Domestic violence and abuse needs assessment 2016
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Foreword

Thank-you for taking the time to read this needs assessment. There are many myths surrounding Domestic Violence and Abuse. This needs assessment is an attempt to document in a factually accurate way the current situation in relation to Domestic Violence and Abuse (DVA) in South Gloucestershire. It captures the views of people with lived experience, other stakeholders, the local and national data and policy positions, and evidence for prevention and interventions.

Why is domestic violence and abuse an issue of importance? Firstly, it is extremely common. About 6000 women in South Gloucestershire will have experienced abuse of this sort in the last year. Secondly, it is pervasive. These women come from all ages, all social backgrounds, and all ethnicities. Thirdly, there are groups of people at risk who either do not seek help or find it hard to get help from our existing services. Data suggest, for example, that DVA is as common in men in same-sex relationships as women in heterosexual relationships. Finally, the impact of DVA is devastating, both on the victims and also on children witnessing abuse.

South Gloucestershire is about to re-commission DVA services and this needs assessment will inform that process. Addressing DVA requires work across organisational boundaries, partnerships between statutory agencies, providers and voluntary and community sector organisations – something history suggests we are not always very good at. I would encourage you to get involved, become a champion within your organisation, and ensure that together we address the problem of DVA in South Gloucestershire.

I would be very grateful for any comments or thoughts that you may have on this needs assessment or about DVA services in South Gloucestershire.

Kind regards,

[Signature]

Director of Public Health for South Gloucestershire
Acknowledgements

A wide range of stakeholders contributed to development of this needs assessment. Below is a list of the organisations who responded to the request; we are grateful to these organisations for the provision of data and to those individuals who gave up their time to share their views and experiences on domestic violence and abuse need and service provision across South Gloucestershire.

Avon and Somerset Constabulary
Avon and Somerset Office of the Police and Crime Commissioner
Diversity
Lighthouse Victim Care
Merlin
National Probation Service
Nextlink
NHS South Gloucestershire Clinical Commissioning Group
Knightstone
Race Equality Network
Stand Against Racism and Inequality (SARI)
Sirona
Solon
South Gloucestershire Council
Southern Brooks
Sovereign
Survive
University of Bristol
University of the West of England
Victim Support
Executive summary

1. Domestic violence and abuse (DVA) is common. The nature of DVA means that incidents, episodes, and patterns of behaviour have the potential to cause victims and their families a great deal of harm. The direct harm to health of victims is clear, and at its most severe can, and does, result in death. However there are also severe impacts on health and wellbeing of victims and to children who may be exposed to DVA incidents in the home.

2. Applying national prevalence rates to the population, we would expect there to be 6000 women in South Gloucestershire who had experienced DVA in the past 12 months. Local data suggest around 300 women per year are identified as being at high risk of serious harm or death. Sexual violence by a partner or ex-partner is common: 4000 women in South Gloucestershire will have experienced this in their lifetime and for 2000 women this will have been a serious sexual assault such as rape.

3. Men in same-sex relationships are believed to experience rates of DVA similar to female victims in heterosexual relationships and DVA in this group is associated with depression, anxiety, substance misuse, and unprotected sex. Rates of DVA for men in heterosexual relationships are lower and the abuse tends to be less severe. National prevalence rates would suggest that 3000 men in South Gloucestershire have suffered from DVA in the past year; prevalence data suggest that the majority of these male victims (70%) will be in same-sex relationships.

4. Other potentially vulnerable population groups are known to be at an increased risk of DVA and include those on very low incomes, full-time students, and people with a long-standing illness or disability. Of the expected 6000 female victims and 3000 male victims over the past twelve months, a third would be expected to have a disability or long-standing illness.

5. Many of the female victims would be expected to have children. It is estimated that at least 5000 children in South Gloucestershire have been exposed to domestic violence; this is likely to be an underestimate as it doesn’t include those aged under
eight. For many of these children exposure to the abuse is ongoing and for a small but important number the violence occurs often or on most days. These children are at increased risk of emotional harm and childhood attachment and behavioural problems in addition to an increased lifetime risk of offending, substance misuse, and entering into violent or abusive relationships themselves.

6. Women from White-Irish and Mixed/multiple ethnic groups may be at a slightly increased risk of DVA however these populations are small in South Gloucestershire. There is no clear evidence that the prevalence of DVA is greater in other minority ethnic groups though there is a lack of data on the risks to members of Gypsy and Traveller communities.

7. Stakeholders in South Gloucestershire are very supportive of the DVA agenda, and believe that the issue is important and impacts wide-ranging. It is generally believed that South Gloucestershire currently provides a good range of support services for female victims; however there is belief that some services may be insufficient to meet demand. There is a desire to modernise the refuge provision in South Gloucestershire, including more self-contained apartments suitable for families which might widen provision to better support men, women with male teenage children, LGBT victims, and adults with very complex needs. More broadly, DVA services across South Gloucestershire were perceived by some to be disjointed with eligibility, access, and referral pathways not always clear. Support for victims at standard or medium risk was identified as a gap.

8. There was a strong desire amongst stakeholders for primary prevention work, particularly with young people and in school settings. Recognition of the overlap between DVA and other safeguarding concerns led to support for strong multi-agency working relationships, with some recommending physical co-location of a DVA service with other Safeguarding professionals.

9. Service mapping identified several services not usually considered as DVA programmes - such as health visiting, antenatal services, and school nursing - involved in prevention and response. A mix of universal (available to all) and targeted (available to those at greatest need) services are available for early
detection and mitigation of harm. Many services to children young people, including primary prevention work in schools, one-to-one support for children exposed to DVA, and play therapy have historically been funded by national charity grants that have now ceased.

10. There is convincing evidence in support of identification and referral of women in primary care (the IRIS programme), and moderate evidence for the effectiveness of advocacy (e.g. Independent Domestic Violence Advisers, IDVAs). Evidence for effectiveness of advocacy is particularly strong for maternity-based IDVAs. Robust evidence exists for a handful of specific programmes or interventions aimed at children who have been exposed to DVA. There is some evidence to support preventive programmes on “healthy relationships” in school settings; these can change knowledge and attitudes towards DVA. Currently the evidence for perpetrator programmes is very weak. There is insufficient evidence to recommend public education and awareness campaigns.

11. In conclusion, the following areas of need were identified:

a) Young women – the prevalence of DVA is high in this group such that considerable numbers in South Gloucestershire are likely experiencing DVA but are not identified and/or receiving services

b) Men in same sex relationships are at a similar risk to women in heterosexual relationships yet service provision and support to address this need in South Gloucestershire is extremely limited

c) Adults with disabilities (including learning difficulties) are at a much greater risk of DVA than the general population. Given the number of people with a disability in South Gloucestershire, this is likely to be a considerable area of unmet need

d) Primary preventive work, particularly in schools, is effective in changing attitudes to DVA and may prevent these young people entering into abusive relationships as they grow up

e) Comprehensive and clear pathways are required to ensure that professionals across South Gloucestershire can offer victims the most appropriate interventions available. Services should meet the needs of those with complex mental health or substance abuse issues, those with disabilities including older adults, men, and LGBT individuals. Whilst the majority of reported DVA occurs outside of these
groups, the current lack of flexibility in service provision means that the needs of individuals from these groups are not being met.

f) Evidence-based support for children exposed to DVA should be accessible to all children with the capacity to benefit.

12. Whilst expected need is calculated from robust and informative national estimate, local data on DVA in South Gloucestershire is very limited. Clear performance monitoring systems, for example using the DASH tool, and anonymised data-sharing agreements could ensure that timely, accurate data are shared amongst those involved in commissioning and providing DVA services.
Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>BMA</td>
<td>British Medical Association</td>
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<tr>
<td>BME</td>
<td>Black and minority ethnicity</td>
</tr>
<tr>
<td>CAADA</td>
<td>Coordinated Action Against Domestic Abuse (now Safe Lives)</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
</tr>
<tr>
<td>CSEW</td>
<td>Crime Survey in England and Wales</td>
</tr>
<tr>
<td>CSP</td>
<td>Community Safety Partnership</td>
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<tr>
<td>DASH</td>
<td>Domestic Abuse, Stalking, and Honour-based violence risk assessment tool</td>
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<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>DHR</td>
<td>Domestic Homicide Review</td>
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<td>DVA</td>
<td>Domestic Violence and Abuse</td>
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<tr>
<td>ED</td>
<td>Emergency Department</td>
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<tr>
<td>FNP</td>
<td>Family Nurse Partnership</td>
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<tr>
<td>GP</td>
<td>General Practice/General Practitioner</td>
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<td>HES</td>
<td>Hospital Episode Statistics</td>
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<tr>
<td>IDVA</td>
<td>Independent Domestic Violence Adviser</td>
</tr>
<tr>
<td>IRIS</td>
<td>Identification and Referral to Improve Safety</td>
</tr>
<tr>
<td>LGB/LGBT</td>
<td>Lesbian, Gay, Bisexual/Lesbian, Gay, Bisexual, Transgender</td>
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<tr>
<td>MARAC</td>
<td>Multi-Agency Risk Assessment Conference</td>
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<tr>
<td>NBT</td>
<td>North Bristol NHS Trust</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<tr>
<td>NSPCC</td>
<td>National Society for the Prevention of Cruelty to Children</td>
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<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
</tr>
<tr>
<td>PADA</td>
<td>Partnership Against Domestic Abuse</td>
</tr>
<tr>
<td>PCC</td>
<td>Police and Crime Commissioner</td>
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<tr>
<td>PHE</td>
<td>Public Health England</td>
</tr>
<tr>
<td>PHOF</td>
<td>Public Health Outcome Framework</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomised Controlled Trial</td>
</tr>
<tr>
<td>SGS</td>
<td>South Gloucestershire and Stroud Colleges</td>
</tr>
<tr>
<td>UWE</td>
<td>University of the West of England</td>
</tr>
<tr>
<td>VAWG</td>
<td>Violence Against Women and Girls</td>
</tr>
<tr>
<td>YOT</td>
<td>Youth Offending Team</td>
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1. Background – domestic violence and abuse in the UK

In this section, estimates of the prevalence and impact of domestic violence and abuse in the UK are presented as a guide to the size of the problem. More specific estimates of local need in South Gloucestershire are presented in section 3. A summary of relevant national guidance and key policy documentation is also provided in this section.

**Key messages**

1. Domestic violence is common, harmful, costly – and preventable. It incorporates incidents, or patterns of behaviour involving psychological, emotional, physical, sexual, and financial abuse.

2. Victims may be male, female, or transgender, of all ages and sexualities, and from any ethnic background. More than one in four women and one in eight men will experience DVA over their lifetime. Recent experience of DVA is most common in young women age 16-19.

3. A high proportion of victims of DVA have mental health difficulties including depression and anxiety, and it is often unclear as to whether these are a consequence or contributing factor to the abuse. There is little evidence to suggest that alcohol and drug use is an important risk factor with a minority of all incidents are believed to involve alcohol use by the perpetrator (17%), with a smaller proportion thought to involve drugs (10%).

4. There is clear evidence of the harm that may be caused to children growing up in homes where DVA occurs: direct harm in the form of child abuse or neglect, and indirect harm to emotional health and behaviour. Children exposed to DVA are at increased risk of entering into abusive relationships themselves.

1.1 Why is domestic violence and abuse a priority?

In health and social care there are many diseases – and many causes of disease – that are evident amongst our population. Identification of many of these conditions and risk factors is straight-forward, and for the most part we have a robust evidence base
upon which treatments and interventions are based. Domestic violence and abuse (DVA) are different. DVA is often hidden, insidious, and can go undetected by professionals – the average duration of abuse before the victim receives help is 2.7 years and the average number of DVA incidents that occur before a victim reports the abuse to the police is believed to be 35 (1).

More than one in four women and almost one in eight men will have experienced DVA during their adult lifetime and for 30% of victims this DVA will be repeated. DVA therefore represents a common, often persistent, and preventable harm, often borne by the most vulnerable.

There is also a considerable financial cost to the public purse: DVA is estimated to cost the state over £3 billion per year in direct costs (i.e. criminal justice system, health service, social services, housing and civil legal aid) and an estimated £2.7 billion in losses to the economy (2). The tangible financial cost is further dwarfed by the estimated human and emotional cost of DVA in pain, suffering, and fear.

It is therefore not surprising that over the past ten years, DVA has become increasingly important to politicians and decision-makers and is now considered a cross-government priority.

1.2 How is DVA defined?

Terminology in domestic violence and abuse varies between and within organisations. For clarity, the following definitions were adopted for the purposes of this project. The definition of DVA is the same as that adopted by the UK government (2013) and that used operationally in South Gloucestershire by agencies involved with the Partnership Against Domestic Abuse (PADA), though the latter’s definition also includes so-called honour-based violence, female genital mutilation, and forced marriage.

**Domestic violence or abuse (DVA)**

Any incident or pattern of incidents of controlling, coercive, or threatening behaviour, violence, or abuse between those aged 16 years of over who are or have been intimate partners or family members regardless of gender or sexuality.

This can encompass, but is not limited to, the following types of abuse:

- Psychological
Physical
Sexual
Financial
Emotional

Controlling behaviour
A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance, and escape and regulating their everyday behaviour.

Coercive behaviour
An act or pattern of acts of assault, threats, humiliation, and intimidation or other abuse that is used to harm, punish, or frighten their victim.

This definition of DVA encompasses inter- and intra-generational violence where perpetrators and victims reside in the same household. This can include abuse between siblings where both are aged over 16; and abuse between parent and child aged over 16 (with parent as perpetrator, child as victim and parent as victim, child as perpetrator). Due to the nature of the parent-child relationship, occurrences of intrafamilial violence may pose additional complexities for service providers.

Overlaps with other areas of work
There are therefore overlaps between DVA and safeguarding children when DVA involves a victim aged 16-17 years. It is recognised that there are also overlaps between DVA and sexual violence and abuse: nearly half of all serious sexual assaults against women are perpetrated by a male partner or ex-partner. Up to one in four rape cases reported to the police involve rape in the context of DVA and at least one in three involve women who were sexually abused as a child (3). More recently, with the rise in social media and smart phone use there has been concern over new forms of sexual violence such as “revenge pornography”, the sending of unsolicited sexual images, and exploitation using “sexting”. There is an absence of wider research on the scale and impact of social media-related DVA. 1.3 Key reports, strategies, and policies.
In 2010 the coalition government published the cross-departmental strategy *Call to end violence against women and girls (VAWG): Action plan*. Emphasis was placed on the need for prevention, provision of support to victims, partnership working, and risk reduction. Whilst the VAWG plan specifically focuses on the risk to females, it acknowledges the need to address the needs of men and boys who may also be affected by DVA. An updated VAWG strategy for 2016-20, *Ending Violence against Women and Girls* was recently published, highlighting the government’s commitment to ending DVA.

