# Domestic abuse and sexual violence in Derby and Derbyshire: health needs assessment

**November 2014**

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# Domestic abuse and sexual violence in Derby and Derbyshire

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**Executive Summary**

Domestic abuse (DA) and sexual violence (SV) represent a significant health burden. This type of abuse is more common than thought, but quantifying the burden accurately is difficult because of under-reporting. For example, victims may fear the consequences of disclosing abuse more than abuse itself.

The health impacts of DA and SV have been shown to be significant for all victims and they are the leading burden of ill health in younger women. Although the immediate health impact on victims is often clearly discernible, the longer-term impacts may be less evident, though they may be more severe and require sustained input and support. These impacts are not restricted to the physical and mental health of individuals; they also affect the wider determinants of health in communities. This represents a substantial cost to health and social care budgets and society.

The families and children of victims may also have related needs for care, as witnesses of abuse. Evidence suggests that experience of adverse childhood events, such as direct or indirect experience of DA or SV, will affect health and social outcomes well into adult life. It is also necessary to address the needs of perpetrators in order to prevent further occurrence of abuse.

As such, a greater emphasis on prevention and management of DA and SV would represent a significant improvement in public health and increase cost-effectiveness and efficient use of resources.

Within Derby and Derbyshire, services for DA and SV are working well and meeting the majority of victims' needs, particularly in respect of social and support needs. However, there are some unmet needs and commissioning and service provision could be clearer and more efficient.

Currently, the majority of specialist provision is through third-sector organisations. These organisations have good links with the criminal justice system, community safety groups, and to children's social care services. Less integration exists with primary and secondary physical and mental health care services, in which awareness of DA and SV is limited and they appear to be packaged as primarily a safeguarding issue. There does not appear to be a robust perception of DA and SV as 'health' problems, despite the impacts mentioned above.

Stakeholder interviews and questionnaires reveal that the commissioning of services is complex and piecemeal, with services receiving funding from multiple sources and from multiple departments within the same organisation. Similarly, the referral processes into and between services lack clarity and service awareness among professionals is very varied. Health care providers appear to have limited involvement after initial assessment of physical injuries, despite the significant longer-term health needs (in particular mental health needs) related to DA and SV.

Services for DA and SV have been subject to the same economic challenges as all other services and sectors over recent years. The services that have been most affected have been those aimed specifically at minority groups including Black and Minority Ethnic (BME) and Lesbian, Gay, Bisexual and Trans-sexual (LGBT) groups. There is a need, particularly in this financial climate, that all services must be equally accessible to and capable of meeting the specific needs of minority groups. The current burden of abuse and demand for services is outstripping current funding, with demand

expected to continue to increase. When the extent of unreported abuse is also considered, there is a clear need to plan future services and funding to meet an increased demand.

Work aimed at prevention is also limited, although this has perhaps the greatest potential to reduce the DA/SV burden. Primary and secondary prevention interventions to increase awareness of what constitutes abuse and challenge attitudes towards it should form part of the approach to tackling DA and SV. These interventions require cultural sensitivity, to address factors that may contribute to lack of recognition of abuse, barriers to reporting it, and cultural normalisation of abusive behaviours.

Recommendations:

In order to meet the needs of the population resulting from DA and SV the following recommendations are made:

**Policy and strategy**

Ensure that development of the new county-wide strategy for domestic violence and sexual abuse takes into account the findings regarding unmet needs in Derby and Derbyshire.

**Prevention**

1. Workforce development should be undertaken with statutory and health organisations to increase awareness of domestic abuse and sexual violence, to reduce stigma and challenge stereotypes.
2. Preventative work in schools should continue and should use evidence based interventions to raise awareness of and change attitudes to abuse.
3. Increased levels of preventive work should be undertaken to support national information campaigns. This work should be culturally sensitive to different population groups and may benefit from a social marketing approach.

**Provision**

4. Encourage commissioners of all public services to require providers to ensure front line staff are appropriately trained to identify and respond positively to domestic violence.
5. Encourage commissioners to require service providers to undertake an equality impact assessment to ensure that commissioned services are responsive to the needs of all victims, including those from minority groups (e.g. male, LGBT and BME victims).
6. Encourage commissioners to require that all providers, including health and social care providers, carry out baseline assessments to evaluate whether practice is in line with the NICE guidance. Guidelines and assessment tools are available at www.nice.org.uk/guidance/ph50
7. Develop a care pathway to ensure all organisations are able to respond positively to disclosure of domestic violence and signpost to appropriate services
8. Review commissioning and service provision around emotional support for children living with domestic violence, to build their resilience and mitigate impact on future health and wellbeing.

**Recovery**

9. Work should be undertaken to understand whether a treatment or recovery model is best suited to people suffering or witnessing abuse. This work should inform future commissioning and service outcomes

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# 1. Background

Domestic abuse (DA) and sexual violence (SV) are separate but overlapping problems. Both types of abuse are more common than generally thought, though it is difficult to measure how much abuse is occurring. This is partly due to social and cultural attitudes to abuse, as some sections of society may be more accepting of abuse and others may fear the stigma of disclosing an abusive relationship.

Both DA and SV can have immediate health and social impacts on victims and also the people living around them such as children, who may be considered secondary victims. Suffering or witnessing abuse can cast a long shadow over a person's life. The health impacts may be felt through reduced mental and physical wellbeing, reduced quality of life and in some cases reduced life expectancy.

People of all genders and sexualities experience DA and SV; however the burden of abuse is greatest for women in heterosexual relationships. Women experience more repeated physical violence, more severe violence, and more sexual violence, most frequently perpetrated by their partner.[1] Social and cultural attitudes and stigma associated with DA and SV mean that many people do not disclose that abuse is taking place. Addressing this stigma at a societal level is essential for prevention of abuse.

Both DA and SV are complex, have multiple causes and require input from a range of health and social care professionals to deal with their consequences.[2] The needs of individuals who are experiencing or have experienced DA and/or SV are likely to be wide-ranging and varied. They may include physical health needs, such as treatment for physical injuries, mental health needs such as counselling, and social needs such as support with housing and finances, all of which will have a significant impact on that individual's health and wellbeing at the time and in the future.

The services required to meet the needs of people affected by DA and SV are varied and may include specialist DA or SV services, physical and mental health services, the police, and housing services, among others. In Derby and Derbyshire there is a joint strategy that underpins the commissioning of specialist services, which are mainly provided by third sector organisations, and coordinates the work of other voluntary organisations. Many of these services have been affected by reductions in funding, which has had an impact on provision.

The National Institute for Health and Care Excellence (NICE) defines health needs assessment (HNA) as 'a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities'[3]. This HNA aims to review needs and services and to identify gaps in provision for DA and SV in Derby and Derbyshire.

## 1.1. Aims and objectives

The overarching aim of this needs assessment is to systematically assess the needs of people affected by DA and SV and to establish whether current services are meeting these needs. This will help inform future commissioning decisions. This will be achieved through review of the evidence base and consideration of the following questions:

1. How many people are subjected to or at risk from domestic abuse or sexual violence each year in Derby and Derbyshire?

2. What behaviours or other factors are associated with domestic abuse or sexual violence?
3. What is the impact of domestic abuse or sexual violence on victims, perpetrators and their families and children?
4. What services exist and how does demand vary for services aimed at helping people suffering directly from domestic abuse or sexual violence?
5. Are there gaps in service provision leading to residual need?
6. What evidence based services and interventions exist to support primary and secondary prevention of domestic abuse or sexual violence?

## 1.2. Scope and population of interest

The population of interest is male and female victims of DA or SV aged over 16 who are residents of Derbyshire Upper Tier Local Authority or Derby Unitary Authority. The children and families of victims are also of interest in this HNA and the indirect effects of DA and SV will be investigated.

The direct health needs of children (<16) who are victims of DA and SV are outside the scope of this HNA. Therefore topics such as bullying, abuse over the internet, and the impact of behaviours such as 'sexting,' while important, lie outside the scope of this work.

Wide ranging definitions of DA and SV have been used for this work, but due to the rapid nature of this HNA and limited timescale the following also lie outside of the scope of this work:

- Migrant groups with no recourse to public funding
- Victims of historic abuse such as child sex abuse, although the impact on demand for services has been noted
- Stalking
- Long term health needs of victims of sexual violence that differ from those for victims of domestic abuse

## 1.3. Definitions

A number of different definitions of DA and SV are used in the wider literature. This work adopted the following broad definitions:

**Domestic abuse**: The cross-government definition of domestic violence and abuse is:

'Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial and emotional.' [4]

**Sexual violence**: The World Health Organisation (WHO) defines sexual violence as:

'Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.' [5] This HNA will focus on serious sexual violence, which is defined by as: rape, assault, inducement, threat or deception to procure sexual activity with a person with a mental disorder.'[6]

The following practices are also defined as abuse:

- **Female genital mutilation (FGM):** 'procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons' [7]
- **Forced marriage**: 'where one or both people do not (or…cannot) consent to the marriage and pressure or abuse is used' [8]
- **'Honour-based' violence:** 'a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour' [9]

## 1.4. National policy and guidance

### 1.4.1. Ending violence against women and girls in the UK

This policy provides the strategic framework guiding the work of government and goes beyond DA and SV. [10] The strategy recognises actions that need to be taken at national level by central government, as well as fostering local partnerships with roles for local authorities (LAs), health and wellbeing boards (HWBs), health services, public health, the voluntary and community sector, community safety partnerships and police and crime commissioners (PCCs). The original strategy has been followed up with several action plans. The most recent version was published in March 2014.[11]

This restates the vision to eliminate violence against women and girls and sets out an ambition to protect victims through prevention and early intervention. Partnership working remains key, along with actions to bring more offenders to justice and increase the confidence of victims to access the criminal justice system. Some of the preventative actions are:

- Changing culture through public awareness of violence against women and girls, helping reduce acceptance of violence against women and girls across agencies and the public.
- Making an authoritative evidence base available, providing local areas with access to good quality materials and effective practice, and driving the development of Government policy.
- An increased take up of perpetrator interventions to break the cycle of violence.
- Prevent girls becoming victims by raising aspirations, confidence and tackling gender inequality, in part through working with education.

There are also a range of tools and orders that can be used such as the Domestic Violence Disclosure Scheme (also known as Clare's Law[12]), Domestic Violence Protection Orders which help provide protection in the immediate aftermath of a domestic violence, Non Molestation Orders and Forced Marriage Orders.

### 1.4.2. Relevant NICE guidance

The guidance below deals specifically with DA or SV, however many other pieces of guidance refer to the mental and physical health needs of people who have suffered DA or SV.

**Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (PH50):** [13] This is the main guidance on domestic abuse issued by the National Institute for Health and Care Excellence (NICE). The guidance focuses on interventions to

identify, prevent, reduce and respond to domestic violence between family members or between people who are (or who have been) intimate partners. It makes recommendations for integrated services that are aimed at meeting the needs of victims of DA and SV. It also recommends services for young people and perpetrators.

**Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (CG110):** [14] This guidance aims to improve service organisation, provide training for staff and enhance service delivery to help address the difficulties experienced by women with complex social factors. It has specific recommendations for services to follow when working with women who are experiencing domestic abuse.

## 1.5. Setting

Derby is a densely populated urban city with around 250,000 residents. Derby has a younger than average population, with a high proportion of 20-29 year olds. Since 2002 there has been a 7.3% increase in population, with a particularly large increase in the number of children aged under 16. This has been driven by recent patterns of migration.

Derbyshire has a population of approximately 750,000 people. The population is most dense along the eastern side of the county. The west of the county is more rural and contains a large part of the Peak District National Park. The distribution of health and social services generally reflects the location of residents.[15] Compared to the England average, Derbyshire has fewer people aged 20-39 than might be expected and a higher proportion of 40-79 year olds.

### 1.5.1. Ethnicity and migration

Over 49,000 people in Derby (19.7% of the population) identify themselves as belonging to a black or minority ethnic (BME) group. This is similar to the England and Wales average, where BME groups comprise 19.5% of the population. Within the BME population the most common groups are South East Asian and White Other (non-British).

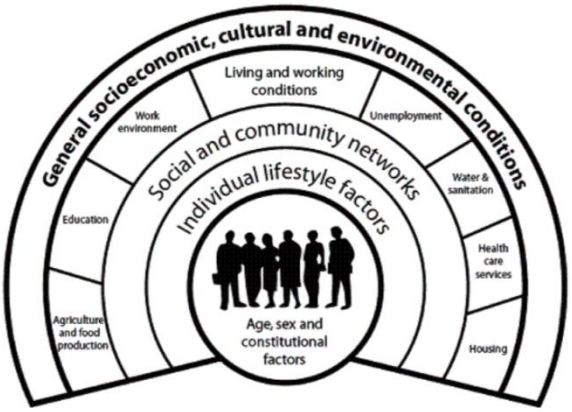
Derby is multicultural with an estimated 180 nationalities living in the city. Consequently there are believed to be in excess of 71 languages spoken in the city. The most commonly used languages other than English are Punjabi (4,287), Urdu (3,510) and Polish (3,267), reflecting recent patterns of migration. BME populations live throughout the city, but there are higher concentrations of people from BME groups living in the South of the city and new migrants often live within the more deprived inner city areas.

By comparison Derbyshire has fewer people identifying themselves as BME. According to the 2011 census, there were 32,652 individuals from BME groups living within Derbyshire (4.2% of the population). The largest BME groups within Derbyshire are White Other, Indian, White and Black Caribbean and White Irish. There is significant variation around the county with small areas of Chesterfield and South Derbyshire (bordering Derby City) comprising a larger proportion of the population that are from BME groups.

### 1.5.2. Wider determinants of health

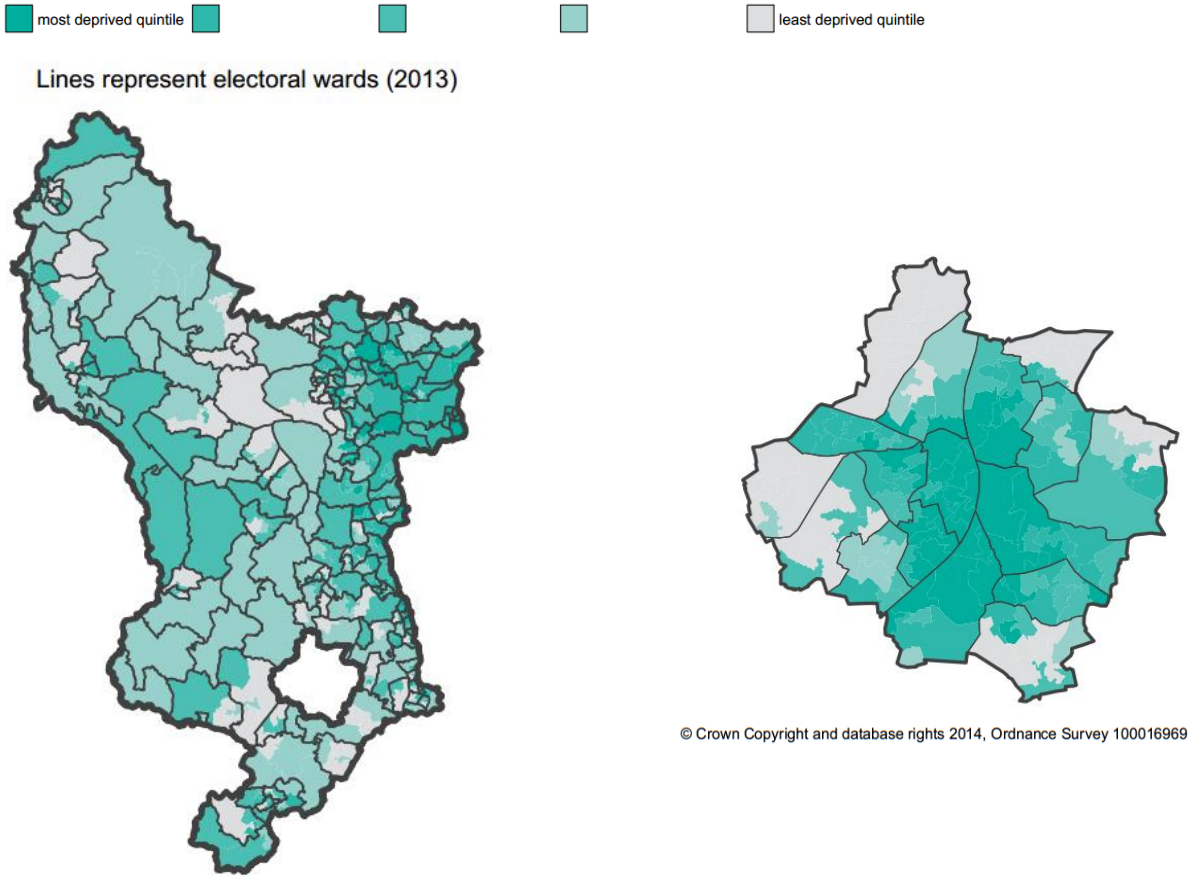
Health outcomes are influenced by the behaviours of individuals throughout their life, along with factors such as genetics and family history. These everyday behaviours are strongly influenced by the attitudes of communities in which we live and wider society, along with other factors. The Dahlgren and Whitehead model (Figure 1) shows that social and economic deprivation can work in various ways to affect the health of a population and individuals. It should be noted that within this context health refers to total mental and physical wellbeing, not just the absence of disease. The impact of wider determinants on the lives of all residents and the gradient of inequality can be observed, with the most disadvantaged suffering from the worst inequalities in health.[16]

**Figure 1 The Dahlgren and Whitehead model of wider determinants of health[17]**




A key measure associated with wider outcomes of health is the index of multiple deprivation (Appendix 2). Figure 2 shows how deprivation varies within each area, with the most deprived fifth of areas clustering in the centre of Derby and the North and East of Derbyshire. The North and East of Derbyshire is historically an area of heavy industry and mining that has seen decline in recent years. Bolsover District is more deprived than other areas in Derbyshire and lies within the most deprived quintile in England. The west of the county is more rural and contains a large proportion of the Peak District National Park. While rural areas may appear more affluent overall, pockets of deprivation remain and there are significant health challenges in the rural community including wellbeing and mental health issues.

**Figure 2 Deprivation in Derby and Derbyshire compared to England. IMD 2010 national quintiles of deprivation. Source: PHE Health Profiles 2013**




Derby remains comparatively deprived – ranked 88th (of 326) most deprived local authorities. Levels of deprivation vary substantially across the city, with inner city areas being more deprived. Separate indices are available for young people and older people; however these follow the same general patterns as the IMD with variation seen throughout each area.

### 1.5.3. Health inequalities

Inequalities in health exist within both Derby and Derbyshire. These can be illustrated by comparing life expectancy at birth between areas. Figure 3 shows the variation in life expectancy at birth between males and females. It also shows the gap between the longest and shortest life expectancy; 3.3 years for women and 4 years for men.

The variation in life expectancy at birth is even greater when looking at wards within Derby and Derbyshire. The gap in life expectancy at birth for males was 15.7 years and for females 18.1 years, however this may have reduced since the last estimates were calculated in 2006.

Healthy life expectancy, an estimate of how long we can expect to live in a 'healthy' state, also varies by area.

