse measures. In contrast, a few studies reported improvements in some, but not all abuse measures or no improvement at all, including a group treatment programme for female batterers and a cognitive behavioural group counselling intervention. However, there is moderate evidence that these short duration group interventions improve attitudinal, psychological and interpersonal outcomes among abusers. The majority of studies reported improvements on the various outcomes measured, although two studies examining a group treatment programme for female batterers, found improvements for some but not all, psychological measures.

Long duration approaches (over 16 weeks) included: CBT programs, psycho-educational components, abuser schema therapy, Duluth-based group therapy, and stages of change MI approach. There is inconsistent evidence regarding the effect of long duration group interventions for male abusers on recidivism or abuse outcomes. Evidence of effectiveness was inconsistent with some studies reporting a reduction in recidivism/ abuse outcomes, some reporting only temporary reductions or improvements in select measures of violence/ aggression (e.g. physical but not psychological aggression), and some studies demonstrating no impact on recidivism. The evidence of effectiveness for long duration group interventions on attitudinal, psychological and interpersonal outcomes is also inconsistent. Evidence of effectiveness is inconsistent, with most studies demonstrating improvements (on measures such as: communication, motivation to change, attitudes towards violence, conflict management skills, etc.), but some studies revealing little positive effect.

Interventions for Addressing Elder Abuse or Maltreatment

There were few studies examining elder abuse (either against elders or against caregivers), which used varying approaches and demonstrated mixed findings (related to effectiveness), and therefore evidence of effectiveness is weak.

Interventions for Couples

There is moderate evidence that behavioural couples therapy (BCT) included within substance use treatment is associated with improved abuse outcomes, and in some studies with improved substance use measures. While these show moderate effectiveness for perpetrators of violence struggling with substance use disorders, weaknesses of these approaches include a lack of grounding in a theoretical framework or acknowledgement of the gendered nature of violence. In addition, these studies were conducted with primarily White samples and therefore the effectiveness of these approaches for ethnically diverse couples and non-substance using couples has not been identified in this review. Only three studies examined

couples interventions (which do not include treatment for substance users).These interventions were diverse in approach, samples used and outcomes measured, and therefore it is not possible to form overall conclusions on the effectiveness of couples-based approaches.

Discussion

Overall, there is a lack of research to address 'honour' based violence or forced marriage, and a lack of evidence on tailored approaches for diverse women and women at different levels of risk. Further research is required to address the need for a spectrum of services, and tailored and coordinated responses for those who have experienced domestic violence. For abusers, most interventions were directed at heterosexual men who abuse their partners and no quality studies were found that evaluated family intervention responses to domestic violence. There was also a lack of interventions delivered within or linked to the health sector.

For victims, there was moderate evidence for advocacy and various approaches to skill development, counselling and therapeutic approaches. However, many studies, particularly within the counselling/ brief intervention and therapeutic intervention approach sections, included small sample sizes. Many studies also reported high rates of attrition, and lacked follow-up beyond programme completion. Larger, more robust studies are required to determine effective approaches to responding to domestic violence among victims.

Intervention approaches for abusers were generally quite uniform, often employing psycho-educational, broad skill development, or cognitive behavioural approaches, including the Duluth Model from the USA. However, there were variations in how programmes for abusers were implemented (setting, facilitator, duration, etc.). Larger, more robust studies and studies comparing different interventions and approaches (including those that compare varying intensities, durations, etc.) are required to respond to domestic violence among batterers, couples and elders.

Q4: Interventions for Children Exposed to Domestic Violence

This review addressed the nature of the interventions and approaches used in health and social care settings for identifying and responding to children exposed to domestic violence. Our review identified one systematic review article within which 25 articles were in the scope of this review, plus 13 additional articles. While the assessment method used in the review article is not precisely the same as the NICE method, the 25 articles were quality assessed for strengths and weaknesses and critically appraised by the review authors. However, the quality of these studies is reliant on what is reported by Rizo et al. (2011), and is therefore a limitation of this review.

Summary of findings

The Rizo et al. review identified four main approaches to responding to child witnesses of domestic violence. Approaches reported on are: counselling and therapy oriented; some that are crisis and outreach oriented; some that focus on parenting and the child-parent relationship, and some that are multi-component, involving more than one of the above in addition to approaches such as advocacy, social support and linkages between agencies. All the findings, including the Rizo et al. studies, were organised into new categories, reflecting factors such as whether or not the intervention was single or multi-component; therapy or psycho-education focused; aimed at children, or mothers and children; and recognizing the mix of aspects such as advocacy, therapy and parenting. An overview of these findings follows.

We found moderate to strong evidence that single component therapeutic interventions aimed at both mother and child are effective in improving child behaviour, mother-child attachment and stress and trauma-related symptoms in mothers and children. All studies included ethnically diverse samples of children and mothers. Intervention approaches varied, including: mother-child therapy, shelter-based parenting interventions, and play/ activity based therapies. In general, all studies reported improvements in the measured outcomes for children and their mothers.

There is inconsistent evidence that single-component psycho-educational interventions aimed at mothers and children are effective in building coping skills, increasing knowledge of domestic violence and improving children's behaviour and mothers' parenting skills. While the majority of studies reported improvements on the outcomes measured for children and mothers, in some studies improvements were not sustained at follow-up, while other studies had significant methodological weaknesses (small sample size, weak analysis, lack of information on intervention, etc.), limiting the formation of strong evidence of impact.

There is weak evidence regarding single component therapeutic interventions. Interventions varied widely, including: play therapy, expressive writing therapy, and equine assisted psychotherapy. Play therapy and equine therapy both demonstrated some improvements with diverse groups of children in behaviour, aggression and self-esteem, but there were only three studies in this area and these interventions are not comparable.

There is moderate evidence that single-component psycho-educational interventions (addressing skills such as: stress and conflict management, coping and relationship skills, understandings of violence, etc.) aimed at children are effective in improving children's coping skills, behaviour, emotional regulation, conflict resolution skills and knowledge about violence. While all studies reported improvements for children, the

studies as a whole were moderate in quality (many lacked follow-up, had small sample sizes, etc.) and limited the formation of strong evidence of impact.