The Department of Health (DH) has produced several reports on DVA in recent years, the most recent of which is the *Alberti report* in 2010 which laid out recommendations for the NHS to respond to DVA and to improve services for women and child victims of DVA. As part of the DH 2013 guidance on “Public health contribution of nurses and midwives” the important role of maternity, health visiting, and school nursing programmes in identifying DVA and providing appropriate support and onward referral is identified(4).

In 2014 the National Institute for Health and Care Excellent (NICE) published guidance on preventing and reducing DVA, “*Domestic violence and abuse: multi-agency working (PH50)*”. The guidance provides seventeen recommendations and emphasises the need for both multi-agency partnerships and ongoing training for staff in identifying and responding to DVA.

In 2014, the Annual Report of the Chief Medical Officer focused on Women’s Health, and a chapter of the report was dedicated to gender-based violence against women. The report included recommendations that policy work should include initiatives that challenge gender stereotypes, involve men and boys, and address the needs of vulnerable groups. Moreover it was recommended that the NICE guidelines (PH50, 2014) were implemented in local areas and used to commission services, ensuring the inclusion of marginalised groups.

1.4 How should DVA be addressed?

Historically, interventions have focused on the criminal justice elements of punishing perpetrators and the safety planning for reducing risk to victims. However such a reactive approach does not deal with the underlying drivers of abusive relationships,
nor does it necessarily prevent perpetrators from re-offending and victims from encountering future abuse. Moreover an exclusive focus on the perpetrator and victim will underestimate the huge potential impact on others — and most importantly, young children — exposed to DVA in the home.

In recent years, recommendations from organisations such as the National Society for the Prevention of Cruelty to Children (NSPCC) and the British Medical Association (BMA), in addition to the publications by NICE, the Chief Medical Officer, and UK government discussed above, have emphasised the need for a multi-agency approach to DVA. Such an approach should incorporate elements of prevention and management, whilst addressing the wider impact of DVA on the individual and their families.

1.5 Why should DVA be a priority in South Gloucestershire?

The relative importance of a problem is usually measured by its size (i.e. the prevalence or incidence) and its impact (i.e. the severity of the consequences). In the UK currently, it can be argued that domestic violence and abuse is both common and has serious and far-reaching consequences.

Data from the Office for National Statistics (ONS) reveals that across Avon and Somerset, nearly one in eight (11%) offences recorded by the police between April and September 2015 were flagged as “related to domestic violence”. Across the UK 12% of sexual offences reported to police were also flagged as related to domestic violence, highlighting the importance of rape and sexual violence in this context. National surveys have led to the belief that the prevalence of DVA and violent crime has gone down in recent years (5). However an in-depth analysis of the data suggests that whilst overall rates may have decreased, there has been a significant increase in violent crime, especially in repeated crimes against the same victims, and especially in domestic violence against women. Moreover it has been shown that any longer term decline in violent crime had ceased by 2008, which coincides with the economic recession (6).

In South Gloucestershire, data published by Public Health England (PHE) for the Public Health Outcomes Framework (PHOF) suggest a recent increase in the
prevalence of domestic violence and abuse, from 11.7 incidents per 1,000 population in 2012/13 to 14.1 per 1,000 population in 2013/14 (Figure 1).

Figure 1 Domestic abuse incidents reported to police, South Gloucestershire 2010-2014

However the data used by PHE should be viewed with caution for several reasons:

- Recent changes to the way in which police forces collect data on DVA mean that trend data cannot be interpreted
- The police crime report rate is calculated at force level so the same rate is provided for Bristol, North Somerset, South Gloucestershire, Bath and North East Somerset, and Somerset. There are clear differences in the populations in these local authorities so the crude rate may be an under- or over-estimate
- The numerator in the PHOF rate estimate is the number of incidents reported to the police. Repeated police reports about the same abusive relationship are counted as individual episodes so the data do not provide a measure of prevalence, nor of repetitive events. Crime Survey England and Wales (CSEW) data suggest that up to 60% of DVA incidents may be experienced by repeat victims
- The incident rate is based on crime reports from the police which have been flagged as relating to DVA so this is likely to be only the “tip of the iceberg” of all cases of DVA occurring in the community

In addition to the PHOF, the Adult Social Care Outcomes Framework 2015-16 includes relevant indicators (see Figure 2).
### Domain vs. Overarching and outcome measures

<table>
<thead>
<tr>
<th>Domain</th>
<th>Overarching and outcome measures</th>
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| 4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm | **Overarching measure**  
4A The proportion of people who use services who feel safe  

**Outcome measures**  
People are free from physical and emotional abuse, harassment, neglect and self-harm  
People are supported to plan ahead and have the freedom to manage risks the way that they wish  
4B The proportion of people who use services who say that those services have made them feel safe and secure  
Placeholder 4C. Proportion of completed safeguarding referrals where people report they feel safe (in development) |

There is no core outcome set for DVA and therefore evaluations of interventions often report a variety of indicators, and use a variety of measures and tools, many of which are not validated. This can be a challenge when identifying evidence of “what works”. Indeed it is often difficult to estimate the severity of DVA experienced by victims, because data systems are often not designed to capture this, and because victims may find it difficult, or be reluctant, to share this information. For example, data from CSEW reveal that 48% of victims of DVA do not wish to disclose how many times they had been abused by their partner over the past year, and a further 20% did not know.

Limitations of data notwithstanding, there is sufficient evidence that DVA remains a significant problem for many individuals in South Gloucestershire - over 290 South Gloucestershire residents were recognised as being “at high risk of serious harm or death” from DVA in the last year and many more sought support from commissioned services. In addition to the large human cost associated with DVA, these incidents and the consequences thereof are costly to local health, social care, and police budgets.
1.6 How does the rate and severity of DVA differ according to gender and sexuality?

It is generally accepted that the vast majority of domestic violence perpetrators are male and their victims are female (80% female: 20% male). Proportionally, violence against women is more likely to be perpetrated by a partner or family member: ONS data from police reports, which represent only a small and specific proportion of DVA incidents, suggest that 50% of violent offences in which the victim was female were attributed to domestic violence compared to 16% of those involving male victims.

DVA by female perpetrators on male victims does occur, however reported DVA where the perpetrator is female is less common, less likely to be severe, and less likely to be repetitive (7). Furthermore, it has been reported that the physical and emotional impacts of DVA are significantly greater for women than men. In a research survey about DVA, many men who reported DVA in the survey but who had chosen not to report this to police made this decision because they believed the incident was “too trivial or not worth reporting” [this is the term used in the research survey] (8). Female homicide victims are considerably more likely than male homicide victims to be killed by a partner or ex-partner (47% and 5% respectively), despite overall homicide rates being higher for men (9).

Thus whilst it is important that a needs assessment of domestic violence and abuse considers the needs of victims of all genders and sexualities, it is also important to recognise that the data show that the greatest harm – in volume and severity – occurs to female victims by male perpetrators.

DVA occurs in same-sex relationships though the available data surrounding the prevalence, nature, and severity are more limited. Research suggests that the lifetime prevalence of domestic violence for men in same-sex relationships is at least as high as it is for females in heterosexual relationships (10). DVA amongst gay men is associated with depression, anxiety, being HIV positive, and harmful behaviours such as substance misuse and unprotected sex (11, 12).
1.7 Does DVA affect people of all age-groups?

The risk of experiencing DVA is greatest for women and men during the ages of 16-19. Females aged 20-34 have the greatest likelihood of a violent offence being related to DVA (60%) according to police reports, and this declines with age. In contrast, the proportion of violent offences against men that are reported to police that are related to DVA is much lower and increases with age, reaching a peak at 24% of offences against men aged 75 and older (13). This is likely to represent the greater amount of non-DVA violence experienced by young men, rather than any absolute increase in risk with age.

Our understanding of DVA is largely based on the working-age population of adults. Less well understood is the prevalence and impact of DVA on older adults, both in the context of intimate partner relationships and amongst family members (elder abuse). Several domestic homicides have involved adults in their late 70s and 80s and in 2013/14 more than 20% of domestic homicide reviews involved victims aged over 60. The vast majority of these victims were female and most were killed by a partner/ex-partner. In addition, there are specific circumstances surrounding aggressive and violent behaviour amongst older adults as a consequence of age-related disability, cognitive decline, and neurodegenerative diseases. It is recognised that dementia is a substantial risk factor for abuse (14).

DVA amongst older teenagers (those aged 16-18) is becoming increasingly recognised. Such abuse can occur in the context of intimate partner relationships (often referred to as “teen dating violence”) and between adolescent and parent.

1.8 What are the associations with mental health and substance misuse?

A systematic review of research estimating the association between mental health disorders and domestic violence revealed that 35% of people who are depressed and 33% of people with an anxiety disorder reported DVA in the past year. Victims of DVA are seven times more likely to develop post-traumatic stress disorder and women who experience DVA in pregnancy are three times more likely to develop postnatal depression. DVA should be considered an important factor in addressing suicide and self-harm: in the latest Crime Survey for England and Wales 4% of individuals
reporting DVA in the past year have tried to kill themselves. People with long-term conditions, including mental health conditions, are at an increased risk of experiencing DVA. It is therefore often difficult to estimate the extent to which DVA plays a role in cause or consequence of the mental health problems as research tends to involve cross-sectional surveys where both are measured at the same point in time.

Associations between DVA and alcohol or substance misuse are not clear. Whilst some research – largely from in the US – suggests that alcohol use is an important risk factor associated with DVA perpetration (15), UK analyses of general practice populations and data from the CSEW do not find that alcohol to be independently associated with DVA (16). Indeed CSEW suggested that the vast majority of incidents of DVA do not involve the use of alcohol or drugs by perpetrator or victim: 17% of people experiencing intimate partner DVA in the past year believed that the perpetrator was under the influence of alcohol, and 10% believed s/he was under the influence of drugs.

1.9 How does DVA impact upon children?

The definition of DVA specifies that the violence or abuse must occur amongst individuals aged 16 years or older. In using this definition it is easy to overlook the impact of DVA on children under 16 who are indirect victims of DVA amongst adult care-givers in the home. Child exposure in the context of DVA is common- it is estimated that the majority of high-risk adult victims of DVA have children (70%) (17). The impact of DVA on children is likely to differ according to the age of the child and may include adverse effects on the child’s emotional health, psychological wellbeing, and behaviour, in addition to their physical health. Effects of DVA on a child may be considered as direct and indirect:

Direct effects of DVA on the child

Children are harmed directly by exposure to DVA in the home or household. Children may be harmed directly by:

- Their mother’s health and capacity to parent being undermined
- Being drawn into the domestic violence (e.g. if the perpetrator uses power and coercive control)
- Abuse or neglect by the perpetrator. Co-occurrence of child abuse occurs commonly when DVA is experienced (18)

Indeed DVA is a persistent and common factor in cases of child abuse, including those resulting in the death of a child. An analysis of Serious Case Reviews (SCRs) – which are a statutory duty following a child’s death – identify DVA as an important risk factor: “Many of the men in these serious case reviews had a history of violence, either against previous partners or other adults or as young offenders. Many were subject to supervision by the probation service and/or youth offending teams” (19).

The risks of harm to children are believed to be increased in specific settings, including (20):

- During pregnancy, where infants are aged under one, and when children are aged under 7
- If there are parental drug, alcohol, or mental health issues
- If the child directly witnesses or is drawn into the abuse
- If the child intervenes to protect the abused parent
- If the victim or perpetrator was maltreated or in care systems as a child

**DVA as a factor in the child’s life course**

Furthermore, children exposed to DVA in their early lives are more likely to have attachment disorders and to engage in higher level aggression with peers, more likely to offend, to become involved in anti-social behaviour, violent crime, substance abuse, and more likely to experience violence in their own relationships (as both perpetrator and victim) (21)(22, 23). It is recognised that there is rarely a direct causal pathway leading from DVA exposure to a particular adverse outcome, and therefore it is likely that effective interventions will need to be timely, appropriate, and tailored to the individual. Nevertheless, it is important to recognise that while exposure to DVA increases the risk of a child suffering later adverse life events, this is not an inevitable relationship. A meta-analysis of the literature in this field concluded that 67% of child witnesses to DVA had worse outcomes than average, and the remaining 37% presented with outcomes that were similar to or better than most of the children who had not witnessed DVA in the home (24).
A further area of concern linked to DVA exposure in children is the recognition that older children aged 13-18 years may be perpetrators or victims of abuse in their own relationships. There is also growing concern about adolescent-on-parent violence and extended family violence. It is therefore critical that we prevent harm to children from exposure to DVA both in the family setting and in their own relationships as they grow older.
2. Scope

DVA often occurs in conjunction with other adversities such as substance misuse, unemployment, poverty, and child abuse. Whilst recognising the importance of integrating this work with other related work streams including, for example, sexual health, forced marriage, child poverty, mental health, and safeguarding, it is necessary to delineate the boundaries and scope of this needs assessment. This section lists the population groups and DVA-related settings that are included in this needs assessment, and those areas that do not fall within the scope of this work.

**Key Messages**

1. A wide and inclusive scope was taken for this health needs assessment including primary prevention, reduction in social inequalities in health, and wider determinants of health and wellbeing.

2. Some specific areas of Safeguarding work – such as Forced Marriage, so-called Honour-Based Violence, and Female Genital Mutilation – overlap with domestic violence; these areas were deemed out of scope as they are covered by other work streams and/or tend to involve victims under 16.

3. Needs of perpetrators incarcerated in custodial institutions and interventions delivered through such settings are out of the scope of this needs assessment.

**Victims**

**Included within this needs assessment:**

- Victims aged 16 or older of all genders, all sexualities, all ethnicities, those with disabilities, those with mental health problems, and those with substance misuse and alcohol problems

- All aspects of DVA (physical, emotional, coercive-controlling, sexual, financial) will be included. All violence and abusive episodes and relationships arising between intimate partners and individuals in a domestic household setting. This includes elder abuse but only where the perpetrator is a family or household member.