**Figure 3 Life expectancy at birth within Derby and Derbyshire Districts, 2008-2010. Source: HSCIC**

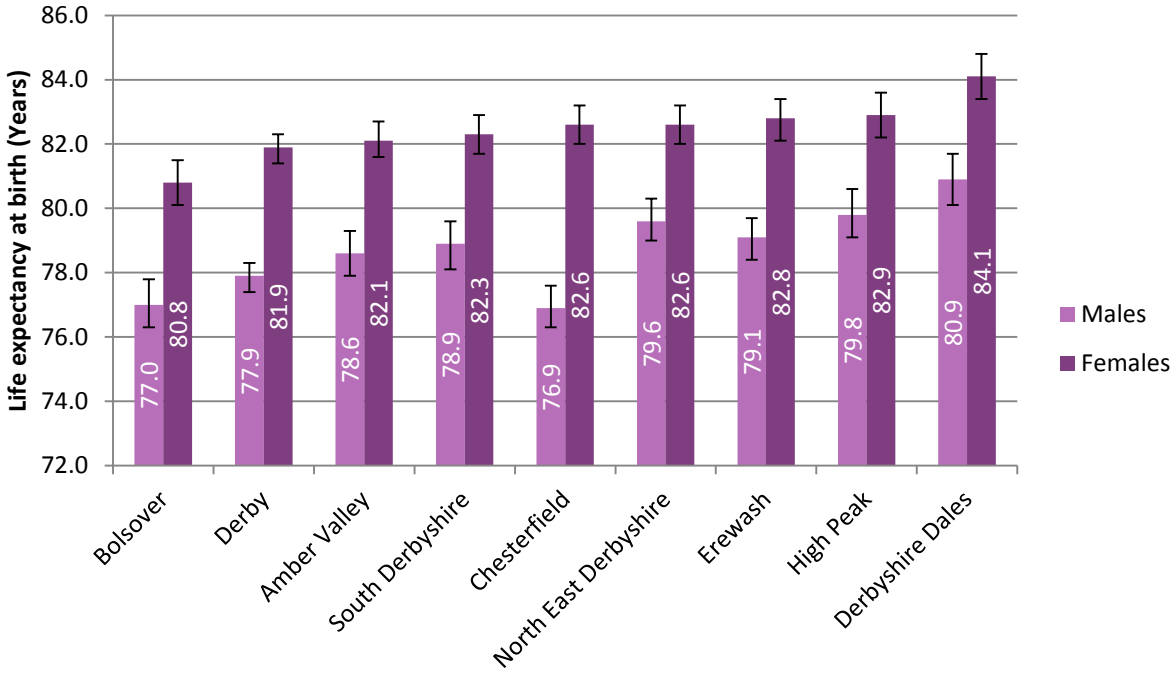
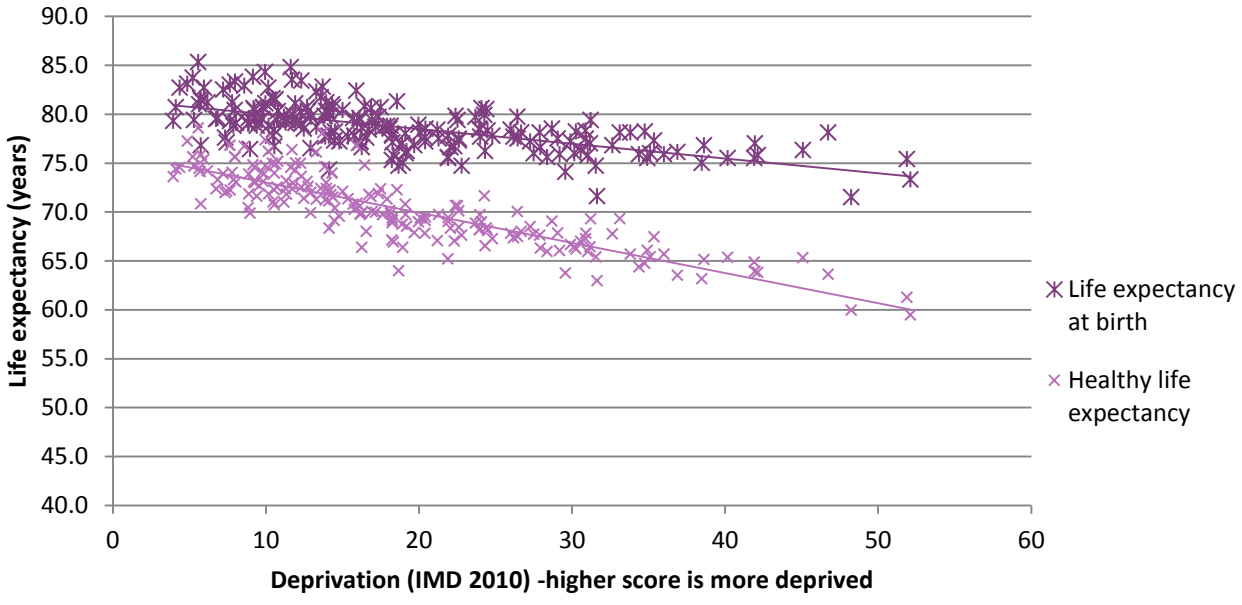



Figure 4 shows a comparison of life expectancy and healthy life expectancy within wards in Derby and Derbyshire. Areas of high deprivation are to the right of the chart. This clearly shows that life expectancy falls as deprivation increases; however the fall in healthy life expectancy is steeper. This indicates that people living in deprived areas not only live shorter lives, but they also have more years of ill health.

**Figure 4 Healthy life expectancy and life expectancy at birth for males and females combined, wards in Derby and Derbyshire (1999 -2003) by average deprivation score (IMD 2010). Source ONS, PHE**



The underlying reasons for these inequalities in health are complex but include individual factors which influence the development of disease such as genetics, and lifestyle choices such as whether people exercise, smoke or use alcohol and other drugs.

The health services in an area also affect how likely people are to recover from diseases and ill health. However all of these factors are influenced by the wider determinants of health, which shape the society and communities in which we live.

DA and SV influence the health of victims, perpetrators and children who witness abuse. The impacts of abuse may be short term or have lifelong consequences, resulting in lasting physical or mental illness and lower wellbeing. Therefore the health impact of DA and SV should be viewed as a long term determinant of health in Derby and Derbyshire, which is likely to increase health inequalities, rather than as a social problem with limited health impact.

## 1.6. Key organisational structures

A number of organisational structures influence services for DA and SV. Unfortunately organisational boundaries are not co-terminus.

### 1.6.1. Council and specialist services

A joint Serious Sexual Violence/ Domestic Violence Governance Board was established across Derbyshire County Council and Derby City Council in 2011. This sits below the Safer Communities and Stronger Safer Communities Boards of each Council.

This is a high level group with wide ranging membership, responsible for overall governance, direction, management and guidance to the five Multi Agency Risk Assessment Conferences (MARAC), the Sexual Assault Referral Centre (SARC) and the Derby and Chesterfield Specialist Domestic Violence Courts (SDVC). The board also links horizontally to adult and child safeguarding boards.

A Domestic Violence / Serious Sexual Violence / Victim and Witness Coordinating Group sits below the board. This group has representation from statutory services and countywide services such as the SARC and Independent Domestic Violence Advisors (IDVA) managers. The group aims to provide strategic leadership and direction in relation to serious sexual violence and domestic abuse and will include work with perpetrators to prevent further violence and abuse. The Group will regularly review performance to identify gaps in service and areas for improvement. The Group will be responsible for the Derbyshire wide strategy in relation to domestic violence and serious sexual violence. There are five Domestic and Sexual Abuse Action Groups (DSAAGs) covering the following areas:

- Derby City
- Amber Valley and Erewash Districts
- South Derbyshire
- High Peak and Derbyshire Dales
- Chesterfield, Bolsover and North East Derbyshire

These groups develop local actions with providers and ensure delivery of the overarching strategy. Each group also acts as a forum for service providers including those commissioned and funded by

the Serious Sexual Violence/ Domestic Violence Governance Board and third sector organisations. The Chairs of these groups are members of the Co-ordinating group.

#### 1.6.2. Health

There are four Clinical Commissioning Groups (CCGs) in Derby and Derbyshire responsible for commissioning secondary care. Two Hospital Trusts provide secondary care: Derby Hospitals NHS Foundation Trust and Royal Chesterfield NHS Foundation Trust; these provide a wide range of services including midwifery.

Whilst GPs are commissioned by NHS England (NHSE), CCGs are also responsible for the quality of care and the populations within their borders. DA and SV come under the safeguarding umbrella and the CCGs are supported by a safeguarding lead. The areas covered are:

- NHS Hardwick CCG: 18 GP practices mainly in Bolsover and NE Derbyshire
- NHS Southern Derbyshire CCG: 56 GP practices in Derby, South Derbyshire, Amber Valley, Erewash, Derbyshire Dales
- NHS Erewash CCG: 12 GP practices mainly in Erewash
- NHS North Derbyshire CCG: 36 GP practices across High Peak, Derbyshire Dales, North East Derbyshire

Adult and children's inpatient and community mental health services are provided by NHS Derbyshire Healthcare Foundation Trust, which works across Derby and Derbyshire.

#### 1.6.3. Criminal Justice

The Derbyshire Constabulary is split into three divisions, which cover

- High Peak and Derbyshire Dales (B Division)
- Chesterfield, North East Derbyshire, Amber Valley and Bolsover (C Division)
- Derby South Derbyshire and Erewash (D Division).

DA prosecutions feed into two Specialised Domestic Violence Courts based in Derby and Chesterfield in an expedited fashion. SV cases are dealt with by the normal criminal court system with fewer allowances for victims.

After 1st June 2014 the Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company manage probation services for medium and low risk offenders, while high-risk offenders are handled by the new National Probation Service (NPS).

There is one Sexual Assault Referral Centre (SARC) based in Codnor. This covers the whole of the County and City area. Patients in Glossop are often referred to the SARC in Manchester. The responsibility for this service will shortly pass to NHSE.

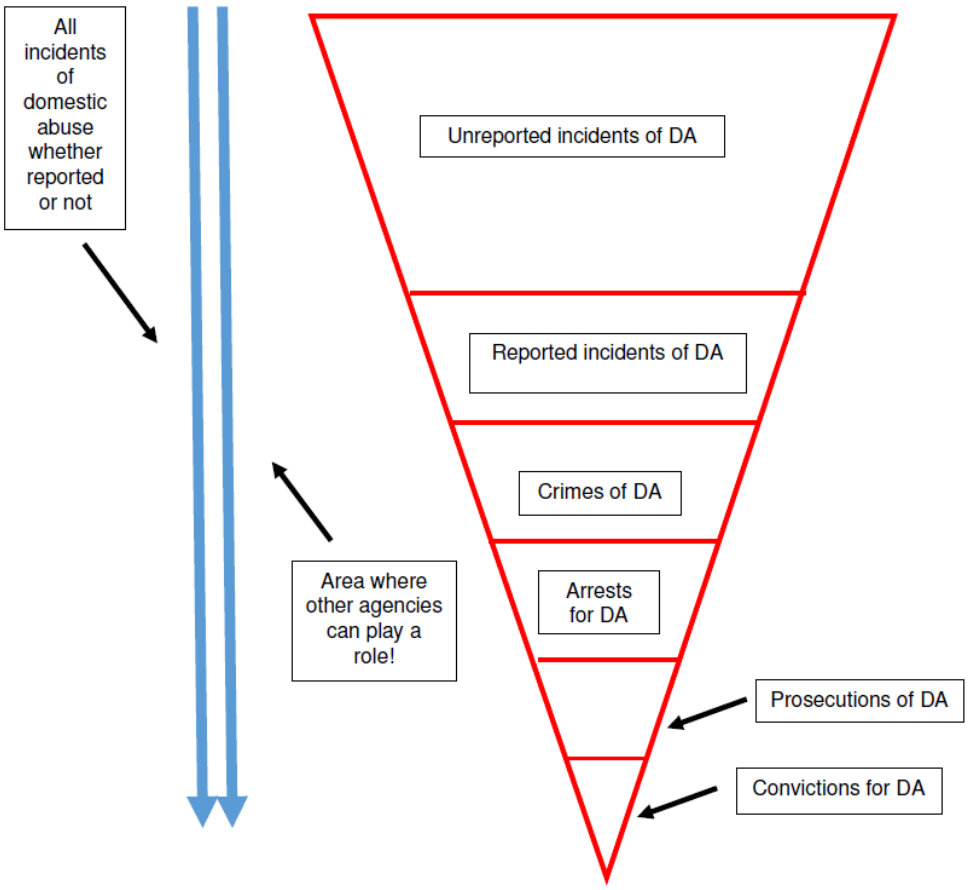
### 1.7. Conceptual models of abuse in Derby and Derbyshire

The refuge movement and many other services aimed at helping people suffering DA and SV originally grew out of feminism movements in the 1970s. In some part many services are still

influenced by this philosophy, although services are no longer restricted to women only. One of the other major changes is the increasing recognition of DA and SV as criminal rather than domestic issues.

The conceptual model presented below describes how people move through the criminal justice system. It shows that from the large pool of people who suffer abuse many never disclose it. Of those who do, few see a conviction. However, these people may access specialist or universal services. This may come via a referral from the police or to a lesser extent by accessing services through another route. This demonstrates that specialist services have a key role in improving access to help for those in need and in increasing opportunities for disclosure of abuse.

**Figure 5 A Conceptual Model of Domestic Violence / Abuse (adapted from Standing Together, 2013)**




This also has implications for strategy and local policy development. Currently there is a national trend for policies to support the services linked to the police and safeguarding (such as IDVAs and MARAC). These are important and attention to these areas in recent years has greatly improved the experience of victims, however due to the nature of the model above they do little to improve services for the majority of people.

Recent research in this area has shown that policy that prioritises a criminal justice response may lead to an increase in the risk of the majority of those affected by DA. This highlights that early intervention and preventative services need to play a more important role in order to reduce the burden of DA and SV.[18]

# 2. Incidence and prevalence of domestic abuse and sexual violence

Both DA and SV are more common than generally believed and can affect any population group. Unfortunately there are no accurate data on the incidence or prevalence of DA or SV as many cases go unreported. Where data is available it is likely be representative of physical abuse, as emotional abuse and controlling behaviour is less likely to be reported or even recognised as abuse. Definitions of abuse can also vary and data may be incorporated into more general statistics and not recognised as domestic abuse.[19]

## 2.1. Adults

The Crime Survey for England and Wales (CSEW) samples 50,000 randomly selected households in England and Wales each year. The survey includes crimes not reported to the police and provides the best estimates of the prevalence of DA and SV. However these are still likely to be underestimates for various reasons:

- People may only associate abuse with physical abuse, ignoring emotional abuse and controlling behaviours
- People may have been groomed over time and accept abusive behaviour
- People may not want to disclose current or historic abuse due to associated stigma
- People may not feel safe to disclose on-going abuse
- The sample only includes 16 – 59 year olds, therefore abuse of younger and older people is excluded.[20]

The CSEW 2012/13 found that, overall, 30.0% of women and 16.3% of men had experienced any domestic abuse since the age of 16. Partner abuse (non-sexual) was the most commonly experienced type of intimate violence, covered by the survey, among both women and men since the age of 16.[21]

The survey also asks about DA and SV experienced in the previous year. Figure 6 shows women were more likely than men to have been victims in the last year (7.1% compared with 4.4%). The differences shown below were statistically significant. It should also be noted that of those experiencing a sexual assault, the majority were less serious sexual assaults, such as indecent exposure, unwanted sexual touching or sexual threats.

**Figure 6 Percentage of adults aged 16 to 59 who experienced intimate violence in the last year, by sex and headline category, 2012/13 CSEW**

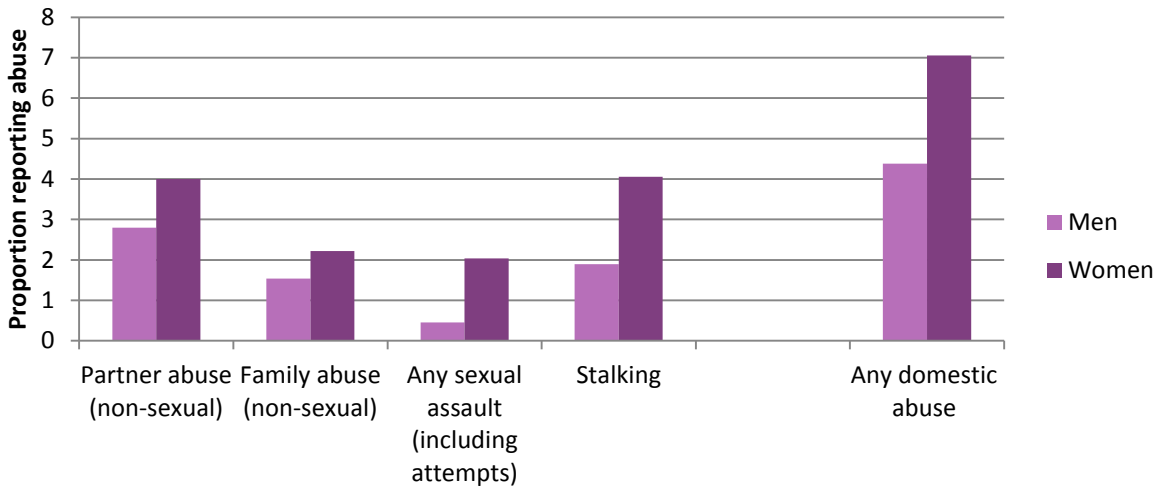
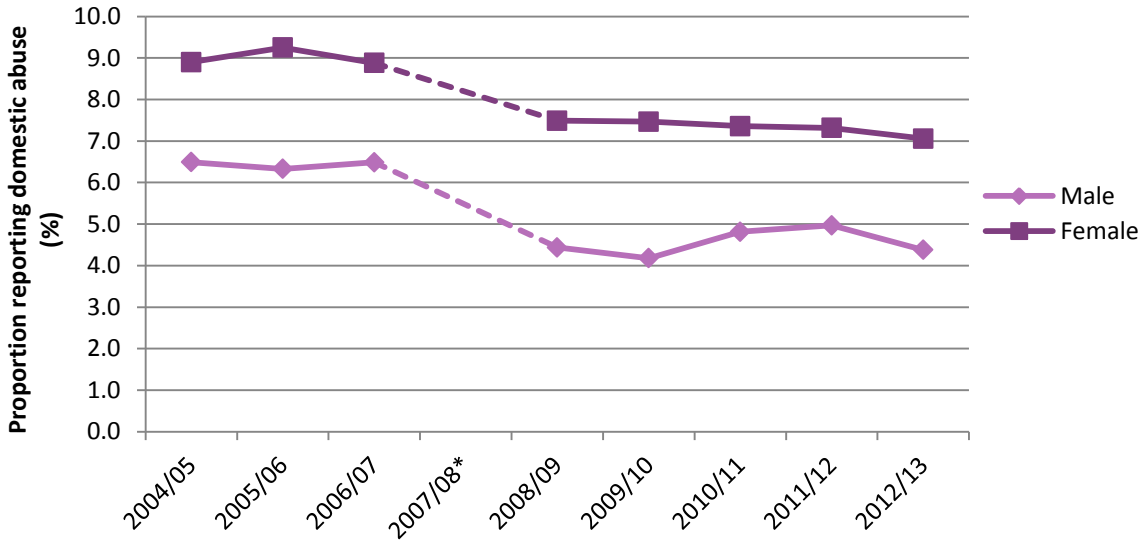



Figure 7 shows the trend of DA and SV reported as occurring in the previous year. This shows that across England and Wales there has been a significant decline for both sexes. This is also true for the subgroups of partner abuse, family abuse and sexual assault.