There is moderate evidence that multi-component interventions with a focus on advocacy are effective in reducing the trauma symptoms and stress in both children and families, and in improving child behaviours such as aggression. Interventions included: community-based service planning, nurse case management, and non-parental child care for disadvantaged families. Overall, these studies reported improvements in psychological and behavioural outcomes for children, with some indicating greater improvement with increased intensity. However, some studies were not very strong (lack of study details, incomplete data, etc.) and therefore only moderate evidence of impact is noted.

There is moderate evidence of effectiveness of multi-component interventions including both therapy and advocacy among diverse populations of women and children, some with co-occurring issues of substance use and mental health issues. All studies were conducted with ethnically diverse samples. These interventions increased knowledge and awareness about violence and safety planning, improved self-esteem and self-competence and improved interpersonal relationships. All studies reported improvements for children (with some noting variations between different age groups of children), but were moderate in quality.

There is moderate evidence of effectiveness of multi-component interventions focused on therapy and parenting aimed at diverse populations of mothers and children. These interventions showed moderate improvement in children's behaviour and emotions, knowledge about violence and reductions in mothers' stress and ability to manage children. All studies reported improvements for both children and mothers, and several of the studies reviewed by Rizo were identified as rigorous. However, the majority of studies had significant methodological weaknesses, which limited the formation of strong conclusions regarding effectiveness.

Discussion

Overall, the majority of studies were before and after studies that did not have follow-up points. The diversity of the interventions and the lack of reporting of benefits specific to sub-components of multi-component interventions also make it difficult to compare and discuss the benefits of different modalities. However, in the case of single focus interventions, interventions aimed at mothers and children together appear to be more beneficial for improved outcomes for both, rather than for single focused interventions for children only. In addition, a number of multi-component studies reported improved outcomes for children tied to improved outcomes on the part of their mothers, confirming the benefits of a continuum oriented approach, with options for parents and children at different levels of risk, and with different preferences for support and treatment.

General population interventions with children, or flexible, community based educational interventions that may reach more children and may offer broad prevention are lacking in the literature. Several grey literature reports that did not meet inclusion criteria also note the benefit of multi-system integrated interventions for children and adults (to be discussed in the following section).

Q5: Partnership Approaches to Domestic Violence

Twenty one studies were included in the review and were organized into four evidence statements: effectiveness for increasing referrals and addressing violence; interagency information sharing and policy development; enabling factors to partnership working; and barriers to partnership working. All studies received a moderate quality rating [+]. These studies included: collaborations among various service providers for handling cases of domestic violence (including: domestic violence agencies, child welfare, police, mental health services), the impact of source of referral on outcomes, MARAC evaluations, evaluations of a community coordinating council, multi-agency approaches to elder abuse, a multi-agency service for gay, bisexual, transgender and heterosexual men who have experienced domestic violence, and a partnership model to address children who witness violence.

Summary of findings

There is moderate evidence that partnerships to address domestic violence were effective at: increasing referrals, reducing further violence, or supporting victims of domestic violence. The majority of studies found that partnership approaches were associated with improvements in various abuse-related measures including: family conflict, risk of mistreatment for elders, re-victimization or threat of violence, response to and safety for victims, and referrals to support services. However, one study found that a multi-agency approach was not effective in meeting the needs of vulnerable adults.

There is also moderate evidence that partnership approaches have been effective in improving relationships, practices and policies of partner agencies to address DV. Findings from these studies were typically based on stakeholder reports, revealing improvements in: relationships and collaboration between partners, training, knowledge and sharing of information and resources, the development of policies and protocols, and involvement of key agencies/ stakeholders.

There is moderate evidence regarding both enabling factors and barriers to partnership working. These studies examined member/ stakeholder responses to identify factors associated with the perceived success of the partnership. Studies identified the following enabling factors as key to effective partnership working: strong leadership, management and coordination, active membership, community

involvement, strong relationships and communication, and training and resources. However, the following barriers were reported: lack of resources (financial and human), differences in the culture of agencies/ organizations, leadership and management issues, lack of commitment, limited monitoring, and addressing diverse populations. Issues related to the inconsistent following of protocols or guidelines, and confidentiality issues among multi-disciplinary case review teams were commonly cited challenges. The lack of diverse representation in partnerships and challenges in addressing domestic violence among specific vulnerable groups, including LGBT, Black and Minority Ethnic (BME) groups and women who experience sexual abuse, were also noted in several studies.

Discussion

Overall, there were no high quality studies, and the majority of studies that were included were ‘before or after’ or qualitative studies providing narrative reports of findings. There was a lack of research addressing ‘honour’-based violence, approaches for diverse sub-groups of women and men, or integrated domestic violence and substance use services. However, many studies were conducted in the UK (nine out of twenty), so applicability of the available evidence is relatively high.

8.2 NICE guidelines summary

This summary of NICE guidelines has been taken directly from NICE documentation[65].

Recommendation 1. Commissioning: planning services

Who should take action?

- Local, regional and national commissioners of domestic violence and abuse and related services.
- Strategic partnerships, for example health and wellbeing boards, local domestic violence partnerships.

What action should they take?

- Local commissioners should use a comprehensive mapping exercise to identify all local services that deal with domestic violence and abuse. (For example, housing, the police, health, criminal justice, education, safeguarding, social care and other specialist services.) Services should be mapped against the Home Office's Coordinated Community Response Model and any gaps identified.
- Local commissioners should use the results of the mapping exercise to inform commissioning. They should develop referral pathways that aim to meet the health and social care needs of all those affected by domestic violence and abuse.
- Regional and national commissioners should work with local commissioners to ensure service support extends across local authority boundaries, where appropriate (for example, within prison services).
- Strategic partnerships should use the results of mapping in the joint strategic needs assessment (JSNA) and other strategic planning tools. They should also make the results widely available to all relevant services and the general public. For example, they could produce a directory of services.

Recommendation 2. Participate in a local partnership to prevent domestic violence and abuse

Who should take action?

Local authorities, health services and their strategic partners (including those in the voluntary and community sectors).

What action should they take?