**Not included within the scope of this needs assessment:**

So-called honour-based violence (HBV); female genital mutilation (FGM); hate crime; and carer violence where the carer is not a partner or family member. The purpose of
this needs assessment is to inform commissioning decisions in areas not adequately
encompassed by other work streams. Whilst HBV, FGM and areas of work are
important areas, they are not exclusively or directly related to DVA. NHS Choices
reports that FGM is usually carried out on infants and girls up to the age of 15 year so
this is out of the scope of this needs assessment, which includes victims aged 16 and
older. Moreover, South Gloucestershire Council, in conjunction with multi-agency
partners such as the Safeguarding Children Board, have developed a policy document
on FGM, HBV, and forced marriage and a strategy to address child sexual exploitation.

Perpetrators

Included within this needs assessment

- Perpetrators of DVA in the community of all genders, all sexualities, all ethnicities,
  those with disabilities, those with mental health problems, and those with
  substance misuse and alcohol problems.

Not included within the scope of this needs assessment

- Perpetrators currently serving custodial sentences.

Children

Included within this needs assessment

- Children exposed to DVA between parents, or between a parent and a partner, ex-
  partner, or other adult in the household.

Not included within the scope of this needs assessment

- Child abuse in the absence of DVA, child sexual exploitation, grooming, gang
  violence amongst youths, bullying amongst peers.

Professionals

Included within this needs assessment

- All professionals who may come into contact with victims or perpetrators of DVA,
  including but not limited to: general practitioners; sexual health clinicians;
  Emergency Department and Minor Injury Unit staff; midwifery and maternity staff;
children’s social workers; health visitors; school nurses; school staff; adult social workers; police and probation staff; community providers of commissioned DVA services; commissioners.
3. Assessment of need: epidemiology

<table>
<thead>
<tr>
<th>Key messages</th>
</tr>
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<tbody>
<tr>
<td>1. Domestic violence and abuse are common. Over 6000 women in South Gloucestershire experienced DVA last year; the largest group affected is young (16-19), White women who do not live in the least deprived wards.</td>
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<tr>
<td>2. Around 3000 men are also believed to have been victims of domestic violence and abuse over this period; it is likely that the majority of these are in same-sex relationships.</td>
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<tr>
<td>3. Those with disabilities including learning difficulties – especially women – are at particularly high risk. Of the 9000 women and men experiencing DVA last year, a third (3000) are expected to have a disability.</td>
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<tr>
<td>4. DVA amongst older adults is often unrecognised. Local estimates suggest roughly 1200 older adults will have experienced DVA from a partner or family member in the past year.</td>
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<tr>
<td>5. In addition, around 4000 children in South Gloucestershire have been exposed to DVA and a considerable number (~160) are being continually exposed to DVA at home frequently through the week.</td>
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<tr>
<td>6. There is an absence of data on several key minority groups including transgender people and those from Gypsy and Traveller communities. DVA occurs at similar rates in most ethnic groups though the expected absolute number of victims in Black and minority ethnic (BME) groups in South Gloucestershire is small in absolute terms. This is due to the relatively small BME population living in the area.</td>
</tr>
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</table>

Methodology and data sources

Population need is estimated by application of national prevalence rates to local population statistics. The main sources of routinely-collected data on violence come from the police crime reports which are collated from individual forces by the Home Office and reported by the Office for National Statistics (ONS), and the self-reported Crime Survey for England and Wales (CSEW), also reported by ONS. Estimates of local need are only an approximate guide to the population at risk as the rates from national surveys, whilst gender-specific, are not adjusted for deprivation or age. True local population need may be greater or smaller than the estimates presented.
Police crime reports

Using police crime report data to estimate the prevalence of domestic violence and abuse is often limited due to multiple and diverse systems for data capture and the likelihood of considerable under-reporting. Victims may not report episodes or patterns of abuse because of restricted access to professionals, social or cultural pressures, safety concerns for themselves or their loved ones, and the complex relationships that may exist with violent and abusive intimate partners or family members. Moreover, ONS-validated police data are also only available at force level, and are not broken down by gender or ethnicity therefore using these risk estimates to model need in specific demographic groups South Gloucestershire is extremely limited. In addition, the ONS has considerable concern about the validity of police reports, which have been deemed “not to meet the required standard for designation as National Statistics”. In particular, ONS urge that trend data in police reports should be interpreted with caution, given recent changes in recording practice (25). As police report data are so limited, they have not been used in this needs assessment to estimate need in South Gloucestershire.

CSEW data

In contrast to the routinely collected data from police offence reports, the CSEW is a face-to-face, weighted population survey in which people resident in households in England and Wales are asked about their experiences of a number of criminal offences, including domestic abuse and sexual violence, in the previous 12 months. The survey items surrounding DVA are comprehensive and include lifetime prevalence (ever experienced DVA) and recent prevalence (experienced DVA in the last 12 months). Moreover CSEW collect data on a range of sociodemographic variables and it is therefore possible to estimate expected need in a variety of population groups. For these reasons, CSEW data have been used to estimate the need in South Gloucestershire.

Public Health England

There are four indicators in the Public Health Outcomes Framework (PHOF) that are likely to be associated with DVA, however PHE does not collect any bespoke data but presents other statistics:
1.11 Domestic abuse (incidents recorded by the police per 1,000 population)
1.12i Violent crime including sexual violence (hospital admissions for violence per 100,000 population)
1.12ii Violent crime including sexual violence (violence offences per 1,000 population)
1.12iii Violent crime including sexual violence (sexual offences per 1,000 population)

Performance on these indicators is published regularly at the local authority level. Data for 1.11, 1.12ii, and 1.12iii come from police reports (the low validity of which are discussed above). Data for 1.12i come from hospital episode statistics (HES).

**Hospital episode statistics**

HES are a robust and valid data source, capturing details of all hospital attendances: emergency department (ED) attendances; outpatient appointments; and admissions. A limitation of HES is that it collates information on each individual episode of care so it is not possible to analyse or account for multiple attendances by the same patient. Data on hospital attendance for DVA incidents are likely to represent only a very small proportion of the total DVA experienced in the population. This is because only severe injuries are likely to reach ED and a smaller group yet are likely to be admitted for medical or surgical management. Moreover, the HES data are not specifically coded as relating to DVA but rather relate to all admissions for violence-related morbidity; it is not possible to make accurate or valid assumptions on the proportion of HES admissions for violence that are associated with DVA. Routinely collected HES data on admissions for violent crime will therefore not be used to predict need in this health needs assessment.

**Bespoke survey data**

In addition to the CSEW, research groups, charities, and other public sector organisations may conduct bespoke and ad-hoc surveys containing data on DVA. These surveys will vary in their methodological rigour and ability to generalise to the wider population, however for particular population groups (such as older adults, people with disabilities, lesbian, gay, bisexual, and transgender [LGBT] individuals) these data may be all that are available.
Expected number of DVA victims over the past twelve months

Details of the population expected to be at risk are discussed in detail below. Figure 3 highlights the absolute numbers of victims are highest in the youngest age groups. This is consistent with the increased risk experienced by people aged 16-19 years. Thereafter, the absolute numbers of victims are similar across the age spectrum, with lower numbers of victims expected in those aged 55-59 years.

Figure 3 Expected absolute number of DVA victims in South Gloucestershire in the past 12 months, by age and gender. Based on CSEW and ONS population estimates

Detailed breakdown: female victims

National estimates of risk

CESW estimates from the year ending March 2015 reveal that 27% of women aged 16 to 59 report having experienced one or more forms of DVA at least once during their adult lives. For 8% of women DVA has occurred in the past 12 months. Women aged 16-19 are at the highest risk with a one-year prevalence of 13%. Stalking by a partner has been experienced by 9% of women aged 16 to 59 and one in twenty
women (5%) in this age range report ever experiencing at least one actual or attempted sexual assault by a partner (25). The prevalence of a serious sexual assault by a partner, defined as rape or assault by penetration and including attempts is 3%. Of those women experiencing DVA by a partner in the past year, the majority of women (63%) suffered non-physical (emotional, financial abuse), nearly half suffered threats (45%), 30% suffered from physical violence, and 7% were sexually abused. Many of the women experiencing sexual assault – including rape or attempted rape – by a partner will have experienced it multiple times over the past year (40%). DVA victims of both genders who seek medical attention for their abuse tend to do so after emotional, financial, or physical violence (62%) rather than after sexual assault (5%).

Local estimates of risk

The ONS mid-2014 population estimate for women aged 16 to 59 in South Gloucestershire is estimated as 77,839. Applying national prevalence rates from the 2015 CESW to the South Gloucestershire population, it is therefore expected that around 21,000 women aged 16-59 in South Gloucestershire have experienced DVA at least once in their lives. It is likely that in South Gloucestershire around 6000 women in this age range have experienced violence or abuse in the past 12 months; 800 of these will be young women aged 16-19. Over 7000 women living in South Gloucestershire have been stalked by a partner at some point in their lives and nearly 4000 women have been sexually assaulted (attempted or actual) by a partner. For more than 2000 women in South Gloucestershire this sexual assault will have included actual or attempted rape or assault by penetration by a partner.

Male victims

National estimates of risk

CESW estimates from the year ending March 2015 reveal that 13% of men aged 16 to 59 report having experienced one or more episodes of DVA during their adult lives. Four percent of men have experienced DVA in the past 12 months. Stalking by a partner has been experienced by 3% of men and less than 1% of men (0.6%) report ever experiencing at least one actual or attempted sexual assault by a partner; the prevalence of serious sexual assault on men is 0.2% (25). Of those men experiencing DVA from a partner in the past year, 56% will have suffered from non-physical abuse.
(emotional or financial), 30% will have received threats, nearly two in five (37%) will have suffered physical force, and 2% will have been sexually abused.

Local estimates of risk

The ONS mid-2014 population estimate for men aged 15 to 59 in South Gloucestershire is estimated as 79,357. Using national prevalence rates from the CESW, it is therefore expected that around 10,300 men aged 15-59 in South Gloucestershire have experienced DVA at least once in their lives. It is likely that in South Gloucestershire over 3000 men in this age range have experienced violence or abuse in the past 12 months. It is estimated that over 2000 men in South Gloucestershire will report being stalked by a partner, and around 475 men will have experienced a sexual assault, and for around 150 men this will have been a serious sexual assault involving actual or attempted rape or assault by penetration.

Victims from minority ethnic groups

National estimates of risk

The CSEW reports prevalence estimates of DVA in the past 12 months based on the victim’s ethnic group.

*White*

The proportion of women experiencing DVA in the past year is 9% for women and 4% for men in White ethnic groups, though these are 12% and 9% respectively for people of White-Irish ethnicity. There were insufficient numbers of individuals from a Gypsy/Irish traveller ethnicity in the survey to provide prevalence estimates.

*Mixed/multiple ethnic groups*

One important finding in the CSEW data is that women from “mixed or multiple ethnic groups” report experiencing high levels of DVA in the previous year at 14%, compared to the overall England and Wales rate of 8%. Conversely men from this ethnic group report lower rates of DVA in the past year compared to the overall rate (2% versus 4%).

*Asian/Asian British/Asian-Indian/Asian-Chinese*

For individuals from an Asian/Asian British ethnicity, the overall prevalence of any DVA in the past 12 months is lower than for other ethnic groups: 3% for women and 2% for men. When national-level data are further broken down, women of Asian-Pakistani
ethnicity and men of Asian-Indian ethnicity have a relatively higher one-year prevalence of DVA (5% of women from the Asian-Pakistani ethnic group and 4% of men from the Asian-Indian ethnic group), though these rates are still lower or consistent with overall rates in the UK. The prevalence of DVA in the past year is notably lower than average in women of Asian-Chinese ethnicity at 0.7% though the small sample size may reduce the certainty around this estimate.

Black/African/Caribbean/Black British
For individuals from a Black/African/Caribbean/Black British ethnicity, the prevalence of any DVA in the past 12 months is 8% for women and 6% for men.

Local estimates of risk
In the 2011 Census, 95% of the population of South Gloucestershire reported their ethnicity as White; 2.5% as Asian/Asian British; 1.5% as Mixed/multiple ethnic groups; and 0.9% as Black/Black British. Given the low reported proportions of other ethnic groups, and uncertainty of the age and gender distribution within these smaller demographic groups, crude estimates of expected need have been calculated and are presented in Table 1 for illustration, but should be interpreted with caution.

Table 1 Crude estimates of prevalence of DVA in the past 12 months according to ethnic group, by gender. Using 2011 Census and CSEW estimates

<table>
<thead>
<tr>
<th></th>
<th>Overall expected population size (from Census 2011 data)</th>
<th>Overall prevalence of DVA in past 12 months (from CSEW data)</th>
<th>Expected number of victims in South Gloucestershire</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female</strong></td>
<td>White (95%)</td>
<td>73947</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>Asian/Asian British (2.5%)</td>
<td>1945</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>Mixed/multiple ethnic groups (1.5%)</td>
<td>1109</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>Black/Black British (0.9%)</td>
<td>701</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Male</strong></td>
<td>White (95%)</td>
<td>75389</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Asian/Asian British (2.5%)</td>
<td>1984</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>Mixed/multiple ethnic groups (1.5%)</td>
<td>1190</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>Black/Black British (0.9%)</td>
<td>714</td>
<td>6%</td>
</tr>
</tbody>
</table>

NB discrepancies due to rounding error
Socioeconomic patterning

National estimates of risk

As with many risks, DVA appears to be socially patterned, though for DVA the gradient is less steep than, for example, smoking prevalence or teenage conception. In the 2014-15 CSEW, one-year prevalence rates of DVA were almost twice as high in women from the most deprived employment quintile (11%) compared to the least deprived quintile (6%). Interestingly this social patterning was much attenuated for male victims (5% v 3%). Unemployed women were more than twice as likely to have experienced DVA as those with a job (one-year prevalence of 15% and 7% respectively), again the gradient is less steep for male victims (5% v 4%).

One-year DVA prevalence is similar for those living in urban and rural areas. In terms of home environments, most victims of DVA in the past year did not live with their abusive partner (66%). Where victims were living with the abuser the majority (60%) did not leave the accommodation after the abuse. Reasons for staying include love for the partner (36%), presence of children (54%), fear of future abuse (9%), and financial reliance on the abusive partner (15%).

Whilst one interpretation is that DVA is socially patterned and more prevalent amongst individuals with lower incomes, it may also be due to reporting bias in that women from higher socioeconomic groups may be less likely to recognise, correctly define, or wish to report DVA – even in an anonymous survey. The BMA have previously noted that there is a limited amount of evidence about DVA occurring within “professional” families, including healthcare professionals (26).