**Figure 7 Percentage of adults aged 16 to 59 who any domestic abuse or sexual violence in the last year, by sex and 2004/05 to 2012/13 CSEW**




*full data not available for 2007/8

The prevalence estimates from the CSEW have been applied to estimate the number of people who may have been victims of DA and SV in Derby and Derbyshire in the last year (Table 1). This shows an estimated 33,556 people aged 16-59 could be affected in a given year.

**Table 1 Estimates of the number of people in each area who have experienced domestic abuse or sexual violence in the past year. Sources: CSEW 2012/13, UK Study of Abuse and Neglect of Older People 2007, NSPCC 2011, ONS population estimates 2012.**

| Area | People (0-10yrs) | People (11-17yrs) | Males (16-59yrs) | Females (16-59yrs) | People (>65yrs) |
|---|---|---|---|---|---|
| **Derby** | **1172** | **538** | **3270** | **5235** | **1555** |
| **Derbyshire** | **2945** | **1566** | **9546** | **15504** | **6016** |
| Amber Valley | 456 | 248 | 1500 | 2461 | 964 |
| Bolsover | 300 | 155 | 962 | 1549 | 574 |
| Chesterfield | 391 | 208 | 1300 | 2107 | 802 |
| Derbyshire Dales | 241 | 143 | 825 | 1310 | 670 |
| Erewash | 448 | 224 | 1408 | 2323 | 842 |
| High Peak | 352 | 189 | 1148 | 1846 | 660 |
| North East Derbyshire | 350 | 192 | 1183 | 1921 | 877 |
| South Derbyshire | 407 | 207 | 1220 | 1987 | 626 |
| **Derby and Derbyshire** | **4117** | **2104** | **12817** | **20739** | **7570** |

Whilst the CSEW data provides the best estimates of prevalence of DA and SV these data may not be robust. They may underestimate the number of people affected due to underreporting in the CSEW and they may hide trends in reporting of abuse and use of services. In 2012/13 for example there was a 9% increase in police recorded sexual offences. This is thought to be due to an increase in reporting of current and historic offences. For instance reporting of offences occurring over 20 years ago doubled, which may reflect greater willingness to report SV due to publicity associated with operation Yew Tree.[22]

Local data are available from the police. These include recorded incidents of DA and SV, indicators which form part of the Public Health Outcomes Framework for each Council. These data are not accurate estimates of prevalence as we know a large number of people do not contact the police after abuse. However trends provide an indicative picture of how prevalence may have changed in recent years.

Figure 8 and 9 show that the rate of DA incidents in adults is much higher than the rate of sexual offences in all age groups. The trend in DA incidents has increased in recent years, but is remaining relatively constant. There is much more variation seen in the rate of sexual offences, however this is in part due to smaller numbers. In all areas there has been an increase in sexual crime in recent years. These changes may reflect increases in prevalence, better access to police or changes in the way police are recording data.

**Figure 8 Domestic abuse incidents (18+) recorded by Police 2007/8-2012/13 (Crude rate per 1000)**

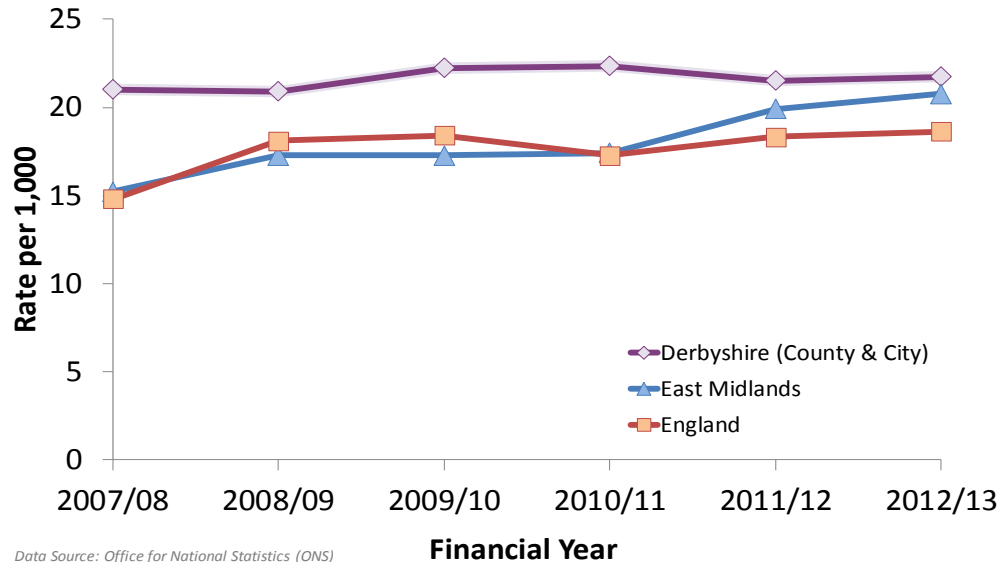
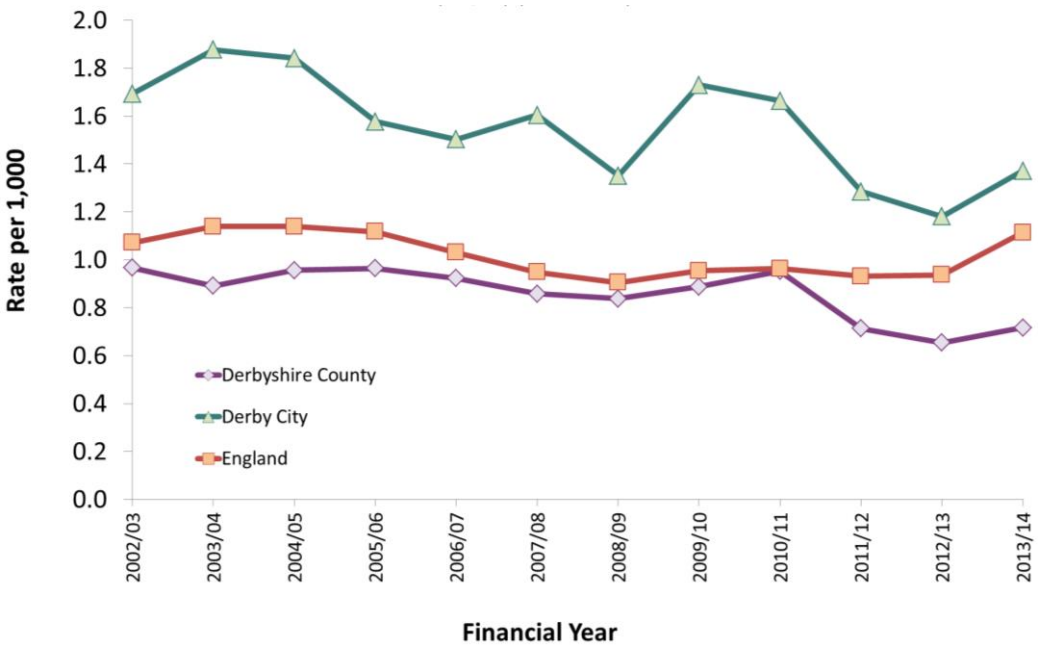



**Figure 9 Sexual crime (all age) recorded by Police 2002/03-2012/13 (Crude rate per 1000)**




### 2.2. Elderly abuse

Results of the CSEW exclude people aged 60 years and over. The most recent work that covers this age group was the UK Study of Abuse and Neglect of Older People carried out in 2006. This was a UK wide survey of 2,100 people aged over 66 living in private households. This found that 4% of people reported psychological, financial, physical or sexual abuse in the last year.[23]

Table **1** shows the number of people in each local authority if this estimate is applied to the population of Derby and Derbyshire. However this assumes the rate of abuse is the same for all people over 65 even if they do not live in private households.

Together with the CSEW data this suggests a minimum of 41,126 people aged over 16 may have experienced DA or SV across Derby and Derbyshire in the last year. The true number is likely to be much greater than this.

### 2.3. Childhood prevalence of exposure to domestic abuse

Understanding the true prevalence of childhood exposure to DA or SV is very difficult as behaviours may be normalised and not recognised as abuse by the child. Work looking at child maltreatment estimated the prevalence of children exposed to domestic violence and family violence within the past year and in their lifetime.

Domestic violence was defined as physical violence and threatening behaviour from an adult partner/ex-partner towards the parent, and family violence included exposure to other forms of physical violence against family members by adults and siblings living in the home.

The work found that 12% of under 11s and 17.5% of 11-17 year olds had been exposed to DA between adults in their home during childhood, and 3.2% of under 11s and 2.5% of 11-17 year olds had been exposed in the previous year. [24] A breakdown of these estimates applied to Derby and Derbyshire is shown in Table 1.

In total these estimates suggest a minimum of 47,000 people living in Derby or Derbyshire have experienced DA or some form of SV in the past year. However this is only an indicative estimate as the sources of data varied and child and elderly abuse estimates excluded SV.

# 3. Evidence review

There is considerable overlap between the evidence base for DA and SV, although the latter is not as extensive or as robust. Despite the limited evidence available, it appears that SV is found in almost all countries and cultures, though to differing extents.[25] Both DA and SV are perpetrated and experienced by both men and women, though the majority of perpetrators are male and the majority of victims are female. It is also recognised that both DA and SV are under-reported and that figures are likely to be inaccurate.[20] Some groups may report and access services more than others, meaning that risk factors identified from these data may be subject to considerable bias.

## 3.1. Factors associated with victims of domestic abuse and sexual violence

Understanding the risk factors associated with DA and SV may not necessarily identify causal relationships, however the information is useful to help identify potential victims and perpetrators. This can be used to inform prevention and early intervention work.

Research tends to concentrate on heterosexual women as victims and heterosexual men as perpetrators and there is less evidence around smaller population groups such as the Black and Minority Ethnic (BME) group and the Lesbian, Gay, Bisexual and Trans-sexual (LGBT) group. There is also risk of bias in the evidence as some groups may be more likely to report DA and SV and to access services than others.

The following risk factors have been identified from the Crime Survey for England and Wales (CSEW) and the wider literature, however caution should be used when interpreting these in isolation as many characteristics are closely linked and may influence the effect of other characteristics. Research suggests that the more risk factors present, the greater the risk of DA or SV.[26,27]

**Gender:** Analysis of CSEW showed women were more likely than men to have been a victim of DA or SV in the last year (7.1% compared with 4.4%), and to have been a victim since the age of 16 (30.0% compared with 16.3%).[21,28] Female victims of intimate partner violence experienced more severe violence and control, with more serious psychological consequences, than male victims. Women are also more likely to be fearful of their partners. [29]

**Age:** the CSEW shows that for both men and women, the prevalence of intimate violence was higher for younger age groups (16 to 24 year olds), however the survey does not consider those over 59 years old.[20] A similar association has been identified for SV alone with girls between the ages of 16 and 19 at highest risk.[30] The association of age with DA and SV may be due to the greater vulnerability of younger women, or it may be due to the greater propensity of younger rather than older men to use violence coupled with the tendency of people to associate with their own age group.[31]

The CSEW showed that young women were also more likely to be victims of sexual assault in the last year; 7.0% of women aged between 16 and 19 compared with 1.8% of women aged between 25 and 34.[32] In addition women aged between 20 and 24 were more likely to be victims of stalking (6.9%) compared with those aged between 45 and 54 (3.1%).[33]

Increasing age is a risk factor with people over 85 compared at higher risk than those aged over 65. This risk is multifactorial, as older age is associated with ill health, greater isolation and greater levels

of dependency upon others. The problem of neglect stood out as the predominant type of mistreatment, followed by financial abuse in over 65s. This is in contrast to the commonly assumed notion of "abuse" as physical violence, although older age groups also remain at risk of SV.[34,35]

**Ethnicity:** There is little variation in reported DA or SV by ethnicity.[21] However, cultural differences between ethnic groups mean that BME specific services are still required to enable people to disclose abuse in an environment in which they feel comfortable.

In some BME populations there may be cultural and social factors that increase the risk of DA and/or SV, such as 'honour'-based violence and forced marriage. These are probably more common in a minority of groups, such as some Pakistani, Kurdish, and Gypsy and Traveller communities, reflecting a more oppressive patriarchal ideology.[36,37] FGM is also more common in migrant groups from in Africa, the Middle East and South East Asia.[38]

**Health:** Analysis of 2012/13 CSEW data suggest that both women and men with a long-term illness or disability were more likely to be victims of DA or SV in the last year. This pattern was consistent across the sub-categories of DA with the largest difference occurring for stalking where 7.5% of women with a long-term illness or disability were estimated to be a victim of stalking compared with 3.4% of women without a long term illness or disability.[39] The wider literature supports this but suggests that causality is not clear with poor self-reported health possibly being a result of rather than a cause of DA.

Mental health is also a concern as depression and suicidal thoughts may be an indicator of low wellbeing or lack of control in a victim. The prevalence of DA and SV is higher in both men and women with mental health disorders, compared to those without.[40,41]

Victims and perpetrators of violence are much more likely than the general population to have severe mental illness with more than a quarter of the burden of adult psychiatric disorders attributable to the effect of experiencing childhood violence or abuse.[42]

**Sexuality**: In absolute terms there are likely to be more heterosexual women suffering DA and SV than other groups. However in relative terms some LGBT groups may be at higher risk of abuse, although there is little evidence looking at LGBT relationships. For example a significant proportion of transgender people (80%) experience emotional, DA or SV from a partner or ex-partner.[43]

There are also several other factors that mean provision of LGBT services is necessary:[44]

- Lack of awareness of LGBT DV (within & outside of LGBT communities)
- Additional LGBT barriers; homophobia, gender stereotypes, coming out
- Lack of services – leading people to think there is no point in disclosure of DA or SV
- Perpetrator/s use additional strategies e.g. threats to out

The following factors are linked to lifestyle and wider determinants of health.

**Substance misuse:** Substance misuse can impair relationships and social functioning, along with physical and mental health. Alcohol consumption is also a significant risk factor for victimisation.[45,46]

**Socioeconomic deprivation:** The 2012/13 CSEW reported that women living in households in the 20% most deprived areas of the England were more likely to be victims of domestic abuse (9.1%) than women in other areas (5.6% for the 20% least deprived areas and 6.7% in other areas).[47] The prevalence of domestic abuse for men was not statistically different between these three area types, which may be due to small sample size.[48] This was also reported in the wider literature.[49] Socioeconomic deprivation is also a risk factor for sexual violence.[25] [50]

**Economic status:** Women in households with an income of less than £10,000 had three and a half times the DA risk of those in households with an income of over £20,000.

**Rural location**: Work comparing the experience of DA and SV amongst women in rural and urban areas found each group equally as likely to experience DA and SV. However rural women tend to perceive that violence against women happens more in urban areas.[51] Women in rural areas may also be socially and geographically isolated and have fewer people to whom they can disclose DA or SV. Rural communities have poorer access to universal and specialist services meaning that disclosure of problems is less likely, which may delay intervention. The role of the GP may be more important, however interviews with rural women revealed concern about the confidential nature of services they received in their communities.[52]

**Relationship status:** Women who were separated had the highest prevalence of any domestic abuse in the last year (21.3%) compared with all other groups by marital status (such as married, cohabiting or divorced). There is an elevated risk of abuse around the time of separation.[53] There is also an association between DA and being a female single parent, but this may be as a result of DA rather than a risk factor for DA.[31] Whilst rare, attempts to end a relationship are strongly linked to intimate partner homicide. Women are particularly at risk within the first two months of leaving an abusive relationship.[54]

**Previous victimisation** has been identified as a risk factor for experiencing further sexual violence [55] [56] [57] [58] and previous domestic violence is the most effective indicator that further domestic violence will occur. Work to support the CADDA-DASH risk assessment found that victims are significantly more likely to experience additional violence, threats and emotional abuse when they report that they are very frightened, afraid of further injury, violence or of being killed, and when they are afraid of their children being harmed.[54]

**Pregnancy or children:** The risk of domestic abuse increases with having children and the number of children, however this is closely linked with relationship status. Nearly a quarter of women living in lone parent households were victims of domestic abuse in the last year (22.7%) compared with around 1 in 20 of those living in a household with other adults and children (5.3%) or a household with no children (6.3%). [59]

Work looking at the effectiveness of IDVAs found that of those people at high to moderate risk of DA with children, 41% had conflict over child contact, 27% of victims were afraid of harm to the children and 11% of perpetrators had threatened to kill the children.[60]

The Avon Longitudinal Study of Parents and Children (ALSPAC) found that fewer women reported DA or SV during pregnancy than they did after birth.[31] This may also be interlinked with the physical and mental health of the mother following birth.

## 3.2. Factors associated with perpetrators of domestic abuse and sexual violence

A considerable amount of research has looked at the attributes and experiences of convicted domestic violence perpetrators and this forms the evidence base for risk factors for perpetration and for interventions aimed at preventing perpetration. However, it cannot necessarily be assumed that the profile of non-convicted perpetrators will be the same. There is less evidence looking at perpetrators of sexual violence, but there appears to be considerable overlap with risk factors for perpetration of DA and with risk factors for sexual victimisation.

The most well evidenced risk factor for perpetration of domestic violence is alcohol abuse. Perpetrator alcohol consumption features in almost two thirds of domestic violence offences and the rate of alcohol dependency among convicted perpetrators has been shown to be around 50%. Drug abuse is also common among perpetrators (19-39%).[61,62]

Similarly, the association between alcohol consumption and sexual violence is the most well-researched and evidenced risk factor for perpetration,[63,64,65,66] with studies across disparate populations demonstrating that up to 50% of sexual assaults are committed by men who have drunk alcohol.[67 68 69] The effects appear to be strongest for those already at risk of perpetration. [69] Alcohol consumption is also a significant risk factor for victimisation.[70 ,71]

Up to 50% of convicted perpetrators of domestic violence also have a previous criminal conviction, about half of which were for previous domestic violence offences.[72 , 73] Research shows that DA tends to be part of a perpetrator's pattern of repeated aggression toward other persons persisting over the life course, with a series of victims including siblings, schoolmates, dating partners, strangers, partners and/or work colleagues. Previous perpetration was also a risk factor for committing further acts of sexual violence. [74, 75, 76]

There is evidence that witnessing domestic violence in childhood is a predictor of perpetration in future relationships, as is childhood physical or sexual abuse. Each of these increased the risk two-fold.[77,78] The risk factors for perpetration of sexual violence overlap with those for victimisation, with some evidence that previous victimisation [79,80] and socioeconomic deprivation [81,82,83] are associated with perpetration of sexual violence.

Other identified risk factors for perpetration of DA include mental health issues, with depression being the most commonly diagnosed condition (22%) and 35% of perpetrators were found to have suicidal ideation or to have threatened suicide. Financial problems were also identified among 45% of convicted perpetrators.[84 85]

## 3.3. Impacts of domestic abuse and sexual violence

The impact on victims and their families is discussed below. It should be remembered that there are also wider impacts on communities and societies that result from crime and particularly violent forms of crime; for example, the fear of sexual violence has been shown to affect social and community wellbeing and have a generalised detrimental impact on health.[86]

### 3.3.1. Impact on and needs of victims

The needs of people subjected to DA and/or SV are broad because of the wide-ranging and far-reaching impact of abuse. Many of the impacts are shared between both DA and SV, though some are specific to a particular kind of abuse.

Current evidence suggests that women are more likely to suffer DA and SV than men; therefore the impacts are greater for women overall. However, there is less variation than might be expected in the impact of DA and SV between BME and LGBT groups and the general population. [87,88]

At an individual level the degree of impact varies between people and is related to the type of abuse, resilience of the individual, their support and background, meaning that all services need to be flexible enough to respond to an individual's needs.