- Ensure senior officers from the following services participate in a local partnership to prevent domestic violence and abuse, along with front line practitioners and service users or their representatives:

  - health services and the local authority (including the chairs of local safeguarding boards for adults and children
  - housing
  - police and crime commissioners
  - criminal justice agencies
  - the Children and Family Court Advisory and Support Service (CAFCASS)
  - voluntary, community and independent sector organisations.
- Regularly review membership of the partnership to ensure it is relevant and inclusive.

Recommendation 3. Commissioning: develop an integrated strategy

Who should take action?

Local strategic partnership on domestic violence and abuse.

What action should they take?

- Establish an integrated commissioning strategy with input from domestic violence and abuse services and from people who have experienced domestic violence and abuse. The strategy should:
  - meet the needs of both those who experience domestic violence and abuse and the perpetrators (including young people)
  - consider the needs of children and young people who are exposed to domestic violence and abuse
  - meet the needs of all local communities.
  - Ensure the strategy is based on the following principles:
  - aligned or, where possible, integrated budgets and other resources
  - one partner takes the strategic lead and oversees delivery on behalf of the local strategic partnership
  - services address all levels of risk and all degrees of severity of domestic violence and abuse
  - services are based on sound commissioning evidence (see recommendation 1).
  - agencies work together to deliver services.
- Monitor implementation of the strategy.

Recommendation 4. Commissioning: establish an integrated care pathway

Who should take action?

Commissioners of services for those who experience or perpetrate domestic violence and abuse.

What action should they take?

- Ensure there is an integrated care pathway for identifying, referring and providing support for both people who experience, and those who perpetrate, domestic violence and abuse. Ensure resources are available to support it.
- Ensure people who have substance misuse or mental health problems and are affected by domestic violence and abuse are referred to the relevant health, social care and domestic violence and abuse services.
- Ensure all service pathways have robust mechanisms for assessing the risks facing those adults (and their children) who experience domestic violence and abuse.

Recommendation 5. Services: create an environment for disclosing domestic violence and abuse

Who should take action?

- Health and social care service managers in the statutory, voluntary, community and private sectors.
- Specialist domestic violence and abuse services.
- Related services. This includes schools, the police, criminal justice (including prisons), housing, early years and youth services and services for older people.

What action should they take?

- Clearly display information in waiting areas and other suitable places about the support on offer for those affected by domestic violence and abuse and the contact details of relevant helplines. (For example, the number of the National Domestic Violence Helpline.)
- Ensure the information on where to get support is available in a range of formats and locally used languages. The former could include braille and audio versions and the use of large font sizes. It could also include more discreet ways to convey the information, for example, by providing pens or key rings with a helpline number.
- Establish a referral pathway to specialist domestic violence and abuse agencies (or the equivalent within a health or social care setting). This should include age-appropriate options and options for groups that may have difficulties accessing services, or are reluctant to do so. (The latter may include people from Black and minority ethnic groups, people who are disabled, people whose immigration status is insecure, older people, trans people and lesbian, gay or bisexual people.)
- Ensure staff know about the services, policies and procedures of relevant local agencies in relation to domestic violence and abuse.

- Provide ongoing training and regular supervision for staff who may be asking people about domestic violence and abuse. This should aim to sustain and monitor good practice.
- Establish clear policies and procedures for staff who have been affected by domestic violence and abuse. Ensure there are opportunities for addressing both personal issues in relation to domestic violence and abuse and any issues arising from working in this area.
- Establish a process for regular staff supervision that monitors and sustains good practice.

Recommendation 6. Services: tailor support

Who should take action?

- Domestic violence and abuse service managers.
- Staff in all health and social care settings, including the voluntary and community sector, and those they work with. This includes: schools, the police, criminal justice (including prisons), housing, early years and youth services and services for older people.

What action should they take?

- Assess what type of service someone needs – crisis, medium- or long-term support – bearing in mind that these stages can be cyclical.
- For those in need of immediate support, consider referral to specialist domestic violence and abuse services. This includes refuges, floating and outreach support and advocacy. It also includes housing workers, independent domestic violence advocates, or a multi-agency risk assessment conference (MARAC) for high-risk clients.
- For those in need of medium-term support, consider referral to floating or outreach advocacy support or to a skill-building programme.
- For those in need of long-term support (for example, following the end of the relationship or because they have previously experienced domestic violence and abuse), consider referral to local group support programmes. If symptoms indicate they have mental health problems, also refer them to mental health services (see recommendation 13).

Recommendation 7. Information sharing

Who should take action?

- Health, social care, education, criminal justice and voluntary and community sector service providers involved with those who experience or perpetrate domestic violence and abuse.

- Commissioners of services for those who experience or perpetrate domestic violence and abuse.

What action should they take?

- Take note of the Data Protection Act and professional guidelines that address confidentiality and information sharing in health services, such as the Caldicott guidelines. This includes seeking consent from people to share their information and letting them know when, and with whom, information is being shared.
- Develop or adopt clear protocols and methods for sharing information, both within and between agencies about people at risk of, experiencing, or perpetrating domestic violence and abuse. Clearly define the range of information that can be shared and with whom (this includes protocols on sharing information with health services on the perpetrator's criminal history).
- Ensure information-sharing methods are secure and will not put anyone involved at risk.
- Ensure the protocols and methods are regularly monitored.
- Identify and train key contacts responsible for advising on the safe sharing of domestic violence and abuse-related information.
- Ensure all staff who need to share information are trained to use the protocols so that they do not decline to cooperate from overcaution or fear of reprisal.
- Ensure any information shared is acknowledged by a person, rather than an automatically generated response.

Recommendation 8. Asking about domestic violence and abuse

Who should take action?

Health and social care service managers and professionals.

What action should they take?

- Health and social care service managers should ensure front line staff are trained to recognise the indicators of domestic violence and abuse and ask relevant questions if the evidence suggests it may be occurring (targeted enquiry).
- Trained staff in services where domestic violence and abuse are commonly seen should ask the people they see, on a one-to-one basis, whether they have experienced such violence and abuse. The enquiry should be made in a kind, sensitive manner and in an environment where the person feels safe. Relevant services where such enquiries should be a routine part of good clinical practice include: antenatal, postnatal and reproductive care, sexual health, substance misuse and mental health services.

- Ensure staff know, or have access to, information about the services, policies and procedures of all relevant local agencies for people who experience or perpetrate domestic violence and abuse.
- All services should have formal referral pathways in place for people who disclose that they have been subjected to domestic violence and abuse (see recommendation 4).