Local estimates of risk

A very small proportion of the South Gloucestershire population is in the most deprived employment quintile. Local analysis from 2015 suggests that there are four Lower Super Output Areas (LSOAs) in South Gloucestershire that are in the most deprived quintile for employment nationally, and the most deprived area – the Pendennis Road area of Staple Hill – is now in the most deprived 10% of LSOAs in England. The analysis notes that 38% of LSOAs in South Gloucestershire are in the least deprived quintile, which carries the lowest prevalence of DVA. Therefore the majority (~60%) of
South Gloucestershire residents would be expected to experience a level of DVA somewhere in the mid-range.

**Older adults**

**National estimates of risk**

Little data exists of the prevalence of DVA amongst older adults; the most robust survey identified was undertaken nearly ten years ago. The 2007 UK Study of Abuse and Neglect of Older People (27) found the one-year prevalence of abuse to be 4%. However, the definition of elder abuse is “a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person”. Such definitions will include abuse by non-family members such as neighbours, friends, and health and social care staff. Further analysis on the relationship of the perpetrator revealed that 35% of perpetrators were reported as partners and 33% other family members. Therefore it is estimated that nationally, 2.7% of older adults have experienced DVA.

**Local estimates of risk**

The ONS mid-2014 population estimate for adults aged 66 and over in South Gloucestershire is estimated as 46,623. Using national prevalence rates from the UK Study of Abuse and Neglect of Older People, it is therefore expected that around **1259 older adults** aged 66 and over in South Gloucestershire have experienced DVA in the past year.

**LGBT victims**

Much DVA research, policy, and practice focuses on the needs of women in heterosexual relationships; this group experience the most DVA (28). It is now recognised that men in same-sex relationships experience the same risk of DVA as women in heterosexual relationships, but gaps remain in our understanding of how to best reach and respond to the needs of LGB victims of DVA. NICE recognise the lack of research on lesbian, gay, bisexual and trans people’s experience of DVA (29). It has been reported that victims of DVA in LGB community can face additional barriers such as homophobia, gender stereotypes, coming out, and a lack of services even if
disclosure occurs. In addition, certain perpetrator strategies are more likely in LGB DVA such as threats to “out” the victim (30).

**National estimates of risk**

In a 2006 survey of individuals in same-sex relationships, prevalence of ever experiencing DVA was 40% for women and 35% for men (31) – somewhat higher than the estimates for the general population. When asked about DVA over the past 12 months, 54% of the survey respondents reported emotional DVA, 18% reported physical abuse, and 21% reported sexual abuse.

In contrast, research conducted for Stonewall suggested that the prevalence of DVA amongst lesbian and bisexual women is similar to women in the general population (25%), and a third of this was associated with male perpetrators (32). Stonewall, a UK charity campaigning for LGBT rights in the UK, also commissioned a Gay and Bisexual Men’s Health Survey in 2013 and reported that nearly half (49%) of gay and bisexual men have experienced at least one episode of DVA in their lives (33). It is also important to recognise that past DVA amongst LGB people is not necessarily within a same-sex relationship.

There are a considerable lack of data around DVA in transgender individuals and insufficient prevalence data to provide reliable estimates on expected local levels of needs for this group.

**Local estimates of risk**

Estimates of the size of the LGBT population in the UK vary. The Integrated Household Survey (ONS) in 2012 provided a UK-wide estimate of 1.3% of adults identifying their sexual identity as LGB. The 2000 National Survey of Sexual Attitudes and Lifestyles of 16-44 year olds found that 5.4% of men and 4.9% of women had ever had a same-sex partner (34). HM Treasury, when undertaking a financial impact assessment of the Civil Partnership Act 2004, used a range from 5-7%. If around 6% of the South Gloucestershire population (aged over 16) are LGB, if we assume the proportion of LGB men and women is roughly equal, and if we assume that the less conservative estimates of DVA prevalence are more accurate – given the high likelihood of under-reporting – then that over **2300 LGB men and 1100 LGB women** aged 16-59 in South Gloucestershire will have experienced DVA in the past.
There are no reliable estimates of the transgender population in the UK and therefore no data from which to extrapolate the size of this population in South Gloucestershire.

**Victims with a long-standing illness or disability**

**National estimates of risk**

CESW estimates that the one-year prevalence of DVA amongst women and men with a long-standing illness or disability is at least twice as high as for the general population (16% and 9% compared to 8% and 4%, respectively).

In support of this, research published in 2013 reported that for people with a physical disability the odds of experienced DVA were twice as high as for those without a disability. Those with disability related to mental illness were at even greater risk – the odds of being a victim of DVA was three times greater than it is for those without mental health-related disability (35).

**Local estimates of risk**

Data from the Department of Work and Pensions Office for Disabilities suggests that 16% of working-age adults, and 45% of those over state pension age, were disabled in 2014. CSEW data on DVA only consider people aged 16-59, so those aged over state pension age will not be considered here – the previous section on older adults will include all residents aged over state pension age.

The South Gloucestershire population of working age adults (18-59) was 74625 (female) and 75818 (male). Using the DWP disability prevalence estimate of 16%, there are therefore approximately 24,000 adults with disability in South Gloucestershire. Applying the estimates of one-year prevalence of DVA from the CESW suggests that in those aged 18-59 nearly **2000 women with disability** and **1000 men with disability** are likely to have been exposed to DVA over the past year. These estimates are based on prevalence rates for all disabilities and over the entire age range. However if we assumed the prevalence rate to be the same across the age group 16-59 then it could be estimated that around **2000 of the expected 6000 female victims** and **1000 of the expected 3000 male victims** of DVA over the past year would have a disability.
Another source of data on the prevalence of disability in South Gloucestershire is the Census 2011, in which residents were asked if they had a disability or were limited to some extent in their day-to-day activities. The prevalence across the whole of South Gloucestershire was reported as 16% which supports the estimates calculated above. There is a very limited amount of research on DVA amongst people with learning disabilities.

The high prevalence of DVA amongst adults with disabilities may be at least partially explained by several factors in addition to the effect of the disability or long-standing illness. Disabled people experience higher levels of lower education and lower employment and are more likely to live in poverty (all risk factors for DVA) compared to the general population. It has also been shown that disabled people have experienced higher rates of psychological and sexual abuse in childhood and youth, which may increase their risk of experiencing DVA as an adult (36).

Qualitative data from women with disabilities suggests that they may feel unsupported by agencies and whilst professionals involved were often aware of the abuse, little or nothing is done because the knowledge is obtained in indirect ways and the women might not ask specifically for help in escaping the relationship (37).

Students and young adults exposed to violence or abuse from a partner

National estimates of risk

The one-year prevalence of DVA amongst full-time students in CESW was 10% of females and 5% of males. Whilst it is likely that the majority of full-time students in the survey were aged 16-21, it is possible that the survey may have many mature students.

Local estimates of risk

Many young people aged 16-18 will attend South Gloucestershire and Stroud College (SGS) for further education. According to the 2014 Ofsted report, in 2014 SGS had around 5000 students aged 16-18 and nearly 4000 students aged 19 and older. The gender split for these students is not available so it is not possible to provide accurate estimates how many SGS students would be expected to have experienced DVA.
The University of the West of England (UWE) is based in South Gloucestershire and has over 27,000 students, of which 12,000 are male and 15,000 are female. Applying the DVA rate amongst students to the UWE population would suggest that 1,500 female students and 600 male students at UWE have experienced DVA over the past year.

Children (exposed to DVA in home)

National estimates of risk

Having a child in the home is associated with an increased risk of DVA. The 2014-15 CESW estimates that the one-year prevalence of DVA is 23% for women who live in a single-adult household with at least one child. This is almost three times higher than for women living with no children (8%). Men living in a single-adult household with a child or children are also more likely to have experienced DVA in the past year.

Moreover DVA between parents is the most frequently reported form of trauma for children (38). UK-wide surveys suggest that around 25% of young people (aged 18-24) recalled being exposed to DVA during their childhood and 3% of children under 17 report witnessing it over the past year (40). Further estimates from this research, commissioned by the NSPCC, reveal:

- 14% of under 18s have lived with DVA against a parent by a partner or ex-partner
- 15% have been exposed to “family violence” – physical violence against family members by adults and siblings living in the home
- Almost 3% experience this in the past year
- 20-55% of under 18s living with DVA are also severely maltreated
- 5% living with DVA severely maltreated in the past year

A “parent throwing or breaking things in the context of a row” was the most common type of DVA behaviour reported in the NSPCC study, however 3.5% of under-11s and 4% of 11-17 year olds reported witnessing a parent being kicked, choked, or beaten up by the other parent. Similar prevalence estimates have been reported in other studies- 4% of 11-17 year olds had witnessed severe DVA in a study by Melzer in 2009 (38).
Local estimates of risk

In 2014/15, over half the schools in South Gloucestershire (54%) were invited to contribute to an Online Pupil Survey (OPS), in which students in year 4, 5, 6, 8, 10, and 12 (i.e. those aged 8-18) were asked about a range of lifestyle and behavioural experiences and attitudes. Over 6000 responses were obtained. The survey included the questions:

“Have you or anyone in your immediate family ever been a victim of domestic abuse or violence?”

“Is this abuse still happening?” (to those answering yes)

“Have you ever been a victim of abuse from a boyfriend/girlfriend?” (to those aged X and older)

“Is this abuse still happening?” (to those answering yes)

“How old is he?” (to those answering yes)

Overall, 16% of pupils reported witnessing or being a victim of DVA in the past, with 8% of these (1.3% of total) reporting that the abuse was still happening and 3% (0.5% of total) stating that this was either quite often or on most days. Applying these rates to the South Gloucestershire population would suggest that over 5000 children aged 8-18 have either witnessed or been a direct victim of DVA, more than 400 are still being exposed to the DVA, and for 160 children this DVA is witnessed on often or most days. National estimates would suggest that between 1000-3000 children in South Gloucestershire exposed to DVA are also severely maltreated.
4. Current provision and gaps
Services commissioned locally by South Gloucestershire Council and partners were mapped; see Error! Reference source not found.. It is recognised that DVA may be addressed by multiple partners in a variety of settings including health and social care services, education, and criminal justice; for simplicity only those services with a primary or substantial objective in addressing DVA are discussed in this needs assessment.

**Key messages**

1. South Gloucestershire has a wide range of commissioned services delivered in a variety of settings. Refuge provision includes facilities suitable for victims with disabilities and an IDVA service for victims with multiple or complex needs is commissioned.

2. The main provider of DVA services in South Gloucestershire, Survive, reports contact with nearly 2,200 victims of DVA in 2014/15. This includes contacts through the telephone support line, attendance at the Freedom programme, refuge provision, IDVA advocacy, and parenting programmes. IRIS supported around 76 women in 2015/16, some of whom are likely to have also received support from Survive. Outreach, floating support, and housing providers are likely to have supported around 100 victims of DVA, again some of whom will have also received services from Survive. At most, it is likely that 2,400 DVA victims in South Gloucestershire received some form of intervention from a service commissioned by South Gloucestershire Council in the past year.

3. The landscape of service provision for DVA across South Gloucestershire can appear confusing. Multiple funding sources commission services often independently, resulting in apparent duplicative provision in places. There is an absence of clear victim care pathways and a lack of clear referral and exit pathways for some services.

4. There is an absence of commissioned provision for primary prevention; much commissioned resource is focused on tertiary prevention for high-risk victims. Charity funding has enabled primary prevention in schools in the past; this provision is now at risk.
5. Services provided locally cater predominantly for female victims; refuge provision caters exclusively for female victims. There are no commissioned services with a specific provision dedicated to LGBT or BME victims.

6. There is an absence of commissioned provision specifically focused on DVA for children at all levels. An overlap in provision, population, and aim occurs with other agencies and organisations including Children’s Services, the Families in Focus programme, and the Community Child Health Partnership. DVA provision would therefore likely benefit from a whole system approach.

**Partnership working**

In South Gloucestershire the Partnership Against Domestic Abuse (PADA) is a body responsible for a collaborative and consultative approach to DVA. PADA retains strategic and operational oversight of DVA service provision across South Gloucestershire and meets regularly to review and monitor activity. The group includes stakeholders from South Gloucestershire Council, Avon and Somerset Constabulary, the clinical commissioning group, provider organisations, and the voluntary and community sector.

**Primary prevention**

**Schools, colleges, and universities**

The aim of primary prevention in DVA is to prevent individuals from becoming victims or perpetrators. Primary prevention aims to address - and intervene to remove - the root causes of DVA, by altering unhealthy or unsafe beliefs and behaviours. South Gloucestershire Council do not commission any training in healthy relationships. In recent years, the Children and Young People team in Survive have developed and delivered a preventive programme, Connect with Respect, in primary and secondary schools in South Gloucestershire. This was originally funded by the charitable sector however that funding source has now ceased and if schools wish to continue with the workshops they must fund it through their own budgets.

The University of the West of England (UWE) deliver a bystander invention, “Intervention Initiative”, which was developed and has been evaluated, though the evaluation has not yet been published. Moreover UWE provide a Wellbeing Service,
delivering support and signposting for students with difficulties. Anecdotally, the 
service reports receiving contact from students complaining of DVA roughly once a 
month. Data collected over the past academic year reveal that 30 students contacting 
the service (1.75%) were categorised as “abuse”. This is not limited to DVA but is 
believed to predominantly be abuse by intimate partners or flatmates. The Wellbeing 
Service offers a range of resources for further support including the police, sexual 
assault centres, and specialist domestic violence services.

Primary prevention in South Gloucestershire and Stroud (SGS) further education 
colleges is unknown.

Screening and identification in antenatal settings

In addition to specifically commissioned services, DVA identification and intervention 
is a key objective of public health services for health visitors, and locally in South 
Gloucestershire routine DVA screening of all women attending for antenatal care has 
been in place following a DH-funded project with North Bristol Trust (NBT) maternity 
services. Data on the delivery and outcomes of antenatal screening were not available.