Disclosure of DA or SV is a key time for victims and may influence the impact of abuse and the recovery of the victim. The model in Section 1.7 demonstrates that many people choose not to disclose abuse. This suggests that knowing about appropriate services to enable early intervention is key. Work with DA and SV survivors has shown that the following are key needs at the time of disclosure:[89]

- To be believed
- To be treated with dignity
- To be reassured that it was not their fault
- To feel safe and comforted
- Not to feel like a 'victim'
- Services that support them and their family
- To feel in control
- To be able to make informed choices

Ensuring people are safe after they have disclosed DA or SV will impact on the lives of victims and may include relocation out of an abusive home. This can have a large impact on someone's life and present a number of practical issues, for example:[90]

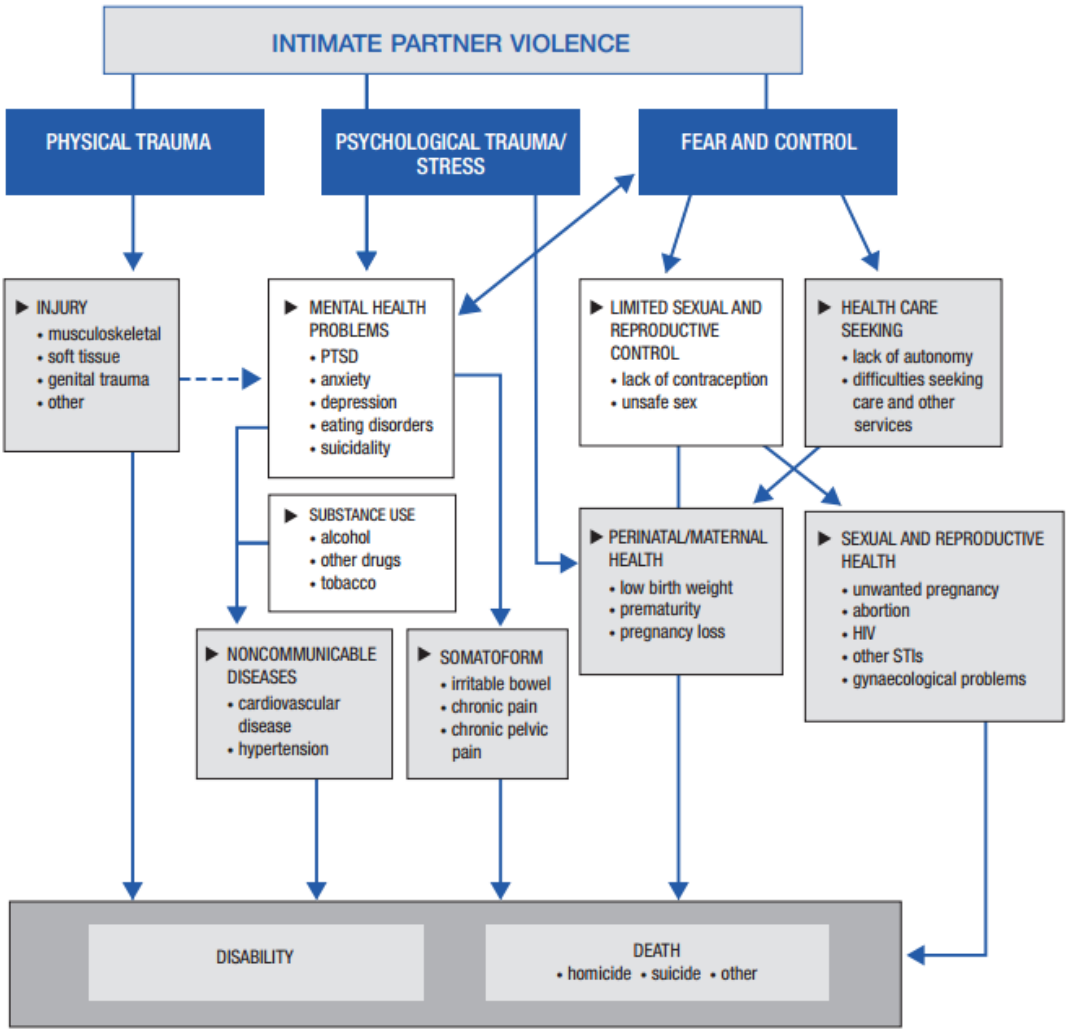
- Breaking a relationship with a partner or breaking up family relationships, leading to feelings of guilt and regret
- Feelings of anger and frustration
- Leaving the home, relocating into refuge or temporary and then permanent accommodation
- Relocating children/ changing schools
- Changing jobs may impact on financial standing of victims
- Need for financial/benefits advice

However leaving an abusive relationship does not always stop the abuse from re-occurring. In a study of 200 women 76% of separated women suffered post-separation violence. This included continued verbal and emotional abuse, threats, physical violence and sexual.[91]

In a study by Shelter, 40% of all homeless women stated that domestic violence was a contributor to their homelessness. Domestic violence was found to be "the single most quoted reason for becoming homeless".[92]

Together DA and SV have a profound impact on the health of victims. The WHO model of health effects of intimate partner violence helps demonstrate that the impacts can be wide ranging (Figure 10).

**Figure 10 Pathways and health effects of intimate partner violence[93]**




There are multiple pathways through which intimate partner violence can lead to adverse health outcomes. This figure highlights three key mechanisms and pathways that can explain many of these outcomes. Mental health problems and substance use might result directly from any of the three mechanisms, which might, in turn, increase health risks. However, mental health problems and substance use are not necessarily a precondition for subsequent health effects, and will not always lie in the pathway to adverse health.

This model excludes violence such as SV not perpetrated by a partner, however it is likely to be representative of the vast majority of DA and SV victims in Derby and Derbyshire.

The CSEW shows that the majority of victims of DA or SV do not report receiving physical injuries. However just under a fifth of those who reported physical injuries had visited a hospital Emergency Department and over a tenth of people had gone on to need specialist mental health or psychiatric services. Together these suggest that both physical and non-physical injuries and trauma and emotional abuse can have substantial impacts on morbidity and mortality.[21]

Further work from Australia estimated that this abuse accounts for 8% of the overall disease burden in the 18-44 year old population. This analysis was based on looking at the outcomes of key health risks associated with DA and SV. Overall the burden of DA and SV is greater in those females aged<45 where it has a greater health burden than any of the following key health issues:

- physical inactivity
- blood pressure
- tobacco
- cholesterol
- alcohol harm
- body weight
- illicit drug use

This indicates that DA and SV have important long-term impacts and should be seen as key health problems for both individuals and society as a whole. The results are less conclusive for women aged over 45 and it is not clear if these results from Australia are fully generalisable to Derby and Derbyshire.[94]

Health impacts of DA can be varied but may include acute and chronic pain, fractures, broken teeth, arthritis, hearing or sight deficits, seizures or frequent headaches. Internal injuries and miscarriage have also been reported. In SV short-term effects on physical health may include bruising and bleeding, sexually transmitted infections and pregnancy.[95,96] Delayed physical effects of SV include gastrointestinal and gynaecological disorders.[97] Other indirect outcomes of DA and SV occur as a result of stress and include stomach ulcers, spastic colon, frequent indigestion, diarrhoea, constipation, angina and hypertension.[98]

DA seeks to control victims and can include many forms of emotional abuse, such as isolation from family members and friends, control of finances and demeaning insults. Over time this can erode the confidence and self-belief and resilience of victims. DA is strongly and consistently associated with mental health disorders such as clinical depression or anxiety and also suicide. Analysis of the adult psychiatric morbidity survey has shown more than half of those who had experienced extensive DA and SV had a common mental health disorder and 16% screened positive for post-traumatic stress disorder.[99] The prevalence of depression and post-traumatic stress disorder increased relative to the severity and duration of the abuse.

Of those with a disorder only a tenth were in receipt of counselling or a talking therapy, however 12% had been admitted to a mental health in patient ward. DA and mental health disorders are also linked to smoking along with drug and alcohol dependence.

There is also evidence that self-harm is linked to DA. A cohort study over eight years found that patients experiencing domestic violence were more likely to present with self-harm, had more Emergency Department contacts and there was a moderate correlation between the number of episodes of self-harm and the number of assaults. The authors concluded that at least 5% of self-harm patients will have suffered DA in the year before presentation.[100]

The effects of SV on mental health are similar to those of DA. They include depression, anxiety, post-traumatic stress disorder and suicidal ideation.[100,101] There is also evidence that victims of sexual violence may be more likely to adopt high-risk health behaviours,[97,102] including alcohol and substance misuse [103,104] and high-risk sexual behaviours.[105]

In addition to the direct health effects, evidence shows that the impact on victims extends into other areas of life, affecting personal and social relationships and employment prospects and achievement, which in turn affect health.[97,102]

### 3.3.2. Impact on child witnesses of DA and SV

Suffering abuse as a child can have profound immediate and long-term health impacts; however this lies outside the scope of this work. Children who live in households where abuse occurs are at high risk of witnessing it or otherwise becoming secondary victims of DA or SV. This can affect children leading to immediate behavioural, problems emotional trauma, and mental health difficulties in adult life.[106,107,108]

Witnesses to SV were found to have symptoms of stress responses, higher levels of aggression, and other negative emotional responses.[109,110] There is evidence that child witnesses of SV against their mothers experienced sleep disturbance, avoidance, memory distortion, withdrawal and regression.[111]

'Secondary victims' include close family and friends of the victim and there is evidence that they too experience negative emotional responses, including traumatisation, fear, anger, guilt and self-blame.[112,113] This can be as a direct result of the assault on someone they love or because they become a target for the victim's own anger and negative emotions. [114]

In over three quarters of incidents of DA, children are in the same or the next room.[115] SV may also occur in the context of DA where children may be exposed. The impact of domestic violence on children is aggravated by the following factors: [116]

- Severity of the violence
- Child being directly abused or neglected
- Combination with problem drinking, drug misuse, mental illness or learning disability
- Witnessing the parent's sexual and physical abuse
- Being drawn into participating in the abuse of a parent
- Colluding in the secrecy and concealment of assaults
- Lack of wider family and community support

A UK study found that DA in the family was significantly associated with partner violence later in life for girls and was a predictor of victimisation for boys. The work also suggested that for boys, peer violence was the strongest predictor of experiencing and instigating partner violence.[117]

Nearly three quarters of children on the 'at risk' register live in households where DA occurs and 52% of child protection cases involved DA in national work.[118,119] In turn this means many young people view violence as a normal aspect of intimate relationships.[120] A further study found that 20% of young men and 10% of young women think that abuse or violence against women is acceptable. [121] This is consistent with anecdotal evidence from stakeholders. For example a GP in Derbyshire felt they commonly saw different generations of the same families with problems related to DA.

Even if immediate problems are not apparent, witnessing abuse can also impact on the health of the child throughout the life course. This may be through impacts on social development or educational

attainment in schools which can both contribute to poor health in later life, influencing health behaviour such as increased smoking, drug use or risky sexual behaviours.

A growing body of work looking at health outcomes in the USA following Adverse Childhood Experiences (ACEs) has found wide ranging associations between childhood maltreatment (including witnessing DA) and later-life health and well being (see appendix 3 for definitions of ACEs). Figure 11 shows the links between ACEs and reduced life expectancy.[122]

**Figure 11 the theoretical link between adverse childhood events, health and life expectancy**


This work confirms many of the impacts cited above. It has shown that trauma alters the function and development of children's brains and nervous systems. This leads to reduced quality of life and problems that influence health behaviours in a dose response relationship and increase the risk of:[122]

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Foetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy

These effects are partially responsible for the findings that people with six or more ACEs died nearly 20 years earlier on average than those without ACEs (60.6 years [95% CI=56.2, 65.1] vs 79.1 years,[95% CI=78.4, 79.9]). The average years of life lost per death was nearly three times greater among people with six or more ACEs (25.2 years) than those without ACEs (9.2 years).[123]

Whilst it is not clear if this work is directly generalisable to the populations of Derby and Derbyshire, it remains likely that similar patterns of health outcomes exist for children witnessing DA or SV.

### 3.4. Summary of key needs

A number of immediate and long-term impacts on the health people surviving DA and SV have been identified from the wider literature and the views of local stakeholders have also been sought. This has helped identify a number of important health needs for the people of Derby and Derbyshire. These include:

- A need to have someone in a position of trust to disclose any type of abuse to whether that be a professional or someone in a social network
- A need to be believed and not stigmatised when disclosing DA or SV
- Help with acute problems following DA or SV including dealing with safety concerns, medical and mental health impacts
- Practical help with problems arising from abuse such as changing accommodation, changing financial support, moving children out of school
- Long term support for the survivor of DA or SV to help with on-going physical and mental health issues such as trauma, to promote wellbeing
- Support for family members and children who witness or who are affected by DA or SV, whilst not being victims themselves
- Services need to be gender specific and patient centred, with a range of options being available for each case
- A need for services to have tailored provision for population groups such as new migrants, BME groups and LGBT

At a strategic level

- A need for strategic leadership of services including responsibility for assuring clinical and wider governance
- A need for active communication and a strategic plan of work linking services
- A need for services to be integrated with health care to ensure social and health care support is provided in an efficient and effective way

At a social level

- A need for preventative work to raise awareness of and change attitudes about DA and SV and to reduce the stigma of DA and SV for victims
- A need for preventive work aimed at stopping potential perpetrators of DA and SV

# 4. Current Services

## 4.1. Specialist services for domestic abuse

The specialist DA pathway (Figure 12) relies on a victim disclosing DA to an organisation or attendance by police at a DA incident. Immediate safeguarding actions may then be required to address urgent safety issues. A DA risk assessment is carried out using a CAADA DASH checklist (see appendices). People identified as high risk (score >14) are assigned an IDVA and enter the MARAC process. Those who are deemed medium risk (score 10-13) are assigned to a medium risk outreach service and those at standard risk (score 0-9) are seen by the Countywide Victim Support service. A separate, but similar checklist is used by the police (ACPO CAADA DASH RIC) and until recently the threshold for high risk cases was defined as a score of 16 or above.

The following services are available for all, with the exception of perpetrators of DA and SV. A range of additional, non-commissioned but important services such as longer term counselling are offered by a variety of organisations for both DA and SV victims.

### 4.1.1. Helpline

Various national charities offer help lines to support people who are victims of DA or SV. The Helpline is funded by Derbyshire County Council. During normal office hours the calls automatically divert to the relevant domestic abuse support provider. Outside of office hours the calls are picked up by the County Council's call centre - Call Derbyshire.

Demand for this service varies. The number of calls has fluctuated over the past 3 months - 369 in January 2014, 202 in February 2014 and 108 in March 2014. The calls generated almost 51 hours of call time, which averages to5 minutes per call..

### 4.1.2. Independent domestic violence advisors (IDVA)

IDVAs are provided across Derbyshire County by DDVSAS for Derbyshire and also in Bolsover and Derby City by local councils. Governance of the Derby and DDVSAS IDVAs falls to the DVSV Board.

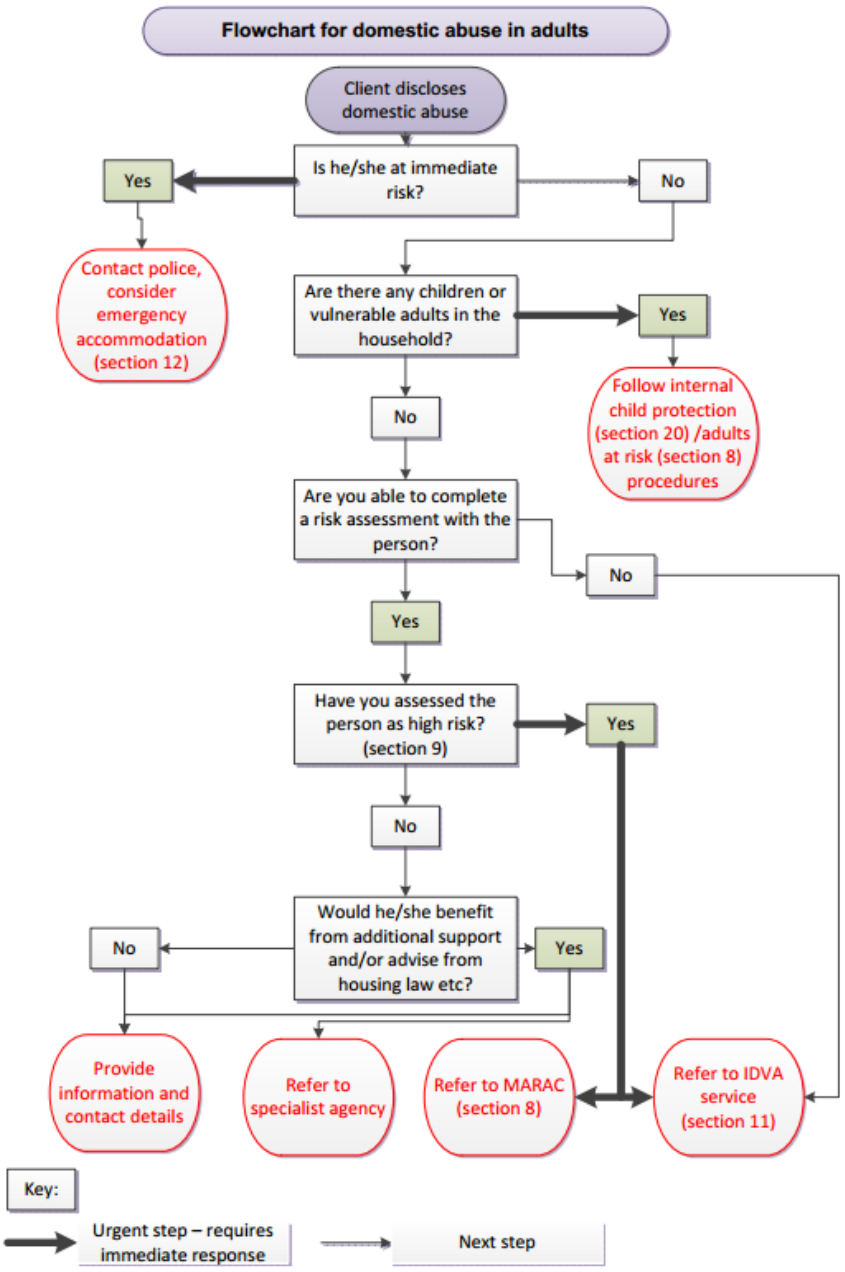
The main purpose of the IDVA is to assess the level of intervention required and address the safety of victims at high risk of harm to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans. Any referral into the MARAC process should also be followed by a referral to the IDVA service.

Within DDVSAS the IDVA pathway has been standardised to 12 weeks in length. Many cases require less support and longer periods of support can be arranged on a case-by-case basis. The main health access point for people using an IDVA is via self-referral to their GP. Within Derby there is not a standardised amount of time set for working with victims. This in part reflects the needs of victims and the lack of commissioned services for medium risk victims in the city.

In Derbyshire County, DDVSAS receive funding for 4.5 WTE IDVAs the County Council, Derbyshire Constabulary and the Police & Crime Commissioner. This is a three year contract, running up to

2016. CAADA recommend a caseload of 100 cases per year per full time IDVA. In 2013/2014 DDVSAS have received over 700 referrals to their IDVAs, considerably more than the recommended, suggesting the service is stretched. It is not clear whether these levels impact on the quality of service provided.