Recommendation 9. Equality and diversity: overcoming barriers to accessing services

Whose health will benefit?

People who may find services inaccessible or difficult to use, for example, people from Black and minority ethnic groups or with disabilities, older people, transexual people, and lesbian, gay or bisexual people.

Who should take action?

Health and social care commissioners and service providers, including in the voluntary and community sector.

What action should they take?

- Identify any barriers people may face when trying to get help for domestic violence and abuse. Do this in consultation with local groups that have an equality remit (including organisations representing the interests of specific groups) and in line with statutory requirements.
- Introduce a strategy to overcome these barriers.
- Train staff who have direct contact with people affected by domestic violence and abuse in equality and diversity issues. (This includes those working with people who perpetrate this violence and abuse.) Specifically:
    - ensure staff assumptions about people's beliefs and values, for example in relation to 'honour', do not stop them identifying and responding to domestic violence and abuse
    - ensure interpreting services are confidential (confidentiality is often a concern in small communities where a minority language is spoken)
    - ensure professional interpreters are used: do not rely on the use of family members or friends
    - ensure people who may be experiencing domestic violence and abuse can be seen on their own (a person may have multiple abusers and friends or family members may be colluding in the abuse).

Recommendation 10. Identifying domestic violence and abuse: children and young people

Who should take action?

- Local safeguarding children boards and other local partnerships with a responsibility for safeguarding children.
- Providers of services where children and young people who experience domestic violence and abuse may be identified. This includes: accident and emergency (A&E), child and adolescent mental health, maternity, sexual health, general practice, dental and other health services; social care; youth services; early years, schools; and voluntary and community sector services.

What action should they take?

- Ensure staff can recognise the indicators of domestic violence and abuse, understand its impact on children and young people, and know when child protection services should be involved.
- Ensure staff are trained and confident to discuss domestic violence and abuse with children when they suspect they are being exposed to it.
- Ensure staff are trained and confident to discuss domestic violence and abuse with young people when they suspect they are being exposed to, experiencing or perpetrating it.
- Put clear information-sharing protocols in place to ensure staff gather and share information to gain a clear idea of the child or young person's circumstances, risks and needs.
- Develop (or adapt) and implement clear referral pathways to local services that can support children and young people affected by domestic violence and abuse. This should include opportunities for consultation with safeguarding leads, senior clinicians or managers and consideration of the appropriateness of a referral to children's services.
- Ensure staff know about the services, policies and procedures of all relevant local agencies for children and young people in relation to domestic violence and abuse.
- Involve children and young people in the development and evaluation of local policies and services.
- Monitor policies and services with regard to children's and young people's needs.

Recommendation 11. Specialist domestic violence and abuse services for children and young people

Who should take action?

- Local safeguarding children boards and other local partnerships with a responsibility for safeguarding children.

- Commissioners and providers of specialist services for children and young people who experience domestic violence and abuse. This includes child and adolescent mental health, sexual health, social care, youth and relevant voluntary and community sector services.

What action should they take?

- Address the emotional, psychological and physical harms arising from a child or young person's exposure to domestic violence and abuse, as well as their safety. This includes the wider educational, behavioural and social effects.
- Provide a coordinated package of care and support that takes individual preferences and needs into account (for example, in terms of where help is provided and what form it takes).
- Ensure interventions are multi-component and include advocacy, therapy and parenting support. They may involve individual or group sessions, or both.
- Ensure support matches the child's developmental stage (for example, infant, pre-adolescent and adolescent). Interventions should be timely and should continue over a long enough period to achieve lasting effects. Recognise that long-term interventions are more effective.
- Provide interventions that strengthen the relationship between the child or young person and their non-abusive parent or carer. Offer them to children and their non-abusive parents in parallel or joint sessions.
- Include support and services for young people experiencing domestic violence and abuse in their own intimate relationships.

Recommendation 12. Advocacy

Who should take action?

- Health and social care commissioners (including clinical commissioning groups).
- Health and wellbeing boards.
- Front line practitioners in a number of settings, in particular, refuges and outreach services.
- Domestic violence and abuse advocates.

What action should they take?

- Provide all those currently (or recently) affected by domestic violence and abuse with advocacy services tailored to their level of risk and specific needs. For example, provide this support in different languages, as necessary. Also ensure that advocates are aware of how racism, homophobia, ageism or the fact that someone is disabled may have contributed to the situation.
- Ensure advocacy support meets national standards of good practice.

- Ensure advocacy support forms part of a comprehensive referral pathway (see recommendation 4).
- Ensure the support is offered (although not necessarily delivered) in settings where people may be identified or may disclose that domestic violence and abuse is occurring. Examples include: A&E, general practice, refuges, sexual health clinics and maternity, mental health, rape crisis, sexual violence, substance use and abortion services.

Recommendation 13. Mental health interventions

Who should take action?

- Clinical commissioning groups.
- Health and wellbeing boards.
- Health professionals working in primary care, mental health and the voluntary and community sectors.

What action should they take?

- Where people who experience domestic violence and abuse have a mental health condition, provide evidence-based treatment for the condition. This may include psychological interventions (in particular, cognitive behavioural therapy), medication and support, in accordance with national guidelines.
- Ensure psychological interventions are provided by professionals trained in how to address domestic violence and abuse and psychological trauma.
- Ensure the treatment programme also includes an ongoing assessment of risk, collaborative safety planning and the offer of a referral to specialist domestic violence and abuse support services. It must also take into account the person's preferences and whether the domestic violence and abuse is ongoing or historic.

Recommendation 14. Commissioning programmes for people who perpetrate domestic violence and abuse

Who should take action?

- Commissioners of these programmes.
- Health and wellbeing boards.

What action should they take?

- Commission programmes for people who perpetrate domestic violence and abuse, in accordance with national standards and based on the local needs assessment (see recommendation 1).
- Ensure programmes primarily aim to increase the safety of the perpetrator's partner and children. Ensure this is monitored and reported. In addition,

programmes should report on the perpetrator's attitudinal change, their understanding of violence and accountability, and their ability and willingness to seek short-term help.
- Link these programmes with specialist support for those experiencing domestic violence and abuse (including children and young people). This should include feedback to those affected on the perpetrator's progress. See also recommendations 1–4.