Family nurse partnership

The Family Nurse Partnership (FNP) in South Gloucestershire provides a support 
service for women who are pregnant and aged under 19. Of the 46 women in South 
Gloucestershire in contact with the FNP, 15% reported experiencing physical DVA 
over the past year, 5% reported being forced to have sexual relations over the past 
year, and 20% reported being physically abused since becoming pregnant. The 
numbers in the sample are very small so the true prevalence of DVA in this population 
may be smaller or greater.
Figure 4 Services involved in DVA prevention and response in South Gloucestershire

Primary prevention
- Addressing root causes of DVA
- Supporting healthy relationships

Secondary prevention
- Early detection
- Preventing continuation or escalation of DVA

Tertiary prevention
- Reducing immediate risk of death or serious injury
- Minimising long-term harm

Universal provision*

Schools
- In-house provision
- Connect with Respect

Further education colleges and universities
- Bystander Initiative (UWE)
- Student Union campaigns

Publicity campaigns e.g. DVA Awareness Week

Generic workforce development on supporting healthy relationships and DASH training

School nurse service

More targeted provision
- Antenatal screening
- Family Nurse Partnership
- Health visitors

Health visitors

Back on track — for children exposed to DVA

1:1 support through Children’s Services

Refuge Women and their female children or male children under 14

Refuge play sessions

Outreach 1:1 work with children 4-17

Parents programmes

Community IDVA

NBT IDVA

Outreach support for standard/medium risk female victims

IRIS advocate-educator

Freedom Programme

Sexual assault and rape centres
- The Bridge
- Kizcar (counselling support)

MARAC

Criminal justice services

UWE Wellbeing Service

Lighthouse
- Signposting
- Victim Support

Youth Offending Team work

CAMHS

Families in Focus
- Worker in Children’s Centres
- Parenting programmes

NB some universal services may be offered locally with exclusion criteria (e.g., women only) however, where not available locally provision is sought from national charities or providers in other locations
Secondary prevention

Whereas the aims of primary prevention are to address the underlying or root causes of DVA, secondary prevention aims to detect DVA at an early stage, and to implement rapid-response management strategies to prevent its continuation or escalation, and to limit adverse outcomes that have already emerged.

Telephone helplines

South Gloucestershire commissions a telephone support line through Survive. Two lines are available, however resource constraints mean that only one line is staffed at a time. This has reportedly led to capacity issues in the past. In 2014-15, over 1800 calls were made to the telephone support line, more than two-thirds (68%) of which were from professionals seeking information and advice on referral. Of the 1800 calls made over the year, 577 came from direct victims, an average of 48 per month.

In addition, residents of South Gloucestershire are able to contact helplines run by national charities. National helplines can provide generic or specific support tailored to particular demographic groups, for example:

- National Domestic Violence Helpline (24h Freephone run by Refuge and Women’s Aid)
- ManKind - advice line for male victims
- Broken Rainbow – advice line for LGBT victims
- Respect (Advice, information and support for men who want to stop being perpetrators)
- Victim support (generic support for victims of all crimes)

IRIS

All General Practices in South Gloucestershire are part of the Identification and Referral to Improve Safety (IRIS) programme. Clinical leads in practices are trained in
how to identify and ask about DVA, to undertake the DASH risk assessment, and to refer to the Multi-Agency Risk Assessment Conference (MARAC) or appropriate services as required. IRIS is commissioned across the whole of South Gloucestershire, and practices may refer to a named IRIS support worker who can work with women at standard or medium risk.

In 2015-16, the IRIS worker received 87 referrals from GPs across South Gloucestershire, 76 of these patients were contacted and received support (87%). Referrals were predominantly for female victims (98%), the majority of whom were White (87%), where the perpetrator was a partner or ex-partner (94%). Interestingly, 24% of referrals were aged over 50 (note this proportion has decreased from 39% in 2013-14 and 33% in 2014-15).

Of the victims supported by IRIS, the majority received emotional support (76%) and provision of information including housing, welfare, and legal support (74%).

**Freedom programme**

Over the course of 2014-15, 181 female victims in South Gloucestershire were referred to the Freedom Programme from the support telephone line, information sessions held with an IDVA and legal support, or for outreach support. Performance monitoring data collected by the CSP reveal that a total of 192 referrals were made to the Freedom Programme and 322 women attended and engaged in sessions over the past year.

**Floating support and support from social housing providers**

Many victims of DVA will be living in social housing in South Gloucestershire, and many victims who have left the family home may move into social housing. The main providers of social housing in South Gloucestershire are Merlin, Sovereign, Solon, and Knightstone.

Merlin recorded 32 incidents of DVA occurring in their properties in 2015/16; the majority of these involved female victims though a small number of male victims were identified. Victims were commonly aged 25-34 and defined as White British
ethnicity. A relatively high proportion of victims were defined as having a disability (12/32, 38%). Sovereign collect data on DVA incidents about which they are notified; these are for properties across South Gloucestershire and Bristol. In the past year (2015-16) they were aware of 23 cases domestic abuse in their social housing properties. Solon identified fewer than 10 DVA incidents in its properties; all were White female victims.

Knightstone are also funded to provide “floating support”– these are support workers aiming to help people with tenancy-related issues, which might include but are not limited to, DVA. In 2015-16, Knightstone were involved in supporting 35 victims of DVA; all were female with a mean age of 38.

Outreach support

Next Link are commissioned by South Gloucestershire Council to provide outreach support to female victims of DVA. In 2015-16, 32 victims were supported along with 22 children. Most of these victims were white (81%) and aged between 21 and 30 (62%).

Youth Offending Teams

South Gloucestershire Council's Youth Offending Team (YOT) will deal with young people (under 18s) who have been violent to a partner either as the primary offence for which they have been referred to the YOT or in the context of a wider review into the young person’s behaviour and lifestyle. Of 54 young people assessed by the Youth Offending Team in the year 2014-15, 20 (37%) reported witnessing DVA in the past, and 20 (37%) reported experiencing DVA themselves. No further details on these young people- such as age, gender, or offending history - are available.
An interesting aspect of the YOT work arises with young people (under 18) who have been violent towards a member of the family – not a partner – which is often the parent, usually the mother. It is reported that these situations are usually managed through the usual DVA process of DASH (Domestic Abuse, Stalking, Honour-based violence) risk assessment with or without MARAC referral; despite the context being more complex than with intimate partner violence, which is most commonly managed by MARAC. It has been recognised that these cases, in which removal of the victim (usually the parent) from the perpetrator (his, her, or their child) is more complex than when the perpetrator is an independent adult with means to live independently.

Perpetrator programmes

There are currently no community, voluntary perpetrator programmes running in South Gloucestershire. A programme designed to support male perpetrators of DVA who also have problems with substance misuse was discontinued due to unexpectedly low uptake.

Building Better Relationships (BBR) is the main perpetrator programme used by the courts. It is recognised locally that adherence is affected by complex issues such as employment, mental health problems, and chaotic accommodation arrangements. Between April 2015 and March 2016 11 DVA offenders completed the BBR programme in South Gloucestershire.
Tertiary prevention

Tertiary prevention aims to eliminate serious harm or the death of victims of DVA. This level of prevention is provided to victims at high risk of harm from DVA, usually identified as those scoring 16 or more on the DASH tool.

Multi Agency Risk Assessment Conference (MARAC)

MARACs are meetings where information on individuals and families involved in DVA is shared between professionals; cases are referred if the abuse or violence is believed to be of high risk. The conferences should be attended by representatives from multiple agencies including the police, children’s social services, and providers of primary and secondary care, mental health services, DVA services, and social housing. The purpose of the meeting is to share information and to discuss the responses by agencies – both those that have been taken and that are planned – to ensure that a coordinated action plan is in place to increase the safety of the victim. A comprehensive review of the MARAC process across Avon and Somerset is underway and the MARAC process will therefore not be covered in this needs assessment.

New cases

Locally collected data reveal that in 2015-16, 222 new cases were considered at a South Gloucestershire MARAC meeting. Of these 222 cases, the vast majority of victims were female (94%) and not from a BME background (88%) with a mean age of 33; the vast majority of perpetrators were male (95%) and not from a BME background (90%) with a mean age of 35. Current or previous alcohol and/or drug use by the victim was identified in only 19% of cases but was relevant for 66% of the perpetrators. Of the very small number of cases known to be LGBT, the majority of victims were male. The prevalence of disability amongst MARAC victims was low (7%) and even lower for perpetrators (1%). A small proportion of victims, mostly female, had learning difficulties; none of the perpetrators of DVA against these victims had learning difficulties themselves.

Mental health diagnoses, including low mood/anxiety/depression, for female victims were relatively common at 49% but less common for male victims (23%). Consistent with national data suggesting pregnancy is a high risk for DVA, 10% of female victims
were pregnant at the time of referral. At the time of referral, only 14% of victims were described as owner-occupier or privately renting and 30% of victims were living in social housing. A small minority (7%) were living in either refuge, supported accommodation, or emergency housing and a very small number of referrals were made for victims living in Traveller sites. One in six victims referred to MARAC last year were on the HomeChoice register; a third of these were still living with the perpetrator at the time of the referral. Just under two-thirds of victims (62%) were already in contact with an IDVA at the time of the MARAC. Referrals were made from a wide range of organisations, with the main referrers being the police (55%). Interestingly, two-fifths of all referrals were made according to professional judgement of elevated risk, rather than DASH score alone.

Repeat referrals
Repeat referrals are victims referred to MARAC once or more times previously. In 2015-16, 76 cases heard at MARAC meetings had previously been notified as high risk. The vast majority of repeat victims were female (95%) and not from a BME background (93%) with a mean age of 31 - slightly younger than new cases. Current or previous alcohol and/or drug use by the victim was more common in repeat cases (25%) compared to new cases (19%). The proportion of repeat referrals with mental health difficulties (46%), or disability or learning difficulties (9%) was similar to new cases.

Independent Domestic Violence Advisers (IDVAs)
IDVAs are trained specialists providing independent advocacy and support to high-risk victims. Their role is to act as a known point of contact for victims, to ensure that safety plans from MARACs are implemented, and to help the victim to navigate through the local and national support services available including specialist domestic violence courts and child protection conferences. “Drop in” information sessions with an IDVA and a legal representative are held in Filton once per month.

The IDVA service at Survive currently comprises of 1 full time IDVA and 2 part time IDVAs. South Gloucestershire Council/Community Safety Partnership (CSP) fund 1.6 whole-time-equivalent (wte) IDVAs; one of these IDVAs specifically provides support for victims with multiple or complex needs and specialises in BME cases. In addition,
Merlin Housing Association fund a separate IDVA at 0.45 wte and one IDVA (designated IDSVA- Independent Domestic and Sexual Violence Adviser) works in the emergency department (ED) at North Bristol Trust (NBT), providing support and advocacy for victims referred by clinicians and nursing staff.

During 2015-16, the IDVAs/IDSVAs received 294 referrals involving 672 children, of which 21% were repeat referrals – higher than the national average reported by Safe Lives of 17%. The primary referral source for IDVAs was the Avon and Somerset Constabulary Lighthouse Integrated Victim and Witness Care (Lighthouse); 64% of the IDVA caseload was identified by Lighthouse. Of the 294 referrals, only 134 victims (46%) received IDVA support in the past year with an average caseload of 23 victims and 15 victims for the 1.6wte IDVAs. The majority of victims referred to the IDVA service were aged 18-35, a small number (28) were identified as having a disability, nine of whom had a physical disability. The proportion of IDVA cases identifying as LGBT was only 4%, consistent with national population estimates but an under-representation of the expected population of victims. Nearly one in five victims (18%) referred to the IDVA service described their ethnic background as non-White, which is considerably higher than the estimated proportion in the overall South Gloucestershire population (5%); the reasons behind this are not clear. Interestingly, data from the IDVA caseload reveal that 11% of victims experienced DVA from multiple partners and more than half (56%) of perpetrators had been abusive in previous relationships.

The ED IDSVA is the only commissioned advocacy service available to male victims of DVA in South Gloucestershire.

Whilst all IDVAs are likely to have undertaken training in LGBT and cultural sensitivity, it was reported that there are no IDVAs specifically dedicated to working with LGBT victims or those from minority ethnic backgrounds.

**Criminal justice services**

*Avon and Somerset Constabulary*

In 2015-16, Avon and Somerset Constabulary were involved with 3656 incidents relating to DVA in South Gloucestershire; in 2014-15 3356 incidents were recorded. Information on gender, age, ethnicity, and sexuality are incomplete but of the data
available the majority of perpetrators were male (81%), White-North European (86%) with an average age of 43 years.

**Lighthouse Integrated Victim and Witness Care (Lighthouse) and Victim Support**
Lighthouse is commissioned by the Avon and Somerset Police and Crime Commissioner (PCC) and provides an enhanced support service to vulnerable or persistently targeted victims of crime, and victims of serious crime, which includes DVA. Each victim of DVA known to Lighthouse is allocated a case worker who is able to refer to other organisations. It is reported that a considerable proportion of the workload of Lighthouse is around DVA. Of 575 DVA incidents in South Gloucestershire managed by Lighthouse in 2015/16, 117 (20%, or one-in-five) involved victims who were assessed as high risk with the remainder of victims assessed as medium or standard risk (41% and 39% respectively). Interestingly, Lighthouse report that of the 942 DVA incidents in which victims were classed as “high risk” over the past five years, nearly one in three have previously been assessed as medium or standard risk.

Additional data were provided by Lighthouse and include demographic details but these were for a short period and were not disaggregated for South Gloucestershire and BaNES so will not be reported here.

The PCC also commissions Victim Support, a national charity dedicated to supporting victims of crime, to accept referrals from Lighthouse. Victim Support can offer face-to-face support with victims and are deemed to be an appropriate service for victims at standard risk. In 2015-16, Victim Support received 40 DVA referrals from the Keynsham-based service (covers South Glos and BaNES). Data are available for the South Gloucestershire victims: 16 women and 7 men; additional data on ethnicity or average age are not available.

**Courts and probationary service**
Of the 190 offenders in South Gloucestershire on which DVA data were available, 106 (56%) had a history of perpetrating DVA and 29 (15%) had also been victims of DVA in the past. The majority of DVA perpetrators assessed were male (96%), White (77%), and aged 31-49 years (56%).
Children brought up around DVA

In 2015-16, police reports suggest that 3196 children aged under 18 were linked to DVA in South Gloucestershire – either because the abuse occurred in the home, involved a care-giver, was witnessed directly, or they themselves were involved in the incident.