**Figure 12 Flowchart for domestic abuse in adults in Derby and Derbyshire**

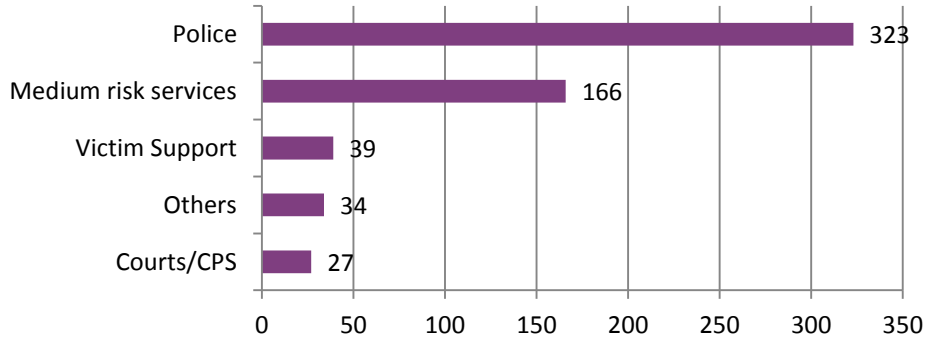



DDVSAS also supply an IDVA to Chesterfield Royal Hospital two days per week. A third of this comes from DCC funding and the remaining from other sources; continued funding for this post is uncertain.

DDVSAS also provide a court-based IDVA, fully funded by the County Council from October 2014.

In the 12 months ending March 2014 DDVSAS had 734 IDVA referrals. Of those, 27 (3.7%) were Male, 12 (1.6%) were LGBT, 23 (3.1%) were from BME groups and 108 (14.7%) had a disability. Referrals into the service come from a range of organisations, with the police being the main source (Figure 13).

**Figure 13 Source of IDVA referrals in Derbyshire 2013/14**




Within Derby the Council funds 2.8 WTE IDVAs and there is a WTE manager who also takes on case work due to the high demand. The number of referrals has increased rapidly. In 2012/13 there were 282 referrals, 4.7% of which were male, however in the first eight months of 2014/15 there have been 362 referrals, 8.2% of which were male.

Full referral data were not available however the vast majority of referrals come from the police Domestic Violence Unit, followed by CYPD and Victim Support. Other referral sources include drug and alcohol services, children's centres, housing department and health visitors.

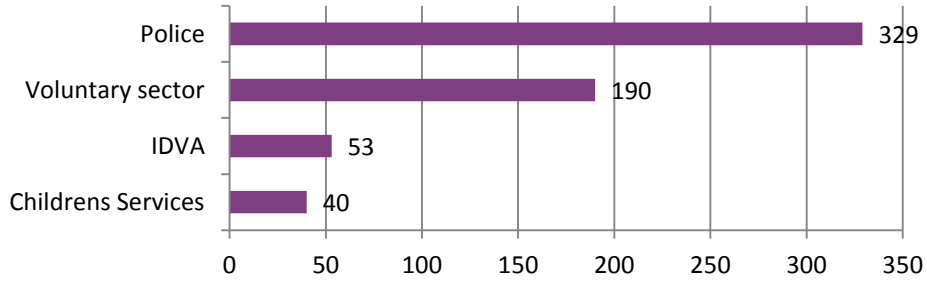
There is not currently a court based IDVA in Derby, however funding is secured for a new post.

### 4.1.3. Multi Agency Risk Assessment Conference (MARAC)

Once identified as being at high risk of serious harm or homicide a DA case is referred to one of five MARAC meetings dispersed around Derby and Derbyshire. These provide a multi-agency approach, enabling sharing of information and joint planning of actions to reduce risk and provide support. The victim does not attend the meetings but is represented by an IDVA who speaks on their behalf.

For the 2013/14 financial year there were 520 cases discussed of which 55 were repeat cases (11%) referred to the County MARACs, and 214 cases discussed of which 25 were repeat cases (12%) within the Derby City MARAC. The main referrers to the MARAC process are the police (Figure 14).

**Figure 14 Source of MARAC referrals in Derby and Derbyshire 2013/14**



Interviews with stakeholders also suggest that there has been an increase in MARAC referrals over the past year. This may suggest increasing demand, or it may reflect less experienced and more risk averse use of the risk checklists. The police have also recently reduced the referral threshold on the checklist from 16 to 14. This has brought them into line with other services and may partially explain the increase in demand.

#### 4.1.4. Refuges and supported housing

There are a number of refuges within Derbyshire, which are operated by third sector organisations. Their use is based on an assessment of need (Figure 12) and whilst this is likely to apply to people at high risk of DA it may not always be the case.

People in need of refuge may be placed in a Derbyshire refuge away from their original location or in neighbouring areas. Refuge places are not limited to high-risk victims only and are offered on the basis of need and individual circumstances. Supported housing is offered by the following organisations:

- DDVSAS – North East Derbyshire, Bolsover, Chesterfield
- Derbyshire WISH – Amber Valley, Derbyshire Dales, Erewash, High Peak
- Derby Women's Centre – Derby City
- Trident Reach – South Derbyshire

The refuges are mainly small properties that can provide temporary accommodation for women in need and their children. There are also a number of dispersed properties that are suitable for men, larger families and those with older male children. Floating support is also provided to help people with a move into their own home. This is funded by the Public Health ring-fenced budget, outside of the Community Safety Department.

Funding for a number of refuge places is provided via Derbyshire and Derby Council. A number of the refuge buildings are owned by Councils and operated by service providers, other refuges are owned solely by third sector organisations. Funding for individuals using refuges is based on their occupancy and there may be a perverse incentive for supplier induced demand. No evidence of this has been identified and it is likely that the need for refuge accommodation outstrips supply; however mechanisms for monitoring this risk were not clear.

#### 4.1.5. Medium risk outreach services

People may be referred to medium risk services after a risk assessment has been carried out using the CAADA DASH checklist (score 10-13), or after completing the MARAC process with an IDVA. In 2013/14 the main source of referrals into the medium risk services was self-referral, however the police, adult and children's social care, Housing Services, IDVAs and Victim Support also played an important role. Some organisations recorded referrals from community mental health teams and GPs, but not all.

Medium risk services around Derby and Derbyshire offer adult outreach services. These vary and are tailored to the needs of the individual but will centre on the Freedom Programme, a 12-week rolling programme providing informal support and advice around a range of issues including housing,

finance and safety. Table 2 shows the services and areas served. It also provides a breakdown of demand in the year up to March 2014. All services contacted reported demand had increased in the last year as awareness of services increased. It is interesting to note that there were very small numbers of LGBT people using services. This may reflect a lack of access for LGBT groups.

The BME population in Derbyshire, whilst small, is not preferentially using the specialised services offered by Hadhari Nari in Derbyshire Dales. Greater numbers of people in a BME group access services in their local area.

**Table 2 Demand for medium risk domestic abuse services in 2013/14 by provider**

| Provider | Area | Total | Repeat referrals | | Male | | LGBT | | BME | | Disability | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | n | n | % | n | % | n | % | n | % | n | % |
| **DDVSAS** | Bolsover, Chesterfield, NE Derbyshire | 1434 | 17 | 1.2% | 76 | 5.3% | 6 | 0.4% | 35 | 2.4% | 149 | 10.4% |
| **HPWA** | High Peak | 218 | 14 | 6.4% | 4 | 1.8% | 0 | 0.0% | 1 | 0.5% | 79 | 36.2% |
| **NextStep** | South Derbyshire | 301 | 300 | 0.3% | 7 | 2.3% | 1 | 0.3% | 11 | 3.7% | 16 | 5.3% |
| **Hadhari Nari** | Derbyshire Dales, County Wide (BME) | 45 | 44 | 2.2% | 1 | 2.2% | 0 | 0.0% | 4 | 8.9% | 0 | 0.0% |

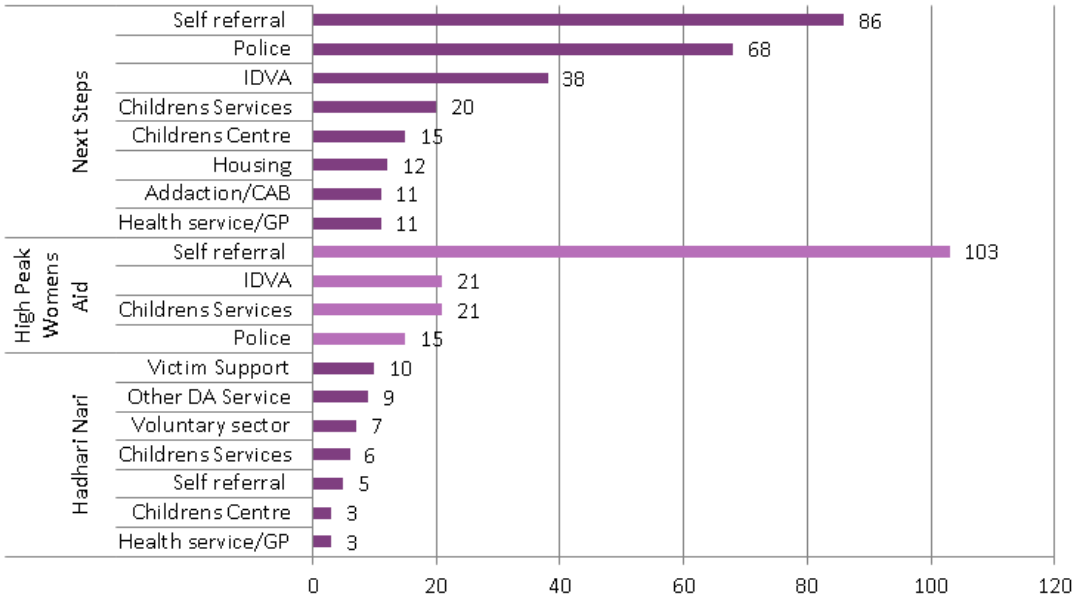
Data not available for Escape in Amber Valley/Erewash or Hadhari Nari in Derby

The source of referrals to medium risk services varied, although this in some part may be explained by differences in reporting activity data and classification of referrals. DDVSAS did not report a breakdown of referrals, however their main sources of referral were:

- Self-referral
- IDVA Service
- Housing Services
- Children's services
- Victim Support
- Community mental health
- Police

Referrals for other services varied (Figure 15) suggesting that the various providers have different relationships with their local stakeholders and there may be an opportunity for sharing good practice in how to access different organisations.

**Figure 15 Source of medium risk referrals in Derbyshire 2013/14**




### 4.1.6. Standard risk outreach services

If people are identified as standard risk (CAADA DASH risk score 0-9) they are referred to Victim Support. This charity provides low risk outreach services across the county for males and females. The Ministry of Justice provides funding and the provider receives information from the police service on a daily download that enables them to contact victims of crime. The service utilises trained volunteers who are not DA or SV specialists.

### 4.1.7. Other services

Outside of the adult pathway funded by the Derby and Derbyshire SDV Board there is a range of other support provided. The funding and governance arrangements for these vary.

Children's Outreach services provide support and advice for children and young people and are not specific to a CAADA DASH risk score. The Children's and Younger Adults Department at Derbyshire County Council fund DDVSAS, High Peak Women's Aid and Trident Reach to provide programmes for children affected by domestic violence and also for young people displaying possible perpetrating behaviours.

Counselling for victims is also provided, however this is not routinely funded and different models of provision exist. For example DDVSAS provide free counselling which uses DDVSAS employed co-ordinator to arrange counselling with local independent councillors. The Counselling Service is a member of the British Association for Counselling and Psychotherapy and follows its code of ethics, but may be at risk due to reductions in funding.

Other organisations such as Relate provide limited free counselling alongside paid for relationship counselling and services in Derby and Derbyshire. In Derby the Derby Women's Centre offers paid for counselling with trained volunteers, who range from the experienced to the pre-qualified. All counsellors adhere to strict codes of ethics and professional conduct set out by the British

Association for Counsellors and Psychotherapists (BACP) and United Kingdom Council for Psychotherapy (UKCP).

Third sector providers also bring added value through additional services:

- Drop-in sessions: Informal support and advice around a range of issues such as housing and finance, safety- including self-referral to refuge. According to service user verbal feedback to DDVSAS, this service is not seen as particularly well used.
- Volunteer Service: Informal 1:1 befriending support, coffee and activity mornings, support of group work sessions.
- Other therapies and support such as art therapy for children and young people.

#### 4.1.8. Perpetrator services

Within Derbyshire there is a specialist service to help men who want to change their behaviours and reduce their risk of perpetrating DA. This service is provided by DDVSAS and offers a 35-week structured programme which seeks to reduce and stop abusive behaviour by offering support so that the perpetrators better understand their own behaviour and the impacts and risks of this behaviour.

The programme also includes a team of Women's Safety Workers who will work with the partners or ex-partners of perpetrators participating in the programme, to ensure the women's safety and that of any dependants.

The perpetrator programme is currently co-funded by Big Lottery funding and Derbyshire County Council's Community Safety Partnership.

### 4.2. Specialist services for sexual violence

The following high-risk services are available for anyone, with the exception of perpetrators of DA and SV. Figure 16 shows the pathway for people who disclose SV to organisations within Derby and Derbyshire. There is one main provider of SV support across the area, a third sector organisation called SV2.

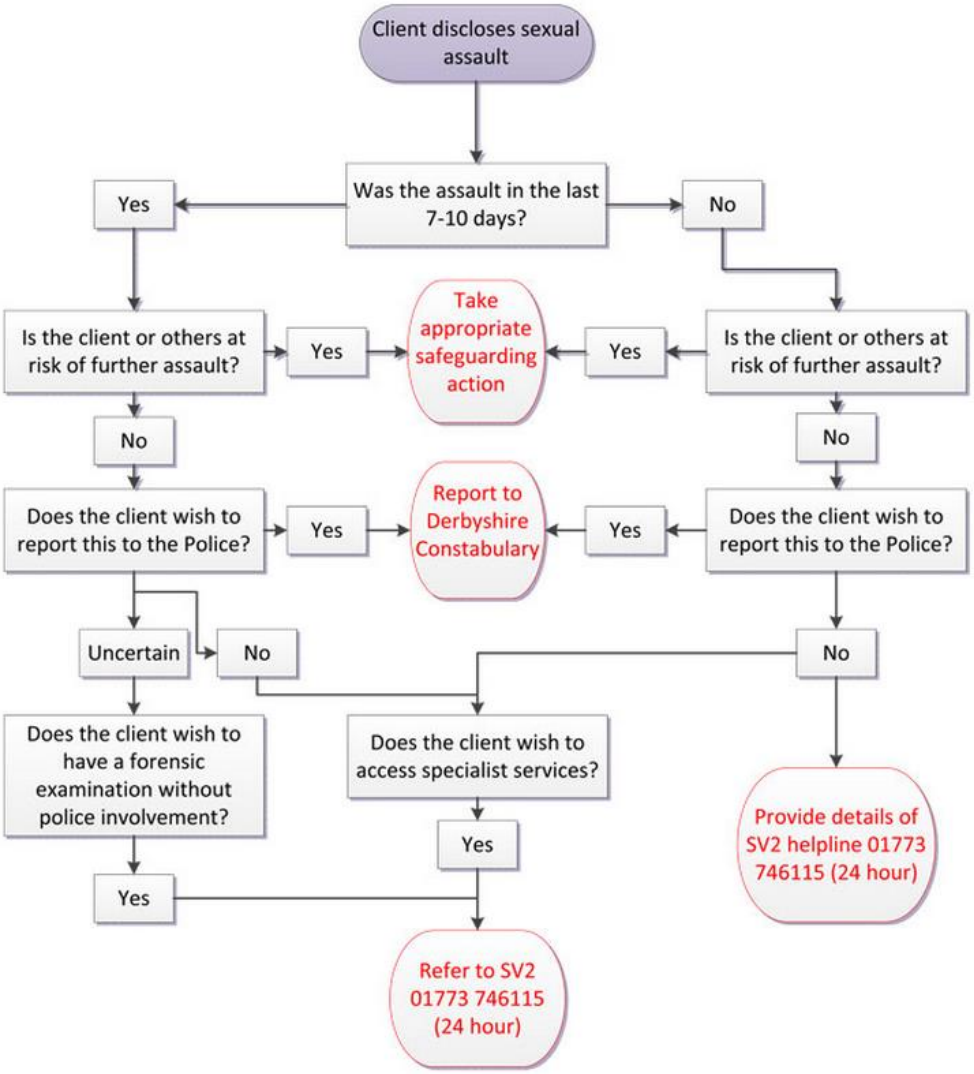
#### 4.2.1. Sexual Assault Referral Centre (SARC) and Independent Sexual Violence Advisors (ISVA)

People who disclose serious sexual assaults are referred to the Sexual Assault Referral Centre (SARC) provided by the charity SV2. Crisis Workers help victims through the immediate aftermath of an assault and act as an advocate for the victim.

A SARC is a specialist 24/7 service for anyone aged 16 years and over who has been raped or sexually assaulted. They aim to provide the following services under one roof:

- Medical care and forensic examination following assault/rape,
- Counselling
- Sexual health services

**Figure 16 Flowchart for sexual violence services in adults in Derby and Derbyshire**

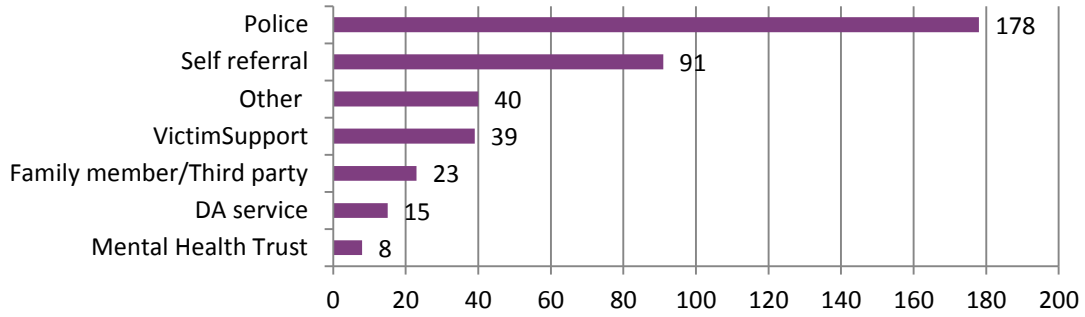



Service users can choose whether they would like to inform the police at a later stage and have their samples stored (for up to 12 years) whilst they are considering what to do next. It is hoped that through this option service users can take back some control over what is happening whilst allowing more time to make such an important decision.

Following contact with the Crisis Worker a victim is offered further support from an Independent Sexual Violence Advisor (ISVA). They ensure victims are offered the support they need from statutory and other services, act as an advocate, and provide information to the victim. The ISVA also provides support with the judicial process.

Funding for Crisis Workers and ISVAs will in the future be provided by NHSE , after commissioning responsibilities for the SARC pass from the police service.

**Figure 17 Source of referrals to SV2 – including the SARC 2013/14**




Within Derbyshire there are also a number of DDVSAS staff who are trained as ISVAs. The aim of this is to provide a single service for people who suffer SV as part of DA. It is aimed at those who do not require access to forensic services from the SARC, but would benefit from long-term support an ISVA can provide, which is beyond the scope of IDVA services.

### 4.2.2. Other Sexual Violence Services

SV2 provide a range of other services alongside the SARC in order to offer an integrated service. A help line is available and on-going support. Patient centred trauma based counselling for up to 26 weeks is also offered on the basis of need. This is a free service to clients and may deal with a wide range of SV victims including those with historic experience of SV. The CORE-32 standardised tool is used to assess outcomes of counselling along with tools for assessing dissociation; one for psychological dissociation (DES II) and one for somatoform dissociation (SDQ20).