Recommendation 15. Training to support different roles

Who should take action?

- Royal medical colleges.
- Professional organisations responsible for setting training and registration standards for clinical, social worker and social care staff.
- Commissioners.
- Heads of health, social care and related services.
- Universities and other providers of health and social care training.

What action should they take?

- Provide different levels of training for different groups of professionals, as follows.
- Training to provide a universal response should give staff a basic understanding of the dynamics of domestic violence and abuse and its links to mental health and substance use, along with the legal duties of staff (for example, their duty of care). In addition, it should cover the concept of shame that is associated with honour-based violence and an awareness of diversity and equality issues. It should also ensure they know what to do next:
    - Level 1 Staff should be trained to respond to a disclosure of domestic violence and abuse sensitively and in a way that ensures people's safety. They should also be able to direct people to specialist services. Typically this is for: non-specialist nurses, physiotherapists, speech therapists, dentists, youth workers, care assistants and non-specialist voluntary and community sector workers.
    - Level 2 Staff should be trained to ask about domestic violence and abuse in a way that makes it easier for people to disclose it. They should also be able to offer a referral to specialist services, where necessary. This involves an understanding of the epidemiology of domestic violence and abuse, how it impacts on people's lives and the role of professionals in intervening safely. Typically this is for: A&E doctors, adult social care staff, children's centre staff, children and family social care staff , GPs, midwives, health visitors, health and social care professionals in education (including school nurses), prison staff and substance use workers. In some cases it will also be relevant for youth workers.

- Training to provide a specialist response should equip staff with a more specialist understanding and enhanced skills:
    - Level 3 Staff should be trained to provide an initial response. In addition to the Level 2 response, this should include a risk assessment and continued liaison with specialist support services. Typically this is for: child protection social workers, safeguarding nurses, specialist midwives and health visitors with additional domestic violence and abuse training, MARAC representatives, substance use workers and mental health practitioners.
    - Level 4 Staff should be trained to give expert advice and support to people experiencing domestic violence and abuse. This is for specialists in domestic violence and abuse. For example, independent domestic violence advocates or sexual violence advocates, domestic violence and abuse and sexual violence counsellors and therapists and children's workers.
- Other training should raise awareness of domestic violence and abuse issues and the skills, specialist services and training needed to provide people with effective support. This is for commissioners, managers and others in strategic roles within health and social care services.
- All levels of training should include increasing amounts of face-to-face interaction, although Level 1 training can be delivered mostly online or by distance learning.
- Ensure face-to-face training covers the practicalities of enabling someone to disclose that they are affected by domestic violence and abuse and how to respond.

Recommendation 16. Training: integration of training and a referral pathway into general practice

Who should take action?

- Commissioners and service managers working in specialist domestic violence and abuse services.
- GPs.

What action should they take?

- Commissioners should commission integrated training and referral pathways for domestic violence and abuse. This should include education for clinicians and administrative staff in GP practices on how to monitor disclosures of domestic violence and abuse and how to make referrals to specialist agencies.
- Service managers should work in partnership with voluntary and community agencies to develop training and referral pathways for domestic violence and abuse.

Recommendation 17. Training: pre-qualifying and continuing professional development for health and social care professionals

Who should take action?

- The royal colleges.
- Professional organisations responsible for setting training and registration standards for relevant clinical, social worker and social care staff.
- Heads of health, social care and related services.
- Universities and other providers of health and social care training.

What action should they take?

- Ensure training is part of the undergraduate or pre-qualifying curriculum for health and social care professionals, as relevant. It should also be part of their continuing professional development programme. It should be delivered in partnership with local specialist domestic violence and abuse services and include both face-to-face and online content.
- Implement a rolling training programme that recognises the turnover of staff and the need for follow-up. The training strategy should:
    - be clear about the level of competency required for each role
    - refer, where appropriate, to existing accredited materials from specialist organisations working in domestic violence and abuse
    - ensure the content on domestic violence and abuse is linked to child safeguarding and adult protection services and vice versa
    - follow the recommended content for each level (see recommendation 15).

8.3 Croydon Domestic Violence Service Mapping (November 2013)

National and regional organisations/ services

Service / Organisation	Target group	Sector / Provider	Description
National Domestic Violence Helpline – Women's Aid / Refuge (0808 2000 247)	Anyone experiencing DV	Voluntary and Community Sector	National 24-hour Domestic Violence support and advice line for women experiencing domestic violence, their family, friends and colleagues and others calling on their behalf. Includes translation services.
Ascent	Women	Voluntary and Community Sector	Primary Agency Contact, part of the Women and Girls' Network, providing counselling and group work, and telephone support for victims of DV and support to service providers.
Broken Rainbow	LGBT	Voluntary and Community Sector	National LGBT Domestic Violence helpline supporting survivors, their families and friends, in addition to service provider support and training.
CASSA (Amicus Horizon)	Women and children under 11	Voluntary and Community Sector	Sanctuary, floating support
Domestic Violence Intervention Service	Men (nationwide, London-based)	Voluntary and Community Sector	Safety Planning, Immediate Network, Primary Contact Agency focused on challenging men, by Self-referrals or referrals from family courts , probation, social services, police or community groups, Referral by a referral form only
Encounter Freedom	Women	Private Sector	Primary Agency Contact offering group work programme for victims of DV
The Freedom Programme	Women	Private Sector	Primary Agency Contact providing group work for survivors of DASV

Service / Organisation	Target group	Sector / Provider	Description
Galop	LGBT	Voluntary and Community Sector	Support, advice and advocacy for LGBT people who have experienced hate crime, domestic abuse, sexual violence or problems with the police.
Jewish Women's Aid	Women and children	Voluntary and Community Sector	Support and accommodation for Jewish women and their children affected by domestic violence
Living Water Satisfies	Women survivors of Domestic Violence	Voluntary and Community Sector	Supporting women and their families to overcome domestic violence and mental ill health
Men's advice line	Male survivors of domestic violence	Voluntary and Community Sector	Advice and support for male survivors of domestic violence
No Recourse To Public Funds (NRPF) specialist refuge	Women And Children under 11	Voluntary and Community Sector	Immediate Network
One in Four	All survivors of sexual violence	Voluntary and Community Sector	Counselling, advocacy and support for survivors of sexual violence
Rape & Sexual Abuse Support Centre	All survivors of Sexual Violence	Voluntary and Community Sector	Advice and support for all survivors of sexual violence, in addition to training and support for providers.
Refuge	Women	Voluntary and Community Sector	A partnership with the National Domestic Violence Helpline, this is a national network providing emergency accommodation, emotional and practical support for women fleeing abuse. Includes culturally specific services for Eastern European, Asian and African families.