Children in South Gloucestershire who have been exposed to DVA at home (or those aged 16+ who have experienced DVA in their own relationships) can access support or receive interventions directly or indirectly through several routes:

- An Outreach Service, provided by Survive, provides children and young people with support in understanding and processing the abuse they have experienced, and developing knowledge and skills to identify unhealthy relationships for themselves in the future. This was funded by national charity grants which have now ceased
- Parenting programmes run by Survive and funded by national charity grants. 40 parents attended these workshops in 2014-15
- Referral to Survive’s “Back on Track” programme, also funded through charity grants which have now ceased. It is not clear how many children received this service.
- A crèche is offered for young children whilst their mother attends the Freedom Programme (69 children cared for in the crèche in 2014-15)
- Children in contact with a social worker may receive direct one-to-one support in overcoming adverse experiences including those associated with DVA
- Children living in a refuge receive play therapy; 72 children received this in 2014-15. This has been funded by national charity grants which have now ceased.
- Children on the “Families in Focus” (FiF) programme may access intense support including family interventions, parenting programmes, and one-to-one support through a specific FiF worker based in Children’s Centres
- The PCC also commission a “Young Victim Service” which is provided by North Somerset Youth Offending Team but available to all children exposed to DVA across Avon and Somerset. Only 4 DVA-related incidents were dealt with by the Young Victim Service in 2015-16.
A map of the pathway for children exposed to DVA is shown in Figure 6.

**Figure 6 Map of services supporting children exposed to DVA**

**Housing**

*Refuge provision (Survive)*

Currently South Gloucestershire has sixteen refuge places. This provision is based on shared living arrangements with victims provided with an individual bedroom and communal living rooms, kitchens, and bathrooms. Family bedrooms are available with en-suite bathrooms; if a female victim has children with her these can stay in the same bedroom (for example one victim had up to five children with her sleeping in the same room). The refuges have a guideline age limit of 14 for male children; this is due older teenage boys to perceived negative impact on the welfare of other refuge victims.

Over 2014-15, 48 families were provided with refuge in South Gloucestershire; this included 72 children. These are new arrivals and does not include women already in the refuge at the start of the period (data not available). The average length of stay in the refuge for a victim or family was 4.5 months; some families remained for up to 6 months. Not all refuge spaces were provided to South Gloucestershire residents (85%). All women providing feedback on the refuge stay (n=20) reported feeling safer and had ongoing support plans in place.
One bedroom in the refuge has been designed in a way suitable for people with disabilities. It was reported that in the past two years, no victim has required these facilities.

Refuge space is also available in other areas through mutual agreements with other providers; and indeed South Gloucestershire refuge places, when available, are offered to victims from other areas. National charities also offer refuge provision for specific groups such as male victims (Mankind), and specific minority ethnicities (e.g. Jewish Women’s Aid; Ashiana).
5. Domestic homicide reviews

A domestic homicide review (DHR) is a statutory review of the circumstances in which the death of a person aged 16 years or over has – or appears to have – resulted from violence, abuse, or neglect by a person to whom s/he was related, with whom s/he has been in an intimate relationship, or a member of the same household. The purpose of a DHR is to establish lessons learned in respect of the way that local organisations and professionals work to safeguard victims. There have been four DHRs conducted in South Gloucestershire; three have been published. A summary of each case and the key issues identified through the review are presented in

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Summary of case from review</th>
<th>Highlighted key issues from the review</th>
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<tbody>
<tr>
<td>SGDHR1 (11/2014) “Pritam”</td>
<td>Pritam was a 42 year old British Sikh female who lived in a multi-generational household with two children. It is reported that her in-laws were very controlling and critical of her, and that she was expected to do everything her mother-in-law told her to do. Medical notes reveal a gradual deterioration in Pritam’s mental health from 1993 to her death in 2013. This was attributed to the controlling behaviour of her extended family and perceived rejection by her children. In 2012 she first reported physical DVA by her husband. The coroner’s inquest concluded that cause of death was suicide.</td>
<td>1. There was little or no evidence that organisations and professionals involved in the case’s care considered domestic abuse in their assessment or management 2. There was no evidence that the police established that an adequate risk assessment had been completed following notification of DVA by the hospital. 3. It was noted that Children’s Social Care, whilst adhering to thresholds and protocols, may not have been aware of the effect of the repetitive DVA on the children.</td>
</tr>
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| SGDHR2 (03/2015)  
| "Carly" |
|---|---|
| There was a delay between referral and IDVA contact following a notification to the provider by police. |
| Carly was a 21 year old female (ethnicity not documented) who was living with her husband of six months and had previously been a Looked After child. |
| Following an argument, Carly's husband left the home, returning a short while after to find the victim face down in the bath. No suicide notes were found and the coroner recorded an open verdict. |
| A review of Avon and Somerset Constabulary databases revealed a “silent” 999 call three weeks before the death, involving a discussion between a distressed female (presumed to be Carly) and a male, presumed to be her husband. This was not logged as DVA. GP records note the involvement of the husband in Carly's mental health care and suggested this was a positive, protective factor. |

| SGDHR3 (04/2015)  
| "Molly" |
|---|---|
| Molly was an 87 year old female living in a care home (ethnicity not documented). Her step-grandson had been in her room shortly before the assistance bell was activated and an attending carer found the bathroom door closed and was advised by a male that there were no problems. On returning to check, Molly was found in the bathroom, not breathing. |
| Due to the non-typical circumstances surrounding this DHR, there were no pertinent issues highlighted. There was no evidence of any prior DVA between Molly and her step-grandson and the review concluded that the death was not predictable. |

1. The review noted that it was unfortunate that the “silent” 999 call was not recognised and logged as DVA. |
2. It was recognised that the process for “handing over” care between mental health organisations could lead to inaction. The lack of recognition of DVA by the GP and ED staff was recognised as potentially avoidable. |
3. The review noted that the process around developing a Pathway Plan with social care services could have been improved. |
4. It was suggested that risk assessment and support plans specifically considering the risk of DVA should have been undertaken by commissioned support services and housing associations involved in the case. |
| Molly’s grandson was arrested stated that he had conducted a “mercy killing” because he thought she had Alzheimer’s disease. He was later diagnosed with paranoid schizophrenia and is detained under Section 37 of the Mental Health Act. | Training for care home staff in responding to assistance alarms was recommended. |
6. Assessment of need: stakeholder views

A wide range of stakeholders were identified and contacted with a request to discuss views and experiences of DVA need, unmet need, service provision, and service gaps. Interviews were conducted with individuals or small groups of individuals. A list of stakeholders contacted is included as Appendix A. The vast majority of interviews were face-to-face; where this was not possible telephone interviews were conducted as an alternative. Key themes emerging from stakeholder interviews and discussions are discussed below.

**Key messages**

1. Stakeholders recognise that DVA is an important area and is a priority for many partner agencies. There was broad support for the aims of agencies and services in addressing the root causes and harms of DVA.
2. Populations perceived to be “hidden” or excluded from services currently include male victims, BME victims, and LGBT victims.
3. There are concerns about refuge provision from a range of stakeholders concerning a variety of aspects including the quantity, quality, type, eligibility, and “exit” pathways.
4. There may be some uncertainty and confusion about the provision of services for victims at medium/standard risk and referral pathways into these services.

**Risk assessment**

Stakeholders were familiar with, felt confident using, and saw the value of the standard DASH risk assessment tool in assessing risk of serious harm or death from DVA.

**Multi-agency approaches**

There was a strong desire for multi-agency responses to DVA from several stakeholders for variety of reasons, including improvements in communication, better understanding of available services, and more effective sharing of information between agencies.
The local MARAC process was viewed as labour-intensive and time-consuming, with many stakeholders expressing a desire for a change in delivery model or caseload discussed at the meetings. Some stakeholders expressed concern that not all agencies attended MARAC in person and the potential risks this could pose.

Physical co-location of DVA specialists with relevant agencies such as the police, health visitors, and children’s and adults’ services – such as in Lighthouse hubs or in the Multi-Agency Safeguarding Hub (MASH) model - was postulated as potentially effective in ensuring safety and appropriate referral into services for victims and their children. It was noted that geographical and logistical limitations may prove to be barriers in practice.

**Unmet needs**

It was recognised that the needs of male victims were poorly addressed by services in South Gloucestershire; the lack of refuge provision for men was often raised. It was recognised that services were often not well placed to identify or address DVA amongst older adults, including those suffering from age-related illnesses and challenging behaviours secondary to cognitive impairment.

Teenagers and young adults as perpetrators of DVA was identified as a gap - there was uncertainty as to which agency would be best placed to manage the case (i.e. Children’s Services or Youth Offending Teams) and whether any interventions could address the DVA. One particular area of need was identified around children abusing their parents.

The lack of specific BME-sensitive services or support was identified as a gap and a perceived lack of engagement with the Gypsy and Traveller community was thought to result in under-estimation of need in this group. Staff providing services were reported to have an appropriate awareness of potential cultural sensitivities surrounding BME victims; this was recognised and appreciated.

The lack of local support specifically addressing the needs of LGBT victims was recognised. A model in which focused services for these groups nested within the wider service provision was desired.

It was believed that a large number of high-risk victims and perpetrators were believed to have drug and alcohol problems yet few were known to services. Whether
substance misuse service provision could be better targeted or promoted amongst high-risk groups was questioned.

**Telephone support line and outreach support services**

The emotional support services provided in South Gloucestershire were viewed positively by stakeholders and service users. These services included commissioned services and support delivered by other providers, for example in social housing and legal services, and the community and voluntary sector.

Concern was expressed about the capacity to meet demand for calls to the commissioned support telephone line and how previous reliance on a volunteer for the second line was unsustainable. A considerable proportion of the calls to the telephone line were reported to be from professionals seeking advice and information about referral.

There was some concern that the referral pathways into outreach support and floating support services may not be clear to all agencies and there was some uncertainty around how these services fit into the picture of provision for women of high/medium/standard risk.

Some stakeholders expressed concern that there was inadequate service provision for victims at standard or medium risk. It was felt that services identifying victims in this risk group (e.g. Lighthouse) did not have adequate service provision available for referral. However, it was recognised that a new “outreach” initiative, designed to provide support for these victims, would relieve some of this demand.

**Housing**

Stakeholders expressed concern that refuge provision in South Gloucestershire may not be as modern as perhaps it could be, several examples of provision in other areas were cited including self-contained flats and apartments. Such an arrangement was described as beneficial as it would enable provision to be offered to those with complex needs and male children aged over 14 years. The service user involved in the stakeholder analysis described how she felt “gutted” that she was unable to access the refuge provision because she could not leave her teenage son.
There was a recognition that refuge provision should meet the needs of particularly vulnerable groups including LGBT people, those with complex needs, and those with disabilities. That refuge provision was exclusively for women in a communal living arrangement and therefore precluded provision for men or potentially those with serious mental health issues or substance misuse was considered inequitable by some stakeholders. It was raised that South Gloucestershire is apparently unusual for not having “safe houses” in addition to communal living refuge places; it was thought that such houses could act as a “step down” option, reducing pressures on the refuge and HomeChoice register. Concerns were expressed about “move on” options for women in refuges. There was a recognition that women staying for longer than necessary is potentially detrimental to the health and wellbeing of the victim, in addition to presenting an opportunity cost of that space not being available for other victims.

Potential solutions were suggested by a range of stakeholders, and these suggestions included a system where all refuge residents are automatically given a Band A or priority status when entering the HomeChoice register, which it was believed might help ensure that exit pathways from refuges are not bottle-necked. Other solutions included other housing options such as private renting or ownership, or reducing refuge use by increased utilisation of Domestic Violence Protection Notices and Orders (DVPNs and DVPOs) to support the victim staying in their own home. Service users described difficulties with accessing housing support for a variety of reasons (including financial assets and low priority status). Informal sources of housing support had been sought (for example, staying with a friend).

Having a housing officer specifically based within the refuge was suggested by several stakeholders as a means of increasing the likelihood that a victim on the HomeChoice list was able to apply for an appropriate property when one became available – the competitive market for properties was identified as one potential reason for women remaining in the refuge longer than desired.

Interest in the number of refuge spaces in South Gloucestershire was expressed, including a query about the number of spaces taken up by victims from outside of South Gloucestershire (as part of a UK-wide agreement between refuge providers).

Due to the nature of refuge provision and contacts with providers in other areas,
difficulties in understanding the relative supply and demand for refuge provision for South Gloucestershire residents was described. Social housing providers described working hard to support the needs of DVA victims who were not at sufficiently high risk to warrant refuge; a mix of support provided by housing officers and systems to re-house victims away from perpetrators was deemed effective in managing risk at this level.

IDVA

There was recognition of the importance of this role by professionals and service users. An extension of Emergency Department (ED) IDVA service to wider hospital settings (e.g. maternity services) was suggested. One stakeholder revealed some confusion existed about the change in name from IDVA to IDSVA and whether the focus remained on DVA rather than sexual violence in a non-domestic setting. There was also uncertainty about whether the ED IDVA was commissioned to accept referrals for male victims outside of the hospital setting. Whilst IDVA support is likely to be less accessible for male victims in South Gloucestershire, a male service user described similar advocacy support received from staff in the community and voluntary sector.

Health and community services

There was a recognition of the importance of DVA amongst patients in primary, secondary, and community care settings. The importance of adequate training was highlighted, though issues in mapping and recording training received by staff were occasionally encountered. Care services had DVA policies and procedures that had either been implemented or in were in development; these were seen as important in supporting staff in identifying and managing DVA amongst patients and service users. The IRIS service was viewed positively, with recognition that it does not directly address the needs of male victims but that the service can signpost to other, national charities. An interesting feature of IRIS referrals locally is the relatively low number of referrals from younger women, and it was suggested that this may be due to the mechanisms by which young, non-complex women receive primary healthcare
currently (i.e. through triage and telephone consultations rather than face-to-face consultations).

**Needs of children and young people**

The Families in Focus programme was recognised as potentially useful in addressing the needs of the most complex families; DVA was described as one of the additional criteria on which selection of families is based. Therefore the caseload of families receiving intensive support locally may include a large number of children exposed to DVA in the context of multiple risk factors.

There was widespread recognition of the importance of healthy relationships training for young people. It was identified that some secondary schools in South Gloucestershire have dedicated time in the school timetable for “life skills” which may include education on healthy relationships and domestic violence, though this was neither exclusive, compulsory, nor universal. Stakeholders explained the difficulties in ensuring universal coverage of any kind of healthy relationships training in schools as it is not a statutory duty (aside from where it may overlap with Safeguarding and Child Sexual Exploitation). Provision in schools was described as historically funded by charities, but with the non-renewal of that funding there are concerns that many schools will not be able to afford to pay ‘out of pocket’ themselves for the programmes. Education through school theatre companies were described positively though it was recognised that these sessions are expensive.