All counsellors are either accredited, (or eligible for accreditation), by the BACP (British Association for Counselling) or the UKCP (UK Council for Psychotherapy). Counsellors follow their associations' ethical and professional codes of conduct and operate within an SV2 Governance Framework.

The demand for counselling services has increased in recent years, putting pressure on this service and increasing waiting times. It is not clear if alternative specialist services exist within the NHS, and if they do they are likely to be very limited. Victims may be referred to IAPT based services, but these may be short term cognitive behavioural therapy approaches that aim to provide coping strategies only.

In the 12 months ending March 2014 SV2 had a total of 661 new service users including users of the help line. Of these 81 (12.3%) were male, 197 (38%) were historic cases and 8 (1.5%) were victims of multiple assaults.

Other services also operate in this area, such as SAIL (Sexual Abuse & Incest Line) based in Chesterfield. SAIL offers a free counselling service and a help line and is funded by voluntary donations.

#### 4.2.3. Primary prevention, awareness raising and training

Preventative work is co-ordinated through the DSAAG in order to meet the strategic aims set out by the Domestic and Sexual Violence Board.

Local services and Councils propagate national campaigns aimed at prevention of DA and SV. A number of local initiatives are also undertaken. Across Derbyshire there is a resource guide for schools to help them be aware of signs of DA and know where to refer. This has replaced a key worker post. Third sector organisations such as SV2 and DDSVAS also carry out preventative work in schools.

DSAAGs also promote work in schools via partner organisations and undertake events around the year to promote services and preventative messages for DA and SV. These vary by area and in their scope.

Developing awareness of DA and SV and the services available is carried out by a variety of organisations. Organisations report that they have worked with local referrers such as GP practices to increase awareness. Direct training for CCGs has also been commissioned from DDSVAS to raise awareness of DA and SV services along with MARAC training.

### 4.3. Cultural sensitivity

DA and SV affect people regardless of race, ethnicity, class, sexual and gender identity, religious affiliation, age, immigration status, and ability. Because victims may experience the abuse and access services in culturally specific ways, service providers should consider the cultural background and the unique issues faced by the victim and their children in order to tailor services to meet their needs. All services should be capable of providing services for all groups and this includes forging links with all potential avenues of disclosure, which may vary between cultures and groups. Similarly prevention and awareness work must address cultural norms and differences to improve equity of uptake and provision.

### 4.4. Health services

No clear overarching pathway for DA or SV currently exists within the health services. Some organisations have specific DA and SV strategies whilst others treat disclosure of DA and SV as safe guarding issues for children and vulnerable adults.

#### 4.4.1. Primary care

Health professionals are often a first point of contact for women, and they deal with the after-effects of domestic abuse on an everyday basis. Women who have experienced abuse use health services frequently and require wide-ranging medical services.

Updated guidance for GP practices was developed by the Royal College of GPs and CAADA and launched in 2012. Recommendations include practice training and referral pathways to specialist domestic violence agencies.[124]

CCGs are now responsible for the quality of care provided by GPs in Derbyshire and Derby. DA and SV Training has been provided for CCGs and some areas have developed specific DA and SV pathways alongside safeguarding procedures.

#### 4.4.2. Midwives and health visitors

Pregnancy and having a new baby are vulnerable times for some women. Midwifery services in Derby and Derbyshire routinely screen for domestic abuse at the booking appointment and throughout pregnancy. NICE guidance recommends that midwifery services have a clear and agreed local protocol developed jointly with police, social care providers and third sector agencies.

#### 4.4.3. Secondary care

Both the Chesterfield Royal and Royal Derby Hospitals provide Accident and Emergency services. These are likely to be used by people who have suffered serious assaults due to DA or SV and forensic procedures are in place in both hospitals to preserve evidence associated with victims.

#### 4.4.4. Derbyshire Healthcare NHS Foundation Trust

Derbyshire Healthcare NHS FT provides community and inpatient mental health services. There are clear links between DA and SV and mental health issues. The Trust has specific domestic violence standards and procedures in place.

### 4.5. Social care

#### 4.5.1. Children's services

Where a child may be at risk from domestic abuse (either as a direct result of abuse aimed at the child or an indirect risk from abuse between parents or other household members) a referral can be made by professionals or members of the public to Children's Social Care. Within Derbyshire this service is managed by Call Derbyshire. Upon receipt, the referral is screened by a senior practitioner co-located to Call Derbyshire to ensure that only cases which meet appropriate thresholds lead to further action.

During the financial year 2013/14 there were 3,924 children referred to children's social care within Derbyshire, where domestic abuse had been identified as a current or partial cause for concern. This equates to a rate of 25.3 referrals per 1,000 children aged 0-17 years. The highest rate of referral was from Chesterfield (33.8 referrals per 1,000), which was statistically significantly higher than the Derbyshire average. South Derbyshire and South Dales had a referral rate of 19.3 referrals per 1,000, which was statistically significantly lower than the Derbyshire average. For all other districts, the referral rate was not significantly different to the Derbyshire average. No data was available for Derby.

In general, districts with higher referral rates tended to have a higher proportion of repeat referrals. Conversely, districts with the higher referral rates tended to have a lower proportion of referrals that led to further action. The higher referral rates experienced for some districts are therefore likely

to be partially influenced by a combination of the number of repeat victims and a cautious approach to the referral process.

There were similar numbers of referrals for males and females, but only 6% (252/4186) were aged over 16 years.

The sources of referrals varied with 53% (2226/4186) from the police, 11% (445/4186) from health services, 8% (343/4186) from individuals and 6% (264/4186) from schools (Table 3).

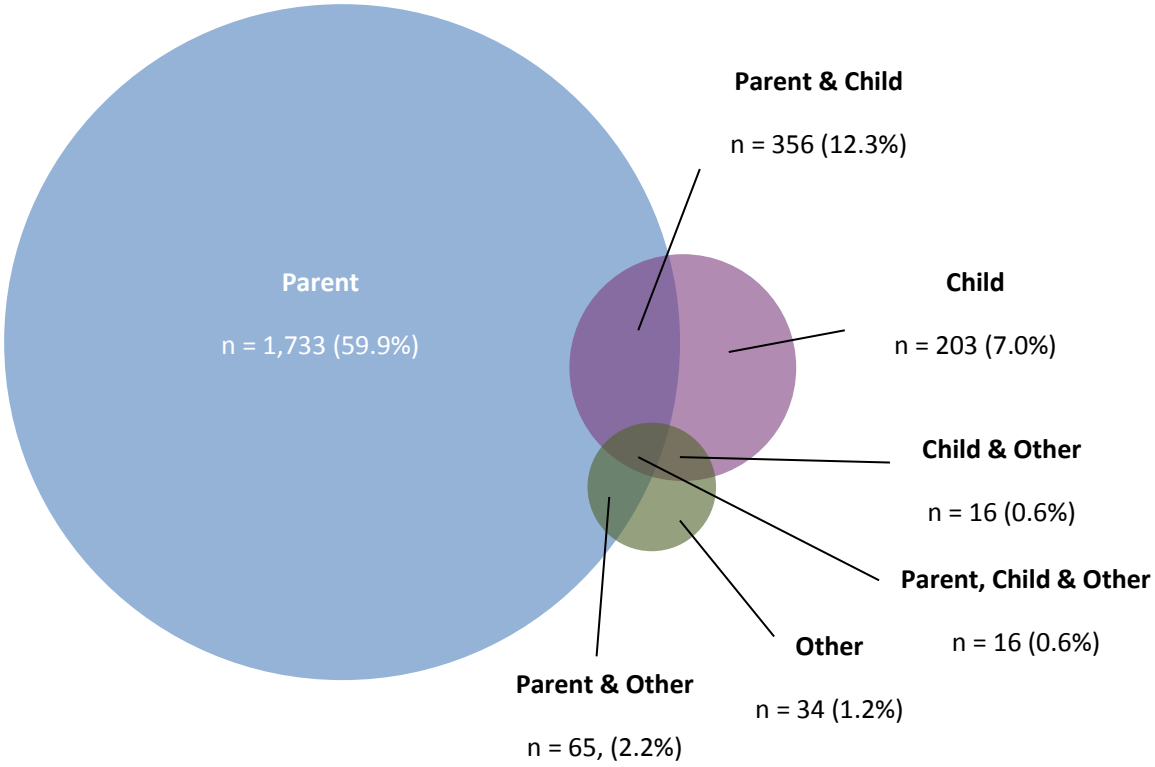
**Table 3 Source of domestic abuse referrals to Children's and Younger Adult's Services in Derbyshire 2013/14**

| Referral Source | Percentage of Referrals | Number |
|---|---|---|
| Police - Central Referral Unit | 44.0% | 1,726 |
| Police - Other | 9.6% | 377 |
| Schools | 6.3% | 248 |
| Individual - Family member/relative/carer | 5.2% | 205 |
| Health services - Other primary health services (eg: Hospital, Clinic) | 5.0% | 197 |
| Other legal agency - probation | 3.4% | 132 |
| LA services - External e.g. from another LAs adult or children social care department | 2.7% | 106 |
| LA services - MAT | 2.7% | 106 |
| Individual - Acquaintance (including neighbours and child minders) | 1.8% | 69 |
| LA services - Social care e.g. adults social care | 1.8% | 69 |
| Health services - A and E (Emergency Department) | 1.6% | 64 |
| Health services - Health Visitor | 1.4% | 56 |
| Anonymous | 1.4% | 55 |
| Health Services - Derbyshire Mental Health Service | 1.1% | 43 |
| Health services - GP | 1.1% | 43 |
| LA services - Other internal department other than social care in LA | 0.8% | 33 |
| Health services - Other (e.g. hospice) | 0.6% | 24 |
| Individual - Other (including strangers, Member of Public, MPs) | 0.6% | 23 |
| Other legal agency - CAFCASS | 0.5% | 21 |
| Housing (LA housing or housing association) | 0.3% | 12 |
| Education Services | 0.3% | 11 |
| Individual - Self | 0.2% | 8 |
| Other | 3.6% | 140 |
| *Unknown* | *4.0%* | *156* |
| Total | 100.0% | 3,924 |

Of all the referrals to Derbyshire children's social care during 2013/14, for the vast majority (59.9%) the direct victim of abuse was the parent only, i.e. a child may have witnessed abuse that was aimed towards their parent (Figure 18). Parents and children were both direct victims of abuse in 12.3% of referrals and in 7.0% of referrals the child was the only victim. In total, children were the direct victims of abuse in 20.5% of referrals, which also includes abuse from other household members.

From the existing data it is not currently possible to readily identify the perpetrator of abuse. However, the national review by CAADA found that where a child has been exposed to domestic abuse, in 73% of cases the perpetrator was the father, followed by 29% of cases where the perpetrator was the mother's male partner. Where the child was the direct victim of domestic abuse, the father was responsible for 66% of cases and mother's male partner for 27% of cases.

**Figure 18 Proportional Venn diagram to show the primary victim of domestic abuse for referrals to CAYA (2013/14)**




### 4.5.2. Adult Social Care

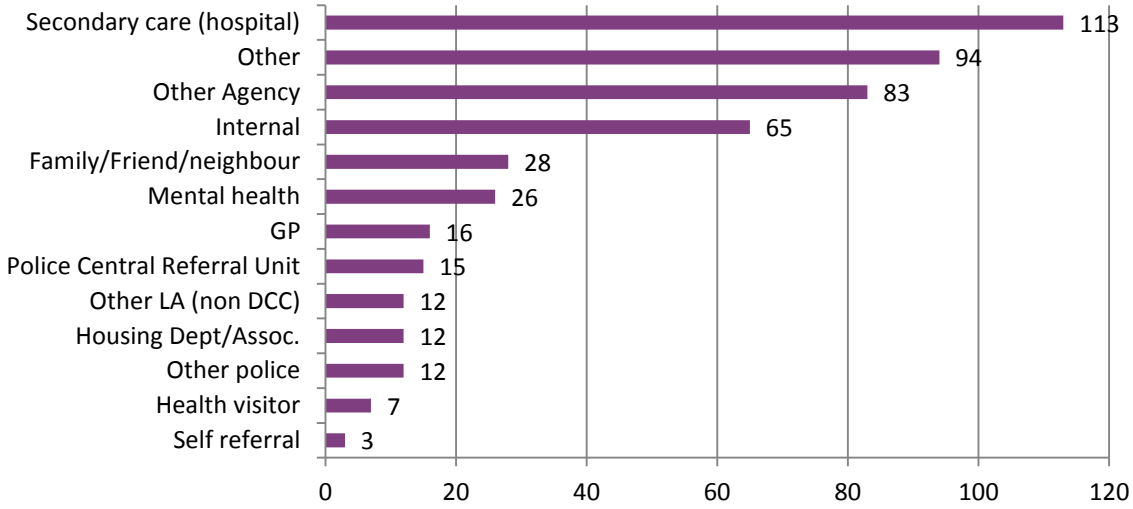
Adult social care works with any adult who has been subjected to abuse and directs them to the appropriate specialist services. In particular there is a focus on those who are likely to be particularly vulnerable:

- A person with mental ill health, physical or learning disability, illness or age related frailty
- Someone who is less able to protect themselves against significant harm or exploitation
- People dependent upon carers or others who are under stress
- People living in difficult community settings such as shared hostels

Using referral data based on incidents that occurred in the home, was physical in nature and in which the alleged perpetrator was known to the individual, provides a snap shot of demand, but will underestimate the true number of referrals related to DA and SV.

In Derbyshire during the 12 months ending March 2014 the County had 486 referrals of which 158 (32.5%) were assessed at a Safeguarding Strategy meeting and 62 (12.8%) were repeat referrals. Of these, 65% (317/486) were female and 53% (253/483) were over 65 years old, however only 6 referrals were recorded as belonging to a BME group. The main referrers were health services (Figure 19). No data was available for Derby.

**Figure 19 Source of physical abuse referrals of vulnerable adults to Adult Services in Derbyshire 2013/14**




## 4.6. Criminal Justice

A clear pathway exists within the criminal justice system for perpetrators of DA or SV. This has benefited in recent years from developments such as MARACs and specialist courts for DA.

### 4.6.1. Police

Derbyshire Constabulary covers both Derby and Derbyshire. The police are frequently involved in incidents that involve DA and SV and may well receive the first disclosure from a victim. However it is likely that the police are involved in incidents that are more serious and also more likely to involve physical harm rather than other forms of abuse and at times police involvement may act as a barrier to people seeking help.

#### 4.6.1.1. Domestic abuse

During 2012/13 there were 17,631 reported incidents of domestic abuse in Derbyshire (County and City), which equated to a rate of 21.7 incidents per 1,000 population aged 18+. Statistically, this was significantly higher than both England (18.6 per 1,000) and East Midlands (20.8 per 1,000) at the 95% confidence level. However, it is important to note that this does not necessarily mean that there is a higher prevalence of domestic abuse in Derbyshire compared to the Country as a whole; this could be influenced by differences in reporting and recording. Figure 20 shows the change in numbers of DA calls for service per 1,000 residents in Derbyshire, and illustrates that demand has increased over time by a small but statistically significant amount.

Between April 2011 and March 2014 the rate of domestic abuse incidents in Derbyshire County and Derby City increased from 23.5 incidents per 1,000 to 24.2 incidents per 1,000. The incident rate in 2013/14 was almost 67% higher in Derby City (34.4 incidents per 1,000) compared to the County (20.6 incidents per 1,000).

**Figure 20 Domestic abuse incidents (18+) recorded by Police 2007/8-2012/13 (Crude rate per 1000)**

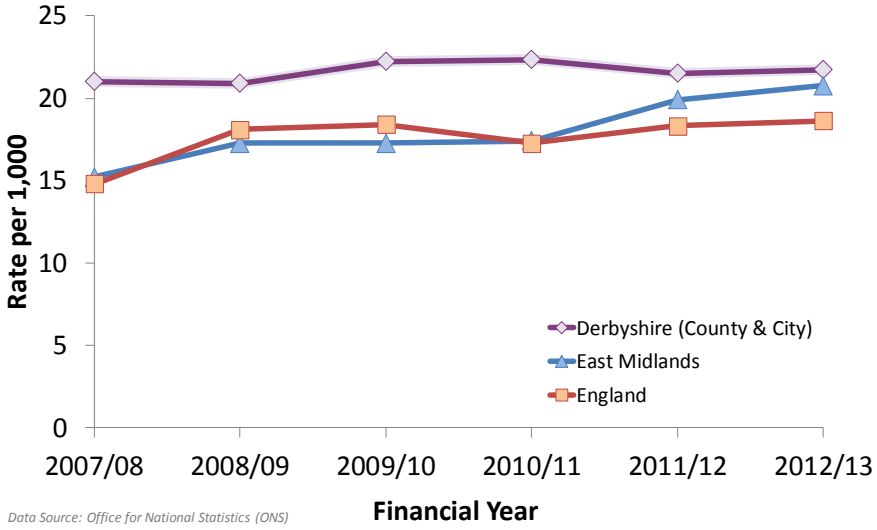
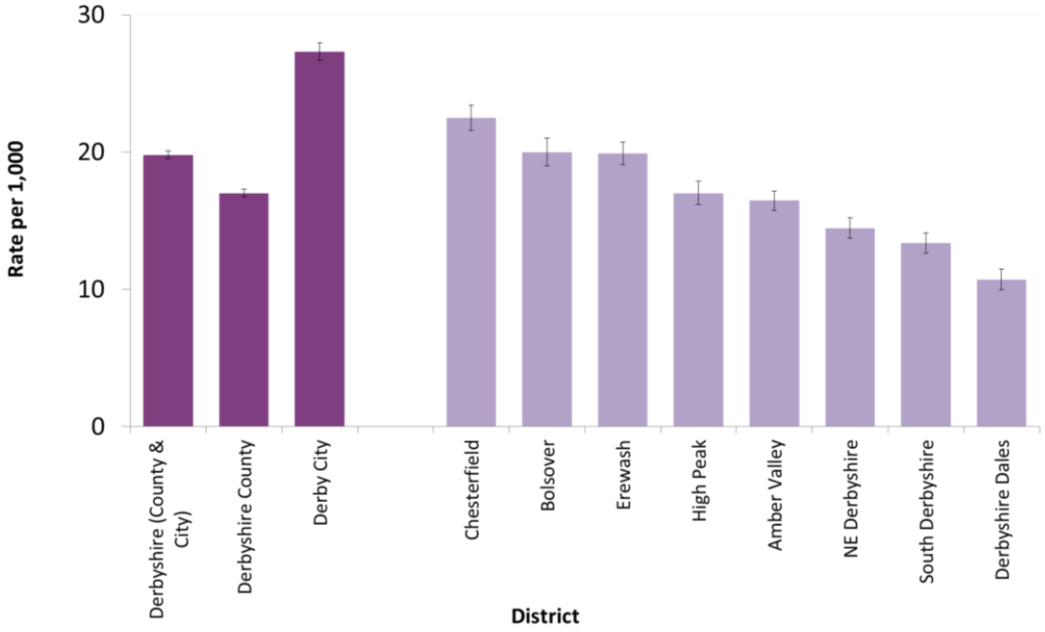



Figure 21 shows the variation in demand in the 12 months ending March 2014. Derby City, Chesterfield, Bolsover Erewash and High Peak had the highest rates of calls for service and there are statistically significant differences in levels of demand between areas. Further variation by area is show in the map in Figure 23.