Service / Organisation	Target group	Sector / Provider	Description
Respect	Male and female perpetrators, young people who use violence and abuse, male victims	Voluntary and Community Sector	Develop, deliver and support effective services
Safer London Foundation	Girls and Young Women	Voluntary and Community Sector	Primary Agency Contact, incorporating the 'Empower' Program focusing on sexual violence and exploitation of young women
South London African Women's Organisation	BME – African Women	Voluntary and Community Sector	Practical and emotional support for female victims and survivors of violence from BME communities.
Survivors UK	Men	Voluntary and Community Sector	Information, support and counselling for men who have been raped or sexually abused, including an advice line, training and consultancy.
IMECE Turkish-speaking women's group	BME – Turkish-speaking women	Voluntary and Community Sector	Immediate support, advice and information on DV, welfare, housing, immigration and outreach services for Turkish-speaking women.
Women and Girls' Network	Women and girls	Voluntary and Community Sector	Counselling and information services for women and girls who have experienced any form of violence of abuse.
Woman's Trust	Women	Voluntary and Community Sector	Immediate network, national body providing one-to-one counselling, support groups and workshops for women survivors of domestic violence.
Victim Support, all victims of Crime	All victims of crime including DASV	Voluntary and Community Sector	Primary Agency Contact

Services and organisations local to Croydon

Service / Organisation	Target group	Sector / Provider	Description
Age UK Croydon	Older people	Voluntary and Community Sector	Identification and referral of older people at risk of and experiencing domestic violence and abuse. Support, information advice and guidance to older people, their carers and families.
Croydon Women's Aid	Women And Children under 11	Voluntary and Community Sector	Immediate Network, providing refuge and floating support, including legal, emotional, practical advice.
Croydon Sanctuary Project	People threatened by violence	Croydon Council Housing Department	Assistance in making homes more secure, for people vulnerable to or threatened by partners or ex-partners who want to remain in their homes.
Croydon University Hospital, GUM Clinic	Sexual Health	Croydon Health Services NHS Trust	Department of GU Medicine, including sexual health and sexual assault services
Croydon University Hospital, Midwifery Department	Women who have experienced FGM	Croydon Health Services NHS Trust	Lead midwife for FGM providing support, information and signposting for women who have experienced FGM
Cassandra Learning Centre	All young people who are DV survivors Young people	Voluntary and Community Sector	One-off advice, support and referral, or a series of appointments depending on need. Also provides education and training.
Edridge Road Community Health Centre	Contraception and Sexual Health (CASH)	Croydon Health Services NHS Trust	CASH, including sexual health assault services
Family Justice Centre, front line DASV service including, IDVA's, MARAC, counselling, legal advice housing, Croydon Family Violence Strategic Partnership Group	All domestic abuse and sexual violence (DASV) survivors	Croydon Council	Safety Planning, Immediate Network, Primary Contact Agency

8.4 Domestic Abuse and Sexual Violence action plan 2014/15

Objective/Action	Outcome/Deliverable	Deadline	Comments
PREVENTION			
Multi-agency Training Package designed, inc Train the Trainer for cascading Multi- agency domestic violence workforce training programme that covers awareness and dynamics of domestic violence, specific skills training on enquiry and completion of Multi- Agency Risk Assessment Conferences (MARAC) risk assessment, safeguarding responsibilities and referral pathways. *(Domestic Homicide Review - DHR) (JSNA)* Training covering use of technology and social media in perpetrating domestic violence and abuse. *(JSNA)* Provide staff with information on the toxic trio (DV, parental mental ill health, drug and alcohol misuse) to inform their safeguarding practice *(DHR)* Different levels of training for different groups of professionals. (*NICE)* Implement rolling training programme that recognises staff turnover and the need for follow up. (*NICE)*	Earlier identification resulting in more MARAC referrals & more early help. Information on the toxic trio embedded within training across adults and children's services. Audit of take up of training per agency *(DHR)* Drug services to explore the dynamic of domestic violence when working with individuals with substance misuse issues *(DHR)* People who misuse drugs or alcohol, have mental health problems and are affected by DASV are referred to relevant health, social care and specialist DASV services. *(NICE)* Support tailored to meet people's needs. (*NICE)* Level 1 - trained to respond to a disclosure of DASV sensitively and safely. (*NICE)* Level 2 - trained to ask about DASV in a way that makes it easier for people to disclose it. (*NICE)* Level 3 - trained to provide an initial response including risk identification and assessment, safety planning and continued liaison with specialist support services. (*NICE)* Level 4 - trained to give expert advice and support to people experiencing DASV. *(NICE)* Other training - for commissioners, managers and others in strategic roles to raise awareness and address misconceptions about DASV. (*NICE)*	May 2014 and ongoing	First round of multi-agency training delivered in November - December 2013 to 32 practitioners from various agencies. Second round of training targeted at partners exposed to DASV in their work but with low referral rates. Training dates set up until December 2014 and disseminated to partners.

Objective/Action	Outcome/Deliverable	Deadline	Comments
Joint media / marketing campaign to raise awareness and mobilise community Clearly display information in waiting areas and other suitable places about the support on offer for those affected by DASV. *(NICE)* Information on where to get support to be availed in a range of formats and languages; including braille, large font, audio and discreet formats. (*NICE)* *Communications to cover use of technology and social media in perpetrating domestic violence and abuse (JSNA)*	Communications strategy resulting in an increase in referrals Wider reach of DASV services to include hidden and vulnerable communities	January 2014 and ongoing	Clear communications strategy written and regularly updated. Currently working with partners to ensure messages are consistent and targeted
Plan implementation and raise awareness of right to know/ right to ask.	Right to know/ Right to ask implemented and well utilised	June 2014	Disseminated through training and communications network in partnership with police.
School & Children's Centres Prevention Programme using Roots of Empathy Evidenced based Programme and develop Values Versus Violence pilot 0-19 – to be launched in March A schools age appropriate early intervention approach that ties in with existing gangs and sexual exploitation programme. *(DHR)*	Children and parents better informed	March 2014 phase 1	Roots of empathy reported to be working well in school. Successful launch of Values Versus Violence programme on 5th March. Low take up of programme so far. Currently raising awareness of programme through Frontier and other schools networks known to the council.