The level of attention given by teaching staff to DVA was discussed, with recognition that some teachers receive training on healthy relationships from sexual health advisers. Some educational settings delivered materials on sexual consent for adolescents as a means of reducing the risk of sexual DVA amongst teenage intimate relationships. In addition to schools-based work, the role of parents in teaching children and young people about relationships was raised as important. The most effective mechanism for engaging with parents and families to support this – particularly in those in which unhealthy, violent, or abusive relationships occur – was identified as a gap.

Where children have been exposed to DVA and are believed to be at risk, there is a desire to provide an alternative model for support that aims to re-unify the family.
Approaches such as the Family Drug and Alcohol Court (FDAC) model run in London were suggested as models of practice that could be translated to DVA settings. Service users strongly expressed desires to protect their children from further harm and to maintain contact so far as possible.

Complicated relationships between male perpetrators and their children were recognised. A lack of effective means by which to reduce the risk of harm whilst enabling a safe and appropriate amount of contact between child and parent (usually father) was identified as problematic. Indeed risk assessment and management in cases of DVA where children were involved was identified as complex. One stakeholder described the perceived perception by professionals that attendance at a Freedom programme by a female victim was sufficient to reduce risk to the victim and the child.

**Perpetrator programmes**

Stakeholders expressed a desire for community-based perpetrator programmes as a way of reducing repeat victimisation and to move away from an emphasis on the responsibility of the victim (usually female) to protect herself and children.

**Views and experiences of victims and survivors of DVA in South Gloucestershire**

There is no local victim or survivor (or perpetrator) forum for domestic violence and abuse facilitated by South Gloucestershire Council or CCG. Service users of both genders were contacted through provider organisations, and kindly provided insight into their experience of DVA and services in South Gloucestershire.
7. Evidence base

Evidence around interventions to prevent, reduce, end, or mitigate DVA has been obtained from a non-systematic review of the published and grey literature. Libraries containing robust reviews of evidence—such as the Cochrane Collaboration and the Campbell Collaboration—were searched, and supplemented by systematic reviews and primary research papers published in journals and in third sector reports. Whilst a thorough exploration of the relevant literature was attempted, it is possible that some primary research studies—especially very recently published research—may not have appeared in these searches. The following is a synthesis of the identified literature.

**Key messages**

1. Evidence for interventions is highly focused on management and response to DVA rather than prevention. The majority of research has investigated intimate partner violence, with minimal evidence on how to prevent or respond to intrafamilial DVA or DVA amongst people with complex needs or disabilities.

2. There is evidence that schools-based interventions on healthy ageing can change attitudes and knowledge about DVA. There is currently a lack of rigorous evaluation of “bystander interventions” delivered in post-16 educational settings.

3. Healthcare-based advocacy interventions, particularly those based in antenatal settings, are effective in reducing physical and emotional violence and reducing depression in victims of DVA, but evidence for their effectiveness to reduce re-victimisation is weak.

4. There is an absence of research around the effectiveness of refuge and safe housing, outreach work, and floating support in preventing or responding to DVA.

5. Much research has been done on interventions for perpetrators, with little convincing evidence of effectiveness at present.

6. There is good quality evidence in support of interventions to support children exposed to DVA.

The Lancet have recently published a systematic review of interventions to reduce violence against women and girls (41). Table 2 summarises the review’s findings for DVA in high-income countries. Interventions shaded in blue have evidence of promise;
those in pink appear ineffective. There is a limited evidence base to comment on other interventions.
<table>
<thead>
<tr>
<th>Response to violence against women</th>
<th>Example of intervention</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women-centred programmes*</td>
<td>Psychosocial counselling; risk assessment; referrals; safety planning</td>
<td>Conflicting</td>
</tr>
<tr>
<td>Perpetrators programmes*</td>
<td>Interventions for men who assault their female partners</td>
<td>Conflicting</td>
</tr>
<tr>
<td>Shelters</td>
<td>Safe accommodation: short-term refuge and other services</td>
<td>Insufficient evidence</td>
</tr>
<tr>
<td>Women's police stations</td>
<td>Specialised police services for DVA; includes psychosocial counselling, referrals</td>
<td>Not applicable/no evidence</td>
</tr>
<tr>
<td>Victim Advocacy*</td>
<td>Case management; connection to legal services and information</td>
<td>Promising</td>
</tr>
<tr>
<td>ICT services</td>
<td>National emergency hotlines or mobile applications</td>
<td>Insufficient evidence</td>
</tr>
<tr>
<td>Population-based prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community mobilisation*</td>
<td>Participatory projects; community-driven development engaging multiple stakeholders and addressing gender norms</td>
<td>Not applicable/no evidence</td>
</tr>
<tr>
<td>Awareness campaigns*</td>
<td>One-off information or media efforts; billboards; radio programmes; posters; television adverts</td>
<td>Ineffective</td>
</tr>
<tr>
<td>Social marketing, edutainment plus group education*</td>
<td>Long-term programmes engaging social media; social media; mobile applications; thematic television series; posters; together with interpersonal communication activities</td>
<td>Insufficient evidence</td>
</tr>
<tr>
<td>Group-based training or workshops for prevention of violence against women and girls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empowerment training for women and girls*</td>
<td>School or community programmes to improve women's agency. Can include safe spaces, mentoring, life skills, or self-defence training</td>
<td>Insufficient evidence</td>
</tr>
<tr>
<td>Men and boys norms programming*</td>
<td>School programmes and community workshops to promote changes in social norms and behaviour that encourage violence against women and girls and gender inequality</td>
<td>Insufficient evidence</td>
</tr>
<tr>
<td>Women and men*</td>
<td>School or community workshops to promote changes in norms and behaviour that encourage violence against women and girls and gender inequality</td>
<td>Insufficient evidence</td>
</tr>
<tr>
<td>System-wide approaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening*</td>
<td>Universal IPV screening among nurses and doctors at all visits</td>
<td>Ineffective</td>
</tr>
<tr>
<td>Home visitation and health worker outreach*</td>
<td>Visits by community health workers or nurses to households</td>
<td>Promising</td>
</tr>
<tr>
<td>Law-enforcement Personnel training*</td>
<td>Mobile courts; increased enforcement; second response</td>
<td>Ineffective</td>
</tr>
</tbody>
</table>

*denotes interventions identified through systematic reviews and meta-analyses, while other interventions are described as responses to violence against women or as population-based prevention strategies.
More detailed consideration of the evidence is described below.

1. Primary prevention
Understanding healthy relationships

Primary preventive approaches are likely to be most effective when delivered or targeted at children. It is accepted that primary prevention is usually most effective when delivered according to proportionate universalism, i.e. when actions are provided universally to all but with a scale and intensity that is proportionate to the level of disadvantage or risk (42).

The evidence for primary prevention of DVA is limited. NICE guidelines support the conclusion that there is a lack of evidence around preventing “teen dating violence” or intimate partner violence amongst adolescents (29) and the Programme Development Group “did not find sufficient evidence to make recommendations on primary prevention programmes”.

A review for the WHO by the London School of Hygiene and Tropical Medicine found that schools-based programmes were the only effective prevention approaches targeting children through to young adulthood. Moreover it was identified that most young people talk to peers rather than adults about their experiences of interpersonal violence and abuse, and that they feel that the home and school settings are most appropriate for prevention interventions (43). A systematic review by the Campbell Collaboration concluded that school-based prevention programmes can increase knowledge and awareness of how to resolve conflict and can change attitudes about the acceptability of DVA amongst participants however there is limited evidence that this leads to behaviour change or reductions in teen dating violence or future DVA (44). There are a handful of interventions that have been evaluated in randomised controlled trials (RCT, the gold standard study design). A healthy relationships intervention developed and evaluated in an RCT in Canada showed convincing reductions in teen dating violence with participants of both genders less likely to be perpetrators and victims in the intervention arm compared to control. The findings of this trial are unlikely to be due to the play of chance (45). “Safe Dates” is a school
based universal adolescent dating violence prevention programme for 11-18 year olds and has been shown in an RCT in the US to reduce physical, and sexual dating violence at four year follow up (46).

The Campbell Collaboration review on primary prevention of DVA concluded that future research should explore the role of bystanders more explicitly, examining how prevention programs may shift the peer culture to be less tolerant of dating violence.

**Bystander interventions**

It is increasingly recognised that DVA is faced by students. The Hidden Marks study conducted in 2010 by the National Union of Students (47) looked at the prevalence of DVA, sexual assault, and rape. The report found that 1 in 7 respondents described experiencing serious physical or sexual assault as a university student, and the perpetrator had been an intimate partner in 35% of serious incidents. In recent years several interventions have been developed and implemented in university and college settings to address this. Locally in South Gloucestershire, UWE has worked with PHE to develop and implement the “Intervention Initiative” which is based on the theory of modifying social norms about the acceptability of DVA and related behaviour in young adults as a means of behaviour change. No rigorous evaluations have been published on bystander interventions in student settings, however the Intervention Initiative study team report that it was implemented as a “control trial”; they have been contacted for further details.

**Parenting programmes**

Parenting support programmes are diverse and may cover multiple elements such as conduct disorders, substance misuse, and domestic violence. They are often recommended as important for children exposed to DVA and their parent, who may be the victim or in some programmes the perpetrator of DVA (48) however no evidence of effectiveness in preventing harm from DVA was identified. A comprehensive and robust systematic review investigating Europe-based parenting programmes for promotion of mental health concluded that effective programmes are likely to consist of combined universal and targeted approaches (49).
Whole-family interventions

There is currently insufficient evidence to comment on the effectiveness of whole-family interventions, such as the Troubled Families programme, in reducing or ending DVA. A before-after, non-controlled evaluation suggested that Family Intervention Projects and services could to reduce the prevalence of DVA by 57% (from 30% to 13%) (50)

Public education and campaigns

A study of two community-based interventions (public education using leaflets and posters; police and social worker home visits) showed that neither intervention affected service-awareness or service-use scores of individuals who experienced abuse (51).

2. Secondary prevention

Secondary prevention involves identifying DVA at an early stage, and intervening to prevent its continuation or escalation, and to limit adverse outcomes that have already emerged.

Identification of victims

By health professionals

Some reviews have recommended universal screening(52) however published research suggests that this is not acceptable to a large minority of women (20%)(53).

Pregnancy is known to be a time of elevated risk for women: it is believed that around a third of all DVA starts or escalates during pregnancy(54). The UK National Screening Committee reviewed the evidence for screening during pregnancy and advised that a systematic population screening programme was not recommended. However routine enquiry about DVA during antenatal care, funded as a project by the Department of Health in 2004, was implemented in North Bristol Trust (NBT) in 2005 and was evaluated by researchers at UWE. A report on the outcomes after five years concluded that there should be “a commitment to the continuation of education and training around domestic violence and routine antenatal enquiry as part of mandatory training. Links should be made with other aspects of safeguarding, including child protection
and substance misuse” (55). The extent to which routine antenatal DVA enquiry is currently delivered in NBT is unclear.

NICE recommends that trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children’s and vulnerable adults’ services ask patients and service users whether they have experienced DVA. It is recommended that this should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse (29).

IRIS (Identification and Referral to Improve Safety) is an evidence-based training and support programme targeted at primary care clinicians and administrative staff. It has been shown to improve referral rates to specialist DVA agencies and to increase recorded identification of female patients’ experiences of DVA (56). More recent work piloting IRIS in sexual health clinics may reveal that this setting could be effective in reaching men in same-sex relationships; the research has not yet been published. The IRIS programme is being extended (IRIS+) to look at improving identification and referral of male victims and perpetrators with an advocated specialising in this group. Previous feasibility work on training GPs to identify and address DVA amongst male victims and perpetrators has been undertaken (HEREMES study). The IRIS+ programme also aims to improve the responses of GP staff in addressing the needs of children exposed to DVA as this has been addressed as a gap in previous research. A feasibility pilot study of IRIS+ will be implemented in 4 GP practices across South Gloucestershire in early 2017 and will be followed by a larger trial across other sites outside of South Gloucestershire. The outcome of the definitive evaluation of IRIS+ - likely to be available late 2020 – is likely to influence commissioning decisions in this area.

Victim support

**Telephone helplines**
There is insufficient evidence about the effects of telephone helplines on preventing, reducing, or limiting harm from DVA.

**Specialist services – including advice, floating support, outreach support**
There is insufficient evidence about the effectiveness of floating support and outreach workers on preventing, reducing, or limiting harm from DVA. Advocacy interventions
– including Independent Domestic Violence Advocates (IDVAs) aim to support women at high risk of harm from DVA and the evidence base for advocacy is therefore discussed in section 3.

**Interventions delivered in pregnancy**

Overall, there is limited evidence in support of DVA interventions delivered in pregnancy and post-partum. One quite robust trial suggesting that a psychological intervention can reduce the incidence of abuse by around 40%. There is no convincing evidence for effects on neonatal outcomes such as stillbirth, APGAR score, prematurity (57). There is also good evidence from the Dutch version of the Family Nurse Partnership (FNP) that the programme reduces the risk or severity of DVA by an intimate partner and this effect was sustained for two years (58). DVA has not been considered as an outcome in evaluations in the US or UK, although an additional component to the FNP model, specifically focused on intimate partner violence, is being piloted in the US.

**Therapeutic interventions including psychological support, cognitive therapy, counselling**

There is a lack of large, robust studies of counselling, skill development, and other therapeutic approaches for people who have experienced DVA(29). Economic modelling on “cognitive trauma therapy for battered women” suggested that such an intervention was likely to save the UK £15 million by reducing harm from DVA, when compared to no intervention(29).

A specialist psychological advocacy intervention has been developed to provide psychological support for female victims of DVA and has been evaluated in a robust randomised controlled trial (the PATH study) (59). The findings of the PATH study are due to be published in late 2016.

**The Freedom Programme**

The Freedom Programme is designed to provide information to victims (primarily female) of DVA, by examining the role of attitudes and beliefs on the actions of abusive men and the responses of victims. In doing so, the programme aim is to help victims make sense of and understand what has happened to them and is described as
information-providing rather than therapeutic (60). The Freedom Programme has been rolled out in several areas across the UK; however there is little evidence of its effectiveness in reducing, ending, or limiting harm from DVA. Local evaluations of individual programmes, including one undertaken of the Bristol Freedom Programme by the University of Bristol, have been conducted but are primarily qualitative in nature, based on small samples, or involve non-controlled before-after studies which are at high risk of bias (61).

Children exposed to DVA

Improving response of professionals
The association between DVA and child maltreatment is recognised in national guidance (RCGP and NSPCC, 2011), though it has been argued that despite effects on the development, educational attainment, and mental health of children, DVA has not been addressed sufficiently in child safeguarding to date (62).