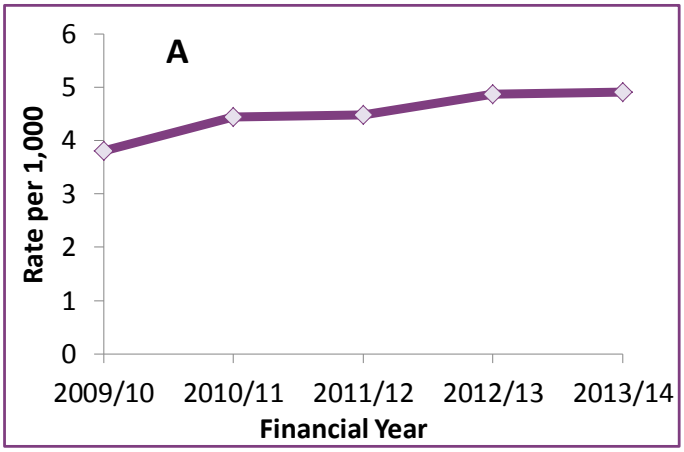
**Figure 21 Number of domestic violence calls (all age) per 1,000 resident population 2013/14 (rate per 1,000 population and 95% confidence intervals)**




Outcomes of police calls are also an important factor as they influence how DA is perceived in wider society. The identification of incidents as crimes, and following them up with a charge or caution (for a first-time offence) acts as a deterrent and a form of secondary prevention.

Although all recorded crime numbers have been falling consistently from 2004, recorded DA offences have been rising from 2007 and this will in part be due to increased understanding and better recording, but also increased reporting due to the many initiatives that have been carried out (Figure 22). In Derbyshire and Derby the number of recorded DA crimes has risen by 1.2% over the last year (4958 in 12/13 to 5018 in 13/14).

**Figure 22 Comparison of domestic abuse recorded crime rate (A) with overall trend in recorded crime rate (B) in Derbyshire and Derby (rate per 1,000 population) 2009/10-2013/14**



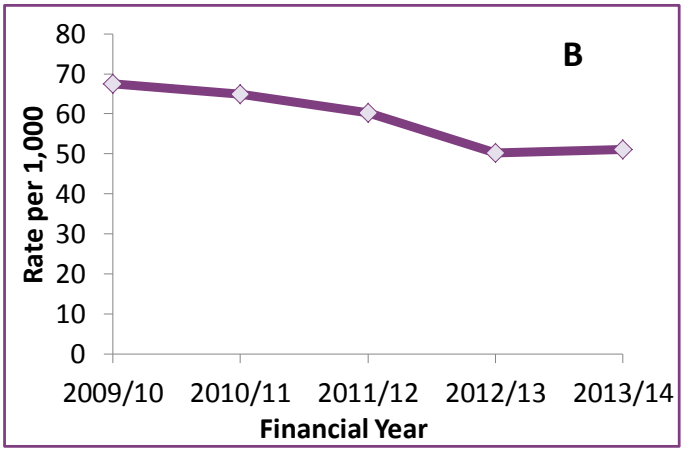
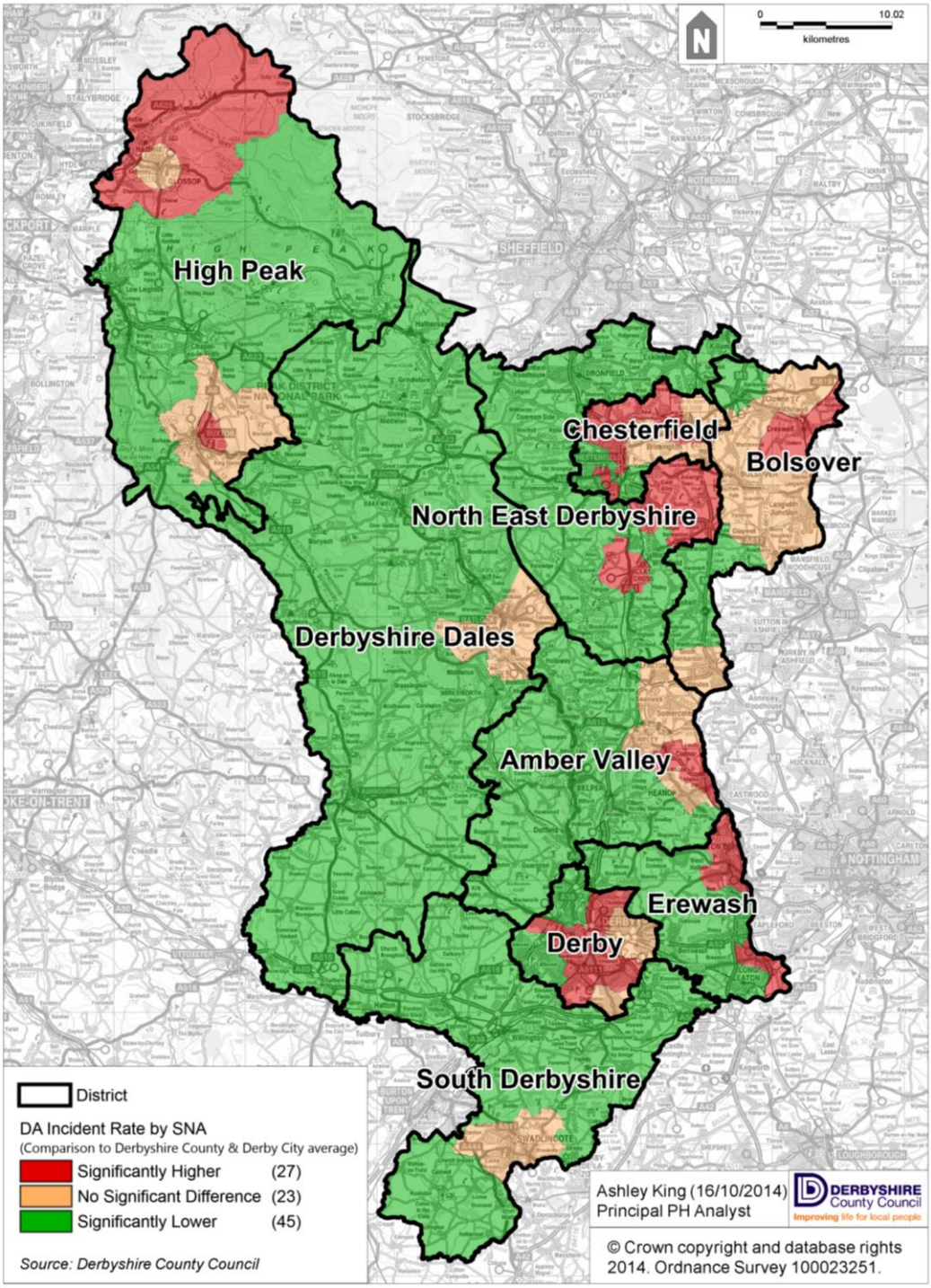



**Figure 23 Areas of significantly higher and lower rates of domestic abuse (all ages) incidents reported by Police, safer neighbourhood areas 2013/14**




#### 4.6.1.2. Sexual violence

The number of calls to police for sex offences has risen slightly from 742 in 12/13 to 786 in 13/14 (+5.9%). This is an increase in the monthly average from 62 in 12/13 to 66 in 13/14).

Police recorded sex offences have increased from 790 in 12/13 to 902 in 13/14 (+14.2%). This is an increase in the monthly average from 66 in 12/13 to 75 in 13/14. During 13/14 31.8% of all recorded sex offences were recorded more than 12 months after the incident date *(the earliest possible date that the incident could have taken place*). This is likely to reflect the impact of Operation Yewtree, which widely publicised investigations into historic sexual offences, resulting in greater awareness and willingness of victims to report historic crimes.

#### 4.6.2. Probation

A new accredited program called Building Better Relationships (BBR) is currently in use by the probation service and has replaced the Integrated Domestic Abuse Programme (IDAP). The intervention is aimed at those male offenders convicted of serious domestic violence, in particular those with an entrenched pattern of violence and aggression.

The 29-session programme, which is primarily delivered in groups, encourages men to change their behaviour and develop strategies for maintaining the change when they complete the course. It aims to reduce re-offending and promote the safety of current and future partners and children.

A snap shot of the Probation caseload in December 2013 indicates that 164 offenders were undertaking an Integrated Domestic Abuse Programme (IDAP) or a Building Better Relationships Programme (BBR). At the end of March 2014, 68 (76.4%) offenders completed the scheme successfully.

#### 4.6.3. Courts

Chesterfield and Derby both house Specialist Domestic Violence Courts. These are a co-ordinated multi-agency response to DA, which combine both criminal justice and non-criminal justice interventions. Some of the specific measures utilised by the court system included:

- Frontline police officers trained on the ACPO guidance for investigating DV
- Access to the IDVA service and witness support to improve the experience of judicial system for victims
- Dedicated prosecutors, specially trained magistrates and legal advisors
- Fast-tracking of DA cases
- Separate entrances, exits and waiting areas so that victims do not face the risk of being confronted by their attackers while attending court

No specialist court exists for SV cases. These are pursued through Magistrate and Criminal Courts. Conviction rates do not reflect the needs of the victims of DA and SV, but again help act as a deterrent to committing crime if there is a perception that DA and SV are not acceptable in wider society.

In the year ending in March 2014 the DA conviction rate in Derby and Derbyshire was 76.4% compared with the National rate of 74.6%. The conviction rate for sexual offences was 80.4% compared with the National rate of 79%. However this reflects the whole Police and Judicial pathway rather than the court process itself.

# 5. Stakeholder feedback

## 5.1. Questionnaire

There were 5 respondents to the questionnaire, equating to a response rate of only 33%. Key points from the stakeholder survey are provided below and full results are given in the appendices.

The majority of stakeholders were mainly working with heterosexual, White British victims of abuse. Work with BME groups was greater in Derby than in Derbyshire, reflecting the distribution of BME groups. Work with other minority groups including LGBT groups, migrant communities and sex workers was reported as intermittent or infrequent by all respondents.

The general picture was that services were either not meeting demand or were only doing so by stretching themselves to breaking point. All stakeholders reported an increase in the number of the referrals they are receiving and cases they are dealing with; they all expect this trend to continue. This was felt to be mainly due to greater awareness of DA/SV and the services available, but was also felt by some to be a direct result of cuts to other services. Despite this there was a common perception among stakeholders that public and professional awareness of the services they provided was poor and represented a barrier to accessing services. Other barriers identified by several stakeholders included language barriers, stigma of DA/SV and fear of the perpetrator.

Apart from issues with capacity, service provision was felt to be generally good, with improvements possible in terms of integrated working, knowledge and awareness of services, and more training for health care professionals and police. Prevention and training were identified as gaps in provision.

## 5.2. Interviews

Semi structured and informal interviews were undertaken with a range of stakeholders that commission and provide specialist and non-specialist services. Face to face interviews were undertaken with DA and SV managers in Derby and Derbyshire Councils, DSAAG Chairs, and key providers DDVSAS and SV2.

Interviews via email were carried out with Chesterfield Hospital (Safeguarding team), East Midlands Ambulance Service (Safeguarding), Southern Derbyshire CCG Designated Nurse for Safeguarding Children (Derby) and the North Derbyshire CCG Head Nurse for Safeguarding Children (Derbyshire).

Telephone interviews were carried out with the High Peak DSAAG chair, who also represented High Peak Women's Aid, and a GP clinical lead for Learning Disabilities in Hardwick CCG.

A common set of themes emerged from this work:

**Services and organisation**

- Derbyshire and Derby are seen to have a good system in place, which has improved in recent years and has benefitted from a joint Board approach.

- Communication works well between the different tiers of commissioner and provider. Providers are generally well connected to each other and work to provide a unified service. However communication horizontally across the system could be improved in some areas.

- There are concerns about the sustainability of current medium risk DA service provision in Derby City. Concerns were expressed about the quality of referrals to the MARAC process, reflecting the need for greater training.

- Services for people at standard risk of DA are provided by volunteers. Some stakeholders felt there was a role for people with greater expertise and specialist training.

**Funding**

- Decreased funding has impacted other services, for example mental health respite accommodation, which has increased demand for refuge accommodation and demands on other specialist services.

- A tension exists between third sector providers as they bid for the same funding pots.

- There is a desire to secure more funding from service commissioners in the Council and health services to reduce the need for non-sustainable funding for charitable organisations. This is tempered by third sector organisations wanting to retain independence and work within defined organisational and cultural values.

**Links across services**

- Some organisations felt that better links with wider health care were required. The majority of stakeholders identified links with mental health services as a problem, with difficulty referring those in crisis in to services.

- Some organisations reported good links with GPs and CCGs whilst relationships varied in other areas. An interview with a single GP identified a lack of awareness of referral pathways into specialist services but an awareness of safeguarding procedures.

- A health stakeholder identified that there is a risk that if DA and SV are viewed as safeguarding issues by health services, that non vulnerable adults may be less likely to be identified as being at risk of DA or SV. One stakeholder felt that some health professionals may overstate the role of patients having capacity to choose to be abused, and further training may be required.

- Links to social services were identified as good. However there needs to be better integration of the needs of DA victims when access to children by a partner is being facilitated, in order not to undermine interventions such as restraining orders.

**Integrated commissioning**

- It was noted that providers might be commissioned for a variety of services relating to DA and SV by multiple organisations and multiple departments within an organisation (e.g. CAYA for children's services and Community Safety for adult programmes). There is no standardised way of reporting to commissioners in one organisation, which creates bureaucracy, and there sometimes appears to be a lack of awareness of services commissioned by different departments.

**Access to services**

- Cultural differences and wider acceptance of DA and SV in some new migrant communities in both Derby and Derbyshire mean these communities are less likely to access services.

- Rural communities may have less access to services and may need to travel and have access to private transport in order to access services

- Changes in funding have impacted on some third sector organisations leading to less support for BME and LGBT populations.

- Fear of the consequences of reporting abuse / accessing services was identified as a barrier, particularly for parents whose fear of having their child removed by social services often outweighed their fear of the perpetrator.

**Demand**

- Demand for DA and SV services is high and waiting lists exist for services such as counselling.

- Services feel they are stretched and some are at breaking point. Many feel that they cannot actively promote their services as they will be overwhelmed

- Greater awareness of historic sexual abuse cases has increased demand for services, reflecting a burden of unmet historic need in the population.

# 6. Gaps in need and provision of services

The needs of people who are victims of DA and SV or those who witness abuse are varied and include both social and health needs. Stakeholders felt that the current system was one of the better examples of responsive DA and SV care that aimed to provide an integrated service. It was noted that services are open to everyone suffering DA or SV with the exception of perpetrators. However stakeholders also acknowledge that there is room for improvement in services.

The following issues have been identified as unmet health needs.

**Burden of ill health**

One of the key findings of this health needs assessment is a perceived lack of awareness of the importance of DA and SV as a cause of ill health. The impacts section of this HNA clearly sets out the risk of long-term health impacts for both victims and children living in homes where DA and SV occur. There is a need for DA and SV to be highlighted as a determinant of ill health and for commissioners of health and social services to recognise its importance. There is also an urgent need to recognise that the burden of abuse currently outstrips funding.

**Prevention**

National campaigns target both victims and perpetrators of DA and SV and the outgoing strategy for DA and SV included prevention work. However, over the course of this HNA it has not always been clear how this has been implemented in local areas. DSAAG groups are responsible for planning local prevention and awareness raising work, however examples of work varied in their scope and ambition, and greater support may be required to plan prevention and awareness raising campaigns that target populations in the greatest need. Groups identified in this HNA could be used as a basis for a social marketing campaign that may help focus prevention messages.

Efforts at population wide secondary prevention should also be considered. An example might be to work with large employers to ensure they are aware of the scale of DA and SV in the community. Employers may have an important role in the recovery of victims of DA and SV and the prevention of further abuse through the support of victims in making changes.

Linking with employer organisations or Public Health groups such as the East Midlands Platform for Health, a network of employers of which some cover Derby and Derbyshire, may be useful in primary and secondary prevention work.

Preventative work in schools is on-going, although it is not clear how sustainable this work is and whether programmes are evidence based. Stakeholders highlighted that previous school prevention programmes funded by the Councils had been replaced with a written guide for schools. Further work may be required to identify the current service provision and whether this is helping change attitudes of children in schools and decrease the stigma of DA and SV.

**Access to services**

DA services are distributed around Derby and Derbyshire however they tend to be focussed in more urban areas. The population in Derbyshire in particular is quite dispersed which may affect access to services due to a lack of transport infrastructure.

This is a particular problem for rural areas, where close-knit communities may decrease the likelihood of victims disclosing abuse to local health services such as GP, pharmacies or the police. People who usually have good social capital in close communities may be less likely to disclose issues to friends for fear of stigma and social repercussions. A single SARC location may also act as a barrier to people accessing SV services. Populations in Glossop currently access SARC services in Manchester to help overcome this issue; however this may change in the near future as the NHS takes over commissioning arrangements, presenting potential issues of access that should be monitored.

Derby and Derbyshire have in recent years had specific support for BME groups provided by Hadari Nari based in Derby, and Derbyshire Friend which supported LGBT groups across the City and County. Both of these third sector organisations have altered their services in response to funding changes in recent months. This may reflect lower demand from these population groups or barriers to access, therefore a culturally sensitive approach to DA and SV services should be embedded in all health statutory services to ensure wider access.

**Integration with health services**

The current system is able to provide a core package of care tailored to an individual's needs. There is historic integration between the social and criminal justice services. However integration with health services is lacking.

Current services encourage people to access health support via their local GP or hospital as required, however no direct pathway exists for referral into health services. This is especially important for mental health services as victims of DA and SV are at higher risk.

Better integration with health services will offer an opportunity to improve multiagency working to support victims and offer opportunities for learning from service delivery models used in health care.

From the information gathered in this HNA it is not clear what NHS pathways exist for patients who are suffering trauma due to DA or SV. It is apparent that stronger links need to be made at a strategic level between the DVSV Board and Derbyshire Healthcare NHS Foundation Trust who provide mental health services for the area.

**Workforce development**

Training of CCG staff has been undertaken and should have a positive impact on the quality of primary health care services. Direct training of health professions and raising awareness of the services available may also help ensure people who are identified as suffering DA or SV within the health service are offered support from the appropriate DA or SV service. This may be best achieved

through training about high risk groups such as those with mental health problems, learning disabilities and those who misuse drugs and alcohol.

Currently only midwives routinely screen people for DA or SV. Disclosure of DA to a GP is likely to be seen as a safeguarding issue and there may be a gap in services for non-vulnerable adults who do not routinely fit within safeguarding systems. There is also a risk that people may be seen as having full capacity and '*consenting*' to abuse – this would appear to be more likely in less severe abuse or emotional abuse.

**Services for perpetrators who are also victims**

Currently there are no services for people who have experienced current or historic DA or SV who are also perpetrators. Services will not work with perpetrators as they feel it will undermine the services for victims. However the wider literature suggests that historic abuse and associated trauma may be one of the causes of abuse.

**Fragmented system**

Current arrangements consist of multiple providers of services for high risk and medium risk DA services. The services provided are commissioned by a variety of departments in each council such as Community Safety, Children's Services and Housing.

Fragmentation also increases the risk of service variation, which may introduce health inequalities over the long term within the Derby and Derbyshire populations. There are opportunities for providers to work together and share good practice across DSAAG groups. This may help organisations make links with wider stakeholders such as GPs.

Fragmentation and variation in services point to a need for more integrated commissioning. Examples can be drawn from integrated commissioning hubs that bring together health and local authority commissioning for a particular problem. Whilst multiagency commissioning may be an ambitious goal there may be local efficiencies to be made by integrating commissioning of DA services within Derby and Derbyshire. This would bring together elements of the service commissioned separately. It would also promote a multi-agency working approach.