Objective/Action	Outcome/Deliverable	Deadline	Comments
Conduct a borough wide review of the response to domestic violence, addressing the gap between strategy and delivery of the strategic aims. Review should include research on pre-disposing risk for victims and perpetrators. *(DHR)* Strategic partnerships should assess the need for DASV services as part of the joint strategic needs assessment. (*NICE)*	Prevention work informed by mapping exercise Better understanding of victims' experiences and issues. Domestic violence protocol, policy and care pathway across the partnership and for each organisation including enquiry and provision for safeguarding children and vulnerable young people. *(DHR)*	Ongoing	
Research on 'what works' evidence based practice	Partners and commissioners better informed about what works	Ongoing – build into JSNA	Area of work to be further informed post final publication of JSNA.
Integrate the recommendations from the 2 Domestic Homicide Reviews with the overarching DASV plan.	Overarching DASV plan responds to the DHR recommendations and actions are measurable and monitored through the Champions DASV group.		Currently analysing the recommendations and combing the required actions. Meeting Carl Parker, policy officer in June to tie this in.
PROTECTION			
Named DASV leads in all organisation and improved DASV screening - GPs /health priority ***Domestic Abuse and Sexual Violence Group (DASV) to have a named lead from every local partner agency.*** *(JSNA)* Regularly review membership of the partnership to ensure it is relevant and inclusive. *(NICE)* Establish clear policies and procedures for staff who have been affected by DASV. *(NICE)*	Easier/appropriate access to services CEG informed and driving agenda. Sustainable partnership funding meets demands/ challenges of DASV. Trained staff to ask service users whether they have experienced DASV as routine even when there are no indicators of abuse. (*NICE)*	From March 2014	Dedicated health and JCP leads identified. Further work to be done with schools and designated safeguarding leads.

Objective/Action	Outcome/Deliverable	Deadline	Comments
Develop hub and spoke model including pilot of IDVAs based in the Police Station & Hospital Provide all those currently and recently affected by DASV with advocacy and advice services tailored to their level of risk and specific needs; including support in different languages as necessary. *(NICE)*	Evaluation of pilot IDVAs showing earlier interventions Hub and spoke model with pilot IDVAs in settings where people may be identified or may disclose occurrence of DASV. (*NICE)* Services that indicate awareness of the effects of discrimination and prejudice on service users. (*NICE)* Specialist support services that meet national standards of good practice and form part of a comprehensive pathway. (*NICE)*	Feb 2014	IDVA pilot slightly delayed through recruitment, due to go live in May 2014. Currently in discussion with adults services regarding co-existing agenda of substance misuse and DASV and the potential for this to be the health post.
Multi Agency Safeguarding Hub (MASH) - pathways in and out of MASH aligned and understood by referring agencies	More consistent response on safeguarding and DASV	May 2014	
Increase the use of injunctive and bail measures	Local action reduces repeat perpetrators. Consistent legal support offer in place. Independent Domestic Violence Advisors (IDVA) working in police station to improve approaches to police protection orders.	April onwards	Anecdotally believe there is an increase but challenging to track due to independent nature of legal representatives.
Cohesive strategy for Female Genital Mutilation /Forced Marriage and Honour based violence	Better data/identification of FGM/FM Safer Croydon Partnership deciding strategic approach and governance arrangements relating to FGM, FM and HBV *(JSNA)*	June 2014	Future work to be planned in partnership with Quality Assurance, Children's and Adults' safeguarding boards. EQIA currently being written to address impact to vulnerable groups.

Objective/Action	Outcome/Deliverable	Deadline	Comments
Improve the working relationships with Crown Prosecution Service / Courts	More ably protect victims - proactive management of perpetrators by engaging with CPS/ Courts better.	May 2014 onwards	Partnership approach with police to improve engagement with CPS and Courts and improve outcomes for service users.
PROVISION			
Provision mapped – improve knowledge and access to community based services Local commissioners should undertake comprehensive mapping exercise to identify all local services and partnerships that work in DASV. (*NICE)*	Easier/appropriate access to servicesServices mapped against the Home Office endorsed Coordinated Community Response model (http://www.ccrm.org.uk/) and gaps identified. *(NICE)*	May 2014	Provision mapped in JSNA. More work to be done.
Further research to better understand data & complexity and baseline for strategy	Staff report better understanding DV	JSNA finalised July 2014	Training plan in place and practitioner forum dates set. Communications network established. Data analysis informing risks and vulnerabilities.
Develop DASV toolkit including pathways/ referrals to support workshops, on-line and training Managers to work in partnership with voluntary and community agencies to develop training and referral pathways for DASV. (*NICE)*	Consistent approach to safeguarding vulnerable adults and children where domestic violence is a feature. Multi-agency borough referral pathway agreement which includes action taken by agencies and outcomes of referrals *(DHR)* Service pathways that have consistent robust mechanisms for assessing risks facing adults who experience DASV and their children. (*NICE)*	March 2014 phase 1	First draft of toolkit written after consultation locally and in line with national practice. Final version to be made available in June.