There is reported uncertainty among GPs in relation to their child safeguarding responsibilities in the context of DVA, including assessment, mandatory reporting, information sharing, and ongoing support to the family. Research undertaken in the RESPONDS programme identified that GP staff found that they were unclear about how to best address the needs of those children who had been exposed to DVA but who didn’t reach the “high risk” thresholds necessary for child protection orders. A lack of confidence in starting a conversation about DVA was a common theme and it was rare for GPs to directly engage children and young people in conversations about the abuse or violence. Clinicians tended to focus on physical abuse of victims and their children rather than issues around neglect and emotional harm; there were particular difficulties with managing families where the risks from DVA were perceived to be uncertain or not high (63). A training and referral package aimed at improving identification, documentation, and referral to services of children exposed to DVA has been developed, and this is undergoing evaluation in South Gloucestershire as part of the IRIS+ research programme discussed previously.

A systematic review of educational and whole-system interventions that aim to improve professionals’ understanding of, and response to, DVA survivors and their children was published recently and concluded that training interventions generally
had positive effects on improving knowledge, attitudes towards DVA, and clinical competence up to a year after the intervention. System-level interventions demonstrated benefit in coordinating change amongst child welfare agencies, primary care, and other organisations (62).

Support interventions
Several interventions have been developed to address the needs of children exposed to DVA in the home. Evaluations of such programmes and interventions are, on the whole, very limited. There is often no hypothesised theory of change; studies use imprecise, heterogeneous, or single outcome measures; many have small sample sizes and often no control groups. However there is some RCT-level evidence of promise for the following interventions:

- Counselling and therapy (64-66)
- Crisis and outreach support (67, 68)
- Multi-component interventions (69-72)

LGBT victims
Evidence from the Broken Rainbow charity suggests that LGBT victims want “appreciation of LGBT cultural issues, to be believed, taken seriously, no stereotyping, appropriate help, counselling, intervention from police, housing, and healthcare agencies” (30).

There is insufficient evidence of interventions directly targeted at LGBT victims of DVA; though researchers are developing interventions to address DVA amongst men in same-sex relationships. A report on DVA amongst LGBT people, published by the Diversity Trust, suggests that people in same-sex abusive relationships may obtain support in different ways, for example, it was reported that women in same-sex abusive relationships may be more likely to seek help from private counsellors or GPs (rather than friends and family and the police) (73).

NICE quality standards for domestic violence and abuse state that victim support services should be “tailored to address the specific needs of people experiencing domestic violence or abuse…. to help men, and lesbian, gay, bisexual or transgender people affected by domestic violence or abuse” (74).
Elder abuse

There is insufficient evidence on interventions developed specifically to address DVA in older adults. NICE also recognises that there is a gap in evidence about interventions to prevent elder abuse (29). The charity Action on Elder Abuse recommend an approach that includes screening and detection, independent and confidential advice and guidance, a coordinated and integrated approach including legal, medical, educational, and empowerment elements and that practical services be followed by empowerment and support. They note that any intervention must be proportionate to the harm, or real possibility of future harm, and which has the overall effect of improving the life of the adult, including their safety, happiness and mental wellbeing (75).

DVA amongst people with long-standing illness or disability

NICE quality standards state that “services should...be accessible to people with additional needs such as physical, sensory or learning disabilities. When interpreters are needed for discussions, these should be professional interpreters who are impartial and have a duty to maintain confidentiality. Family members or friends should not act as interpreters for enquiries or discussions” (74).

DVA in the context of substance misuse

There is some poor quality evidence suggesting that an intervention training partners to pressure heavy drinkers to change may reduce domestic violence compared with no intervention, however the sample size was small and any difference in DVA rates may be due to chance (76).

Perpetrator programmes

The evidence base around domestic violence and abuse perpetrator programmes is weak. Evaluations of perpetrator programmes in the US concluded that re-offending rates were similar in perpetrators in programmes and those not in programmes (77). Many perpetrator programmes have been evaluated, however the study designs are often at high risk of bias. Studies often involve men who have been ordered to attend
a perpetrator programme by the court following a DVA conviction, and study authors compare repeat incidents (measured either as new arrests, or partner reports of violence) among men who have completed the programme with those among men who have dropped out or never attended the programme. Overall, these programmes have very high dropout rates, and it is probable that men who attend and complete these programmes are different in many ways to the general population of perpetrators (e.g. more motivated to change, receiving subsequent support and help).

“Project Mirabel”(78) was a wide review of community-based (non-probation) UK perpetrator programmes. A before-after study design was used and the authors reported improvements in all measures. Large differences were reported in several important self-reported measures such as: “he tries to prevent me seeing or contacting friends/family” (65% reported at baseline; 15% reported at one year); “he made me do something sexual that I did not want to do” (30% at baseline; 0% at one year); “he slapped me, pushed me, or threw something at me” (87% at baseline; 7% at one year). Project Mirabel is limited as there was no control group, and the programmes often contained multiple components in addition to the group and one-to-one perpetrator programme (e.g. women’s support workers and children’s support workers) making it difficult to attribute the effects to the perpetrator programme per se. Nevertheless, the accompanying qualitative study and a quantitative study looking at children’s feelings about their father before and after the programme certainly suggests evidence of promise of perpetrator programmes. Two large-scale research projects on perpetrator programmes are currently underway (DRIVE (79) and REPROVIDE (79)).

**Cognitive Behavioural Therapy (CBT)**
A Cochrane review(80) concluded that perpetrator CBT might reduce the risk of violence compared to usual care and process-psychodynamic therapy may perform marginally better than CBT, however in all trials the effects were small and consistent with chance.

**Anger management**
There is no evidence that a generic anger management programme is effective in reducing or ending DVA in intimate relationships.
3. Tertiary prevention

Tertiary prevention interventions aim to reduce the immediate risk of death or serious injury and minimise long-term harm. The NICE guidelines recognise the lack of evidence around tailored approaches for women facing different levels of risk (29).

Independent Domestic Violence Advocacy

Advocacy may contribute to reducing abuse, empowering women to improve their situation by providing informal counselling and support for safety planning.

Independent Domestic Violence Advocates (IDVAs) are trained to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members. Their role includes securing the safety of the victim and any children in the home. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk. A training course and professional qualification, endorsed by the UK Home Office, has been developed by Co-ordinated Action Against Domestic Abuse (now Safe Lives).

IDVAs in general

There is some weak evidence that intensive advocacy can reduce severe physical abuse at 24 months— but not at 12 or 36 months— in women who leave a shelter (81). A non-randomised, non-controlled evaluation of IDVAs concluded that self-reported DVA is reduced after intervention from an IDVA, and that this reduction is dose-dependent in that more intensive support increases the likelihood of cessation of DVA (82).

NICE used the estimates from this study in an economic model and found IDVAs to be cost-saving compared to no intervention, in that IDVAs were seen to improve quality of life and reduce overall spend. It was explained that the cost of DVA is so large that even marginally effective interventions are likely to be cost-effective (29). A large, multi-site evaluation of IDVAs suggested that almost 80% of victims said that they felt safer after receiving support from an IDVA, and for just over half of victims the DVA stopped or reduced considerably in the three-to-four months after contact with an IDVA (83).
IDVAs in hospital settings including the emergency department (ED)
There is no evidence that brief advocacy (less than 12 hours) in healthcare settings reduces physical DVA at 12 months except in antenatal settings (see below) (81); however there is evidence that brief advocacy in healthcare settings can substantially reduce the risk of depression. Interestingly there is no evidence that more intensive advocacy in healthcare settings reduces depression (81). In addition, the THEMIS study is a quasi-experimental study with moderate risk of bias and aims to compare the caseload of hospital IDVAs to community IDVAs. One interesting finding from this study is that hospital-based IDVAs are more likely to have contact with victims who have co-morbid mental health, suicide, and self-harm disorders compared to community IDVAs(84).

IDVAs in antenatal settings
There is evidence that advocacy in antenatal settings may reduce minor physical DVA at one year and reduce emotional abuse in the short-term. It is possible advocacy may reduce the risk of depression in pregnant women, though this may be due to the play of chance. Moreover there is evidence that a multi-component intervention, incorporating advocacy, in an antenatal setting can increase the likelihood that physical DVA ceases immediately after advocacy (81).

MARAC
CAADA (now Safe Lives) recommends the implementation at local level of MARACs, which allow local agencies to pool knowledge about individual victims of domestic violence and identify a safety and risk management plan, with a named individual to take the lead for implementing such a plan, in order to reduce and manage risk. Research – based on economic modelling - has claimed to show a cost saving impact of MARACs (85) although it is not clear how much of the risk reduction was the impact of the MARAC specifically and how much the impact of the interventions of relevant agencies who might have been providing this activity in any case.

Housing
Shelters, refuges, safe housing
No current evidence of suitable quality exists in the literature reviewed to evaluate the effectiveness of shelter stay as a means of decreasing the incidence of violence (51).
PTSD in children exposed to DVA

For children suffering from post-traumatic shock disorder following exposure to DVA, there is evidence that CBT can help (86).
8. Conclusion

Summary

There are key areas of unmet need surrounding DVA provision in South Gloucestershire. In addition to a large number of mostly young, female, victims not identified or receiving services, there is a particular need for people with disabilities, men in same-sex relationships, and people on very low incomes. Individuals from these demographic groups may be hidden from services currently.

Several elements of DVA provision in South Gloucestershire are very well received, such as identifying and supporting victims of DVA: the IRIS programme in general practice; IDVA services, particularly those in healthcare settings; multi-agency working such as the MARAC; and the Family Nurse Partnership. Many services are provided for DVA victims however the existence, eligibility criteria, and referral processes for some of these services are not clear to all agencies in contact with victims.

Primary prevention in schools – and possibly further education colleges and universities – can change attitudes and behaviours, which may result in a reduction in DVA as these children grow older. Funding for schools-based primary prevention in South Gloucestershire has been via national charities and the sustainability of this provision is therefore at risk.

There is widespread recognition that refuge provision must meet the needs of our population and stakeholders have identified elements that may be modified to enhance this provision. It is difficult to comment on capacity as places may be used by victims from other areas in a reciprocal agreement. Systems for supporting victims to “move on” from refuge need to be improved.

It is likely that some of the current demand on services could be relieved by simple system changes. For example, the telephone support line is overwhelmed and has a high number of calls from professionals; web-based information and referral options could reduce this pressure.
A review of the MARAC process by Avon and Somerset Constabulary is likely to identify further opportunities for reducing the burden and increasing the efficiency of this process.

Assessment of need, and understanding of activity and reach, could be improved by better systems for data recording, reporting, and monitoring. Particular data needs exist around services provided to children exposed to DVA, and police notification and referral through Lighthouse. A robust system for collecting data will enable the PADA to monitor and evaluate impact of service provision, including that for people identified as having high or unmet needs.

Recommendations

1. Provision should focus on the group with the greatest need i.e. young women, and those with high unmet need i.e. men in same-sex relationships and people with disabilities.

2. Sustainable funding for schools-based primary prevention on healthy relationships should be considered to reduce the risk of these children becoming adult victims and perpetrators.

3. A well-developed web-based information hub aimed at professionals and victims will improve professionals’ knowledge about services, reduce demand on existing services, and may increase identification of victims.

4. Consideration should be given to moving the IDVA service from an exclusive ED base to a shared ED/antenatal base.

5. Support for medium/standard risk women is patchy and the evidence base for non-advocacy interventions is weak. A comprehensive pathway for women deemed to be at standard or medium risk should be developed, including regular risk assessment to ensure service provision remains at the appropriate level.

6. Greater local understanding of DVA prevalence and need amongst the Gypsy and Traveller community would enhance service provision to this population.

7. There is a lack of research and understanding about the scale of intrafamilial violence, including child-on-parent violence. Better data collection locally could support future decisions around intervention. Youth offenders involved with DVA should be managed as children rather than adult offenders.
8. Given the high degree of overlap with other council, health, and police services, DVA should be managed using a “whole system” approach which will reduce duplication and ensure harmony between agencies. Existing mechanisms and arrangements for partnership working are strong and these can be further built upon to improve service provision.

9. Provision of safe accommodation should support victims with complex mental health or substance misuse needs, LGBT victims, those from BME groups, and those with teenage children. “Move on” exit plans should be considered at an early stage to ensure victims are not forced to stay longer than required.

10. It would be worth exploring the feasibility of setting up a South Gloucestershire forum for survivors and victims of DVA, including their children, in order to help ensure that service users can be fully consulted on service design and provision.

11. There is a substantial need for better reporting mechanisms to ensure that accurate and complete data are collected. Activity data are useful to monitor capacity issues, however they do not capture whether the service is effectively reducing risk or harm. In the absence of a validated, core outcome measure, locally agreed measures—such as the widely used DASH tool—should be used to measure risk of harm over time.

12. Current systematic collection of monitoring data may be limited by complex commissioning arrangements with performance monitoring the responsibility of different departments. A unified and consistent approach to data collection and monitoring is critical to ensure that provision reaches those at greatest need.

**Next steps**

A needs assessment aims to capture the current situation in terms of expected need, stakeholder views, current service provision, and local activity. It identifies gaps where there is unmet need, and potential opportunities to address these. Having assessed the need in the local population, the next logical step is for key stakeholders to identify and agree strategic priorities to address the unmet need. These strategic priorities can then inform a statement of commissioning intentions, from which optimal service provision can arise.
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Appendix A

Representatives from the following organisations were contacted and invited to discuss their experiences and views of domestic violence and abuse need and provision across South Gloucestershire.

- Avon and Somerset Constabulary
- Avon and Somerset Police and Crime Commissioner
- Court and probation service
- Diversity Trust
- Knightstone
- Merlin
- NextLink
- North Bristol NHS Trust
- Stand Against Racism and Inequality (SARI)
- Sirona
- Solon
- South Gloucestershire and Stroud College
- South Gloucestershire Council
  - Community Safety Partnership
  - Public Health
    - Sexual health
    - Schools
    - Drugs and alcohol
  - HomeChoice
  - Integrated Children’s Services
  - Education
  - Safeguarding Children
  - Equalities
  - Youth Offending Team
- South Gloucestershire Clinical Commissioning Group
- Southern Brooks
- Sovereign
- Survive
- University of the West of England
- Victim Support

In addition, we are very grateful to the individuals who contributed to this needs assessment by providing their “lived experience” of domestic violence and abuse in South Gloucestershire.