Objective/Action	Outcome/Deliverable	Deadline	Comments
Develop Young Persons Violence Advocate role and approach to DASV in 16-18 year olds, raising awareness amongst young people of the issue of relationship violence and publicising what support is available. *(DHR)*	Young people's DASV addressed Support and services for children and young people experiencing DASV in their own intimate relationships. (*NICE)* Support tailored to meet people's needs (*NICE)*	March 2014 onwards	YPVA in post since January 2014, working across gangs, serious youth violence, sexual exploitation and care leavers to inform practice. YPVA holding an active caseload.
Develop and pilot interactive web based IDVA support service, utilising family and practitioner space for cost-effective early support.	Pilot evaluation showing value and cost effectiveness of web-based IDVA	Sep 2014	Not yet able to access required expertise to follow this through.
Develop perpetrators programmes and Caring Dads programme evaluated Repeat Perpetrator programme build on perpetrator intelligence and reduce repeat perpetrators Commission and evaluate tailored interventions for perpetrators of DASV in accordance with national standards and based on local needs assessment. (*NICE)* Identify and link with existing initiatives that work with DASV perpetrators. (*NICE)* Link perpetrator services with victim services e.g. ongoing risk assessment of the perpetrator being linked with safety planning and support for the victim. (*NICE)*	Perpetrator programme impacting on behaviours and reducing repeats Robust evaluations of interventions. Monitored interventions that aim to increase the safety of the perpetrator's partner and children whereby perpetrators' attitudinal change, understanding of violence and accountability as well as ability and willingness to seek help are reported upon. (*NICE)*	April 2014	Multi- agency sub group established to look at evidence based perpetrators programmes. Consultation with RESPECT underway, to further develop perpetrator work including working with young perpetrators.
Develop volunteer based floating support service to support victims and survivors	Develop provision through volunteer workforce Floating support provided by CASA Support tailored to meet people's needs (*NICE)*	June 2014	Working in partnership with CASA to develop floating support offer. Floating support post (17 hours a week) recruited to by CASA.

Objective/Action	Outcome/Deliverable	Deadline	Comments
PARTNERSHIP			
DASV Multi- agency guidelines & pathways agreed by champions and agencies to be on message Ensure senior officers participate in a local strategic multi-agency partnership to prevent DASV along with representatives of front line practitioners and service users or their representatives. (NICE)	Practitioners involved in both operational and strategic multi-agency initiatives. (*NICE)* **DASV Multi- agency guidelines & pathways** agreed by champions and agencies to be on message	May 2014	Pathways and guidelines written and widely distributed.
Multi-agency information sharing protocol written and agreed across relevant organisations Develop / adapt clear protocols and methods for sharing information, both within and between agencies about people at risk, experiencing or perpetrating DASV. (*NICE)* All staff who need to share information are trained to use the information sharing protocols so that they do not decline to share information because of being overcautious or for fear of reprisal. (*NICE)* Identify and train key contacts responsible for advising on safe sharing of DASV related information. (*NICE)*	Information shared to support victim Clear protocols and secure methods for information sharing, which are regularly monitored and do not put anyone involved at risk. (*NICE)*	July 2014	MARAC protocol written and distributed to relevant partner. To be signed off by CEG. Broader information pathways to be developed as part of the DASV toolkit.
Adopt a systemised approach to further assess the needs of protected groups in relation to domestic abuse and sexual violence *(JSNA)* Help people who might find DASV services inaccessible or difficult to use. *(NICE)* Identify barriers protected groups may face when trying to get help. *(NICE)*	Impact demonstrated by wider reach of services, inclusive of hidden and vulnerable communities Undertake an EQIA.	February onwards	Partly met through relationship with CVA and DASV forum. EQIA currently being written to address impact to vulnerable groups

Objective/Action	Outcome/Deliverable	Deadline	Comments
Engage a broader range of faith based stakeholders, non-specialist voluntary and community sector organisations working with groups at risk of experiencing domestic abuse and sexual violence partnerships (*JSNA)*Commissioners and service providers in the statutory, private, voluntary and community sector help people who may find it difficult to access services (NICE)	Strategy to overcome barriers to accessing DASV services. *(NICE)*Frontline staff trained to understand equality and diversity issues for victims and perpetrators of DASV. *(NICE)*Professional interpreters from confidential services are used. (*NICE)*		
Community based DASV forum to be supported and developed	Community groups fully engaged and supported to deliver DASV support	March 2014 onwards	Work continues and members are represented in relevant sub-groups e.g perpetrators group.
Progress on the DASV to be reported to the Safer Croydon Partnership through the children and adults safeguarding boards. DASV Strategy to be refreshed.	Safer Croydon partnership overseeing implementation of the recommendations from the domestic homicide reviews *(JSNA)* Safer Croydon Partnership continually updating DASV strategy in light of best available guidance and evidence *(JSNA*)	June 2014	
Highlight and explain the Think Family Approach *(DHR)*	Practitioners, professionals and clinicians understand the Think Family Approach and their responsibilities regarding safeguarding children. This to be evidenced through commissioned and non-commissioned services.	June 2014	
Review the process of the early offer of help, to examine its effectiveness especially CAF implementation within health services and how domestic violence is included in this assessment *(DHR)*	Early intervention measures targeting children, young people and families *(JSNA)* Early Help pathways fully established, facilitating support to access services Early Help guidance fully embedded within universal and targeted services	June 2014	

Objective/Action	Outcome/Deliverable	Deadline	Comments
Disseminate learning from the two current reviews widely across the partnership. This is to be in the form of a written briefing, dissemination sessions and incorporating findings in to any domestic violence training. *(DHR)* The Joint Strategic Needs Assessment on domestic violence should reference the findings of the two domestic homicide reviews *(DHR)*	Partnership Action Plan and Joint Strategic Needs Assessment reflect findings from the domestic homicide reviews.	July 2014	
Establish an integrated commissioning strategy which includes a quality assurance framework that highlights the impact of local interventions. *(JSNA)* Use results of needs assessment and mapping exercise to inform commissioning. (*NICE)* Develop an integrated commissioning strategy (*NICE)* Commission integrated care pathways *(NICE)* Regional and national commissioners work with local commissioners to ensure DASV support services extend across local authority boundaries where necessary, for services such as prisons that cover broader geographical areas. (*NICE)* Regional and national commissioners work with local commissioners to provide specialist service across local authority boundaries where there is not enough local need to justify setting them up e.g. services to prevent forced marriages, LGBT affected by DASV, those affected by HBV and stalking. (*NICE)*	Formal commissioned system providing appropriate out of hours adult service *(DHR)* Integrated care pathways that identify, refer and provide interventions to support people who experience DASV and manage those who perpetrate it. *(NICE)*	July 2014	Work to commence in June.