# 7. Evidence based Services and interventions

There is very little evidence on the effectiveness of interventions for DA and SV, as very few interventions have been rigorously evaluated.[125] In addition, most of the evidence has methodological limitations and is restricted to specific groups. [126]

A comprehensive evidence review was carried out for NICE in 2013.[127] This review found that the interventions below had some effect, but this tended to be in terms of raising awareness and changing attitudes rather than in behaviour change.

**Approaches targeting young people**

There is evidence that educational programmes aimed at primary and secondary prevention among younger people lead to improved outcomes including knowledge about interpersonal violence and attitudes towards violence and gender roles, and reduction in violent behaviours.

**Awareness-raising in health settings**

There is evidence that provision of materials in healthcare settings to increase knowledge and disseminate information about interpersonal violence and available services leads to improved outcomes including knowledge about and attitudes towards violence.

**Media campaigns**

There is some evidence that media campaigns about domestic violence are effective in raising awareness of interpersonal violence and of services available, particularly among women, but this is inconsistent. They tended to be effective when there was good awareness of the campaign among target groups.

**Approaches targeting at-risk groups**

There is some evidence that tailored, community-based programmes targeted at high-risk groups, particularly vulnerable women, are effective for increasing knowledge among these groups, but this is limited.

The Early Intervention Foundation has also reviewed the evidence for interventions for victims and perpetrators, with broadly similar conclusions, i.e. that there has not been sufficient evaluation of most current interventions to draw conclusions about their effectiveness. The exception for this was in terms of perpetrator programmes to reduce recidivism, which have not demonstrated significantly improved outcomes, although there is good evidence for the need for personalised rather than generic approaches. Given this, they recommend a greater focus on preventive work while programmes are developed further and evaluated more robustly. [128]

Despite the lack of evidence, some innovative approaches appear to offer promise for preventing DA. Such prevention and early intervention provides an important opportunity to reduce some of the long-term consequences of such abuse and to deliver long-term savings. These include approaches in schools to develop a zero tolerance approach to domestic violence and abuse, prevention through augmentations to parenting programmes and through support to the quality of parenting relationships. The evidence base for these interventions still needs further research.

## 8. Limitations of the HNA

There are several limitations to this work; firstly there is a lack of available data to fully assess the number of people at risk of DA and SV and it is difficult to assess the population need for services. This is compounded by a lack of collated data on demand for all services, which may reflect the multiple providers and fragmented nature of services in Derby and Derbyshire. Therefore understanding normative need in this population is difficult.

This work is also limited by the nature of data collection. Stakeholders from various commissioner and provider organisations provided information. However these data sources are open to bias as independent service providers have an incentive to promote their own services.

Due to time constraints and the sensitivities around dealing with people who have previously been victims of DA and SV this work did not seek the direct views of service users.

# 9. Conclusions and recommendations

It is impossible to accurately measure the incidence of DA or SV. Crime statistics and surveys suggest that we are living in an increasingly safer society where crime is falling, but DA and SV are increasing. This is reflected in data from specialist services that have seen an increase in demand for services.

In reality these data are likely to represent the tip of the iceberg, the worst cases that come to light or where someone has the opportunity to disclose abuse in a trusted environment. Both DA and SV are more common than is perceived in broader society. Cultural barriers, such as accepting some levels of abuse, or fear of the stigma or practical consequences of disclosing abuse, mean that many people are living with abuse on a regular basis.

The wider evidence base shows that there is a range of factors that may work alone or together to increase the risk of DA or SV. This information can be used to target prevention efforts and plan services. However we may be missing important risk factors as this work is based only on people who disclose abuse.

When people disclose abuse to the police or another service there are a range of specialist services that support people and help them overcome problems associated with DA or SV. The current range of specialist DA services are provided by a range of third sector organisations. There is a perception that the system is currently working well and is able to help DA victims from around Derby and Derbyshire using a person centred approach based on their risk of DA. Services for SV are more specialised with a single provider and location serving Derby and Derbyshire.

It is apparent that demand is increasing for these services and current funding may not be sufficient to meet this demand. There are also specific areas such as medium risk DA services in Derby and culturally appropriate approaches for BME and LGBT groups that require further development.

There appear to be good links between the criminal justice system and specialist DA and SV services, and some areas have linked with local GP practices as shown through referral data. However on the whole, the links between the health system and specialist services need to be strengthened. This agenda has historically been seen as criminal justice and social problem, however there is a large amount of evidence that shows clear links between abuse and long term health problems; for example, abuse is the leading burden of ill health in younger women, and victims and perpetrators of violence are much more likely than the general population to have severe mental illness.

Many health services lack clear DA and SV pathways and these problems are under-detected in primary and secondary care, partially due to a lack of training among professionals.

The health burden of abuse is not only carried by direct victims , but also by people who witness or live in the households where DA or SV occur. The impact on children can be life-long, with reduced quality of life and poorer health; for example, more than a quarter of the burden of adult psychiatric disorders is attributable to the effect of experiencing childhood violence or abuse.

Taken with the wider evidence which shows reductions in life expectancy for both victims and children of victims there is a clear need to alter the perspective of DA and SV as a criminal, social and safeguarding issue. Abuse needs to be seen as a key health burden that affects a significant number of people in the wider population. Work must be done to ensure that more victims of abuse have

trust in the services available and are not afraid to disclose abuse. More prevention work is required to change cultural attitudes of the general public and workforce development is required to raise professional awareness of DA and SV to ensure that when people need help it is available.

## 9.1. Recommendations

In order to meet the needs of the population resulting from DA and SV the following recommendations are made:

**Policy and strategy**

Ensure that development of the new county-wide strategy for domestic violence and sexual abuse takes into account the findings regarding unmet needs in Derby and Derbyshire.

**Prevention**

1. Workforce development should be undertaken with statutory and health organisations to increase awareness of domestic abuse and sexual violence, to reduce stigma and challenge stereotypes
2. Preventative work in schools should continue and should use evidence based interventions to raise awareness of and change attitudes to abuse
3. Increased levels of preventive work should be undertaken to support national information campaigns. This work should be culturally sensitive to different population groups and may benefit from a social marketing approach.

**Provision**

4. Encourage commissioners of all public services to require providers to ensure front line staff are appropriately trained to identify and respond positively to domestic violence.
5. Encourage commissioners to require service providers to undertake an equality impact assessment to ensure that commissioned services are responsive to the needs of all victims, including those from minority groups (e.g. male, LGBT and BME victims).
6. Encourage commissioners to require that all providers, including health and social care providers, carry out baseline assessments to evaluate whether practice is in line with the NICE guidance. Guidelines and assessment tools are available at www.nice.org.uk/guidance/ph50
7. Develop a care pathway to ensure all organisations are able to respond positively to disclosure of domestic violence and signpost to appropriate services
8. Review commissioning and service provision around emotional support for children living with domestic violence, to build their resilience and mitigate impact on future health and wellbeing.

**Recovery**

9. Work should be undertaken to understand whether a treatment or recovery model is best suited to people suffering or witnessing abuse. This work should inform future commissioning and service outcomes

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# 11. Appendices

## Appendix 1: Methods

### Model of HNA

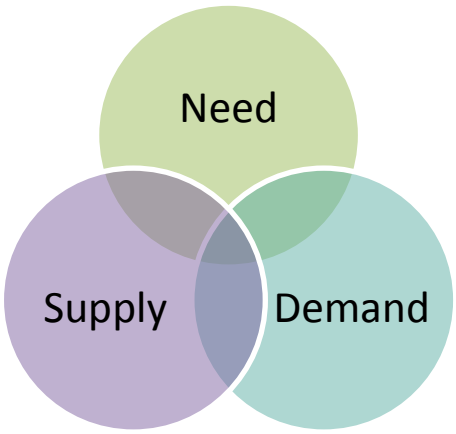
This rapid HNA used a combined approach, as described by Stevens and Raftery, which has three main elements:

- Epidemiological. This approach considers the epidemiology of the condition, current service provision, and the effectiveness and cost-effectiveness of interventions and services.
- Comparative. This approach compares service provision between different populations. Large variations in service use may be influenced by a number of factors, and not just differing needs.
- Corporate. This approach is based on eliciting the views of stakeholders – these may include professionals, patients and service-users, the public and politicians – on what services are needed. Elements of the corporate approach (i.e. community engagement and user involvement) are important in informing local policy.

The epidemiology of DA and SV were considered along with current service provision, and the evidence for effectiveness and cost-effectiveness of services. In addition, views were gathered from as wide a range of stakeholders as was possible in the time allotted. Unfortunately, due to the time constraints and the particularly sensitive nature of the topic, it was not possible to collect views from service users.

When undertaking HNA it is important to consider both individual and population needs, to ensure a top down approach to service design is not enforced. This is generally achieved through inclusion of the views of service users and their representatives; in this case by talking to people who work directly with service users. Therefore need is best thought of the capacity to benefit from effective services[129] rather than a need for health, which is broader and can include problems for which there is no known treatment. This is in contrast with demand (what patients ask for) and supply (what is provided). Figure 1 demonstrates how these interact, with the central area showing the ideal relation.

**Figure 24: relation between need, supply and demand.**



Health needs incorporate both needs directly related to healthcare, as well as the wider social and environmental determinants of health. This is particularly pertinent for the subject matter of this HNA. The needs were assessed using Bradshaw's taxonomy of need.

**Table 4 Bradshaw's taxonomy of need** [130]

| Type of need | Definition | How the need will be assessed |
|---|---|---|
| Normative need | Need that is defined by experts. Normative needs are not absolute and there may be different standards laid down by different experts. | Evidence review |
| Felt need | Need perceived by an individual. Felt needs are limited by individual perceptions and knowledge of services. | Interviews with / survey of service providers. |
| Expressed need | Felt needs turned in to action. Help seeking (demand for services). | Review of service use |
| Comparative need | Individuals with similar characteristics to those receiving help. | Consideration of the equity of distribution of services |

**Literature reviews**

Two literature reviews were undertaken, the first looked at evidence of risk factors for abuse occurring and what factors mean abuse is likely to be more harmful if it is taking place (or what factors amplify the effect of domestic abuse and sexual violence). This used the following questions:

a) What factors increase the risk of domestic abuse occurring?
b) What factors increase the risk of sexual violence occurring?
c) What factors lead to worse outcomes for the victims of domestic abuse (including their families)?
d) What factors lead to worse outcomes for the victims of sexual violence (including their families)?

The second review considered what evidence-based interventions exist to help prevent domestic abuse and sexual violence, and what interventions exist to help those who have been subjected to abuse (including their families and children). The following questions were developed:

a) What evidence-based interventions exist to prevent domestic abuse?
b) What evidence-based interventions exist to prevent sexual violence?
c) What evidence-based interventions exist to treat victims of domestic abuse (including families and children)?

d) What evidence-based interventions exist to treat victims of sexual violence (including families and children)?
e) What evidence-based interventions exist to treat perpetrators of domestic abuse?
f) What evidence-based interventions exist to treat perpetrators of sexual violence?

Inclusion criteria focused on English language reports of research carried out in OECD countries since 2000 with studies including trials and randomised control trials, evaluations, observational studies, reviews, and systematic reviews (with or without meta-analysis) and economic evaluations. Searches were carried out by the Public Health Knowledge Services Team in Derbyshire County Council in August 2014 using a range of data bases such as Medline, EMBASE, CINAHL, PsycINFO, AMED, NHS Evidence, NICE and Google (for evaluations/reports published by Government/Council/health bodies).

**Epidemiological and service data analysis**

Evidence reviews revealed a number of DA and SV national data sources and local data was also collected from commissioners and providers of services. This data was used to better understand the prevalence and incidence of DA and SV and to understand the demand for current services. Descriptive analyses were performed using MS Excel.

Statistical association was assessed using 95% confidence intervals. Where statistical comparisons are made statistically significant difference is defined as non-overlapping 95% confidence intervals calculated around point estimates. This equates to 95% confidence that any observed difference was not due to chance alone.

It should be noted that a statistically significant finding does not account for any systematic errors or biases in each analysis or the effects of confounding factors such as age or sex.

**Qualitative work**

A number of key stakeholders were interviewed using a semi structured interview technique. Questions were developed through the interviews as key themes developed and were based around:

- Current organisation systems and structures
- Vertical and horizontal lines of communication in these structures
- Current funding
- Local populations and specific needs
- Minority and high risk groups (LGBT, BME, Elderly, new migrants, sex workers, substance users)
- Local services and gaps in services
- Demand for services, including reasons for change and perceptions of future demand
- What works well in Derby and Derbyshire and what needs improving

Representatives of the following were interviewed in person

- Derbyshire County Council Commissioning Leads
- Derby City Council Commissioning Leads

- DSAAG chairs from all areas
- IDVA managers for Derby and Derbyshire
- Derbyshire Domestic Violence and Sexual Abuse Service
- Supporting Victims of sexual Violence (SV2)
- High Peak Women's Aid (phone interview)

Where possible interviews were carried out by two people with one recording information and a basic thematic analysis was conducted with themes emerging between interviews. Both interviewers felt that saturation of issues had been reached by the end of the interview process.

A stakeholder questionnaire was developed and piloted. This was circulated to all Medium and High Risk DA services commissioned by Derby and Derbyshire Councils, Victim Support who provide low risk services, SV2 who provide sexual violence services and various other third sector organisations identified by DSAAG Chairs. The full questionnaire is available in the appendices.

**Discussion and gap analysis**

A synthesis of all available data sources, including information from the evidence base and local stakeholder feedback was used to assess the normative and to some extent felt need of victims and those at risk of DA and SV in Derby and Derbyshire.

Routinely collected activity data and stakeholder feedback was used to develop a picture of services in Derby and Derbyshire and how they work together to meet the needs of victims. Residual needs were assessed by combining these data sources and identifying gaps in service. The gap analysis also used qualitative stakeholder information.

## Appendix 2: Indices of Multiple Deprivation [131]

The Indices of Multiple Deprivation (IMD) uses 38 indicators arranged in several domains to understand the impact of a variety of factors on the population within an area. This then allows areas to be ranked, taking account of the following (listed according to the weighting given in the indices):

- Income Deprivation
- Employment Deprivation
- Health Deprivation and Disability
- Education, Skills and Training Deprivation
- Barriers to Housing and Services
- Crime
- Living Environment Deprivation

## Appendix 3: CDC Definitions of Adverse Childhood Experiences

The following categories all occurred in the participant's first 18 years of life.

**Emotional Abuse.** Often or very often a parent or other adult in the household swore at you, insulted you, or put you down and sometimes, often or very often acted in a way that made you think that you might be physically hurt.

**Physical Abuse.** Sometimes, often, or very often pushed, grabbed, slapped, or had something thrown at you or ever hit you so hard that you had marks or were injured.

**Sexual Abuse.** An adult or person at least 5 years older ever touched or fondled you in a sexual way, or had you touch their body in a sexual way, or attempted oral, anal, or vaginal intercourse with you or actually had oral, anal, or vaginal intercourse with you.

**Emotional Neglect.** Respondents were asked whether their family made them feel special, loved, and if their family was a source of strength, support, and protection. Emotional neglect was defined using scale scores that represent moderate to extreme exposure on the Emotional Neglect subscale of the Childhood Trauma Questionnaire (CTQ) short form.

**Physical Neglect.** Respondents were asked whether there was enough to eat, if their parents drinking interfered with their care, if they ever wore dirty clothes, and if there was someone to take them to the doctor. Physical neglect was defined using scale scores that represent moderate to extreme exposure on the Physical Neglect subscale of the Childhood Trauma Questionnaire (CTQ) short form constituted physical neglect. Collected during the second survey wave only (N=8,667).

Household Dysfunction

**Mother Treated Violently.** Your mother or stepmother was sometimes, often, or very often pushed, grabbed, slapped, or had something thrown at her and/or sometimes often, or very often kicked, bitten, hit with a fist, or hit with something hard, or ever repeatedly hit over at least a few minutes or ever threatened or hurt by a knife or gun.

**Household Substance Abuse.** Lived with anyone who was a problem drinker or alcoholic or lived with anyone who used street drugs.

**Household Mental Illness.** A household member was depressed or mentally ill or a household member attempted suicide.

**Parental Separation or Divorce.** Parents were ever separated or divorced.

**Incarcerated Household Member.** A household member went to prison.

## Appendix 4 CAADA DASH checklist

**Name of victim:** **Date:** **Restricted when completed**

**CAADA-DASH Risk Identification Checklist for use by IDVAs and other non-police agencies[3] for identification of risks when domestic abuse, 'honour'-based violence and/or stalking are disclosed**

| Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned.<br>Tick the box if the factor is present ☑. Please use the comment box at the end of the form to expand on any answer.<br>It is assumed that your main source of information is the victim. If this is not the case please indicate in the right hand column | Yes (tick) | No | Don't Know | State source of info if not the victim e.g. police officer |
|---|---|---|---|---|
| 1. Has the current incident resulted in injury?<br>(Please state what and whether this is the first injury.) | ☐ | ☐ | ☐ | |
| 2. Are you very frightened?<br>Comment: | ☐ | ☐ | ☐ | |
| 3. What are you afraid of? Is it further injury or violence? (Please give an indication of what you think (name of abuser(s)...) might do and to whom, including children).<br>Comment: | ☐ | ☐ | ☐ | |
| 4. Do you feel isolated from family/friends i.e. does (name of abuser(s) .....) try to stop you from seeing friends/family/doctor or others?<br>Comment: | ☐ | ☐ | ☐ | |
| 5. Are you feeling depressed or having suicidal thoughts? | ☐ | ☐ | ☐ | |
| 6. Have you separated or tried to separate from (name of abuser(s)....) within the past year? | ☐ | ☐ | ☐ | |
| 7. Is there conflict over child contact? | ☐ | ☐ | ☐ | |
| 8. Does (.....) constantly text, call, contact, follow, stalk or harass you? (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.) | ☐ | ☐ | ☐ | |
| 9. Are you pregnant or have you recently had a baby (within the last 18 months)? | ☐ | ☐ | ☐ | |
| 10. Is the abuse happening more often? | ☐ | ☐ | ☐ | |
| 11. Is the abuse getting worse? | ☐ | ☐ | ☐ | |
| 12. Does (.....) try to control everything you do and/or are they excessively jealous? (In terms of relationships, who you see, being 'policed at home', telling you what to wear for example. Consider 'honour'-based violence and specify behaviour.) | ☐ | ☐ | ☐ | |

[3] Note: This checklist is consistent with the ACPO endorsed risk assessment model DASH 2009 for the police service.



2

**Name of victim:** **Date:** **Restricted when completed**

| Tick box if factor is present. Please use the comment box at the end of the form to expand on any answer. | Yes (tick) | No | Don't Know | State source of info if not the victim |
|---|---|---|---|---|
| 13. Has (.....) ever used weapons or objects to hurt you? | ☐ | ☐ | ☐ | |
| 14. Has (.....) ever threatened to kill you or someone else and you believed them? (If yes, tick who.)<br>You ☐ Children ☐ Other (please specify) ☐ | ☐ | ☐ | ☐ | |
| 15. Has (.....) ever attempted to strangle/choke/suffocate/drown you? | ☐ | ☐ | ☐ | |
| 16. Does (.....) do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? (If someone else, specify who.) | ☐ | ☐ | ☐ | |
| 17. Is there any other person who has threatened you or who you are afraid of? (If yes, please specify whom and why. Consider extended family if HBV.) | ☐ | ☐ | ☐ | |
| 18. Do you know if (.....) has hurt anyone else? (Please specify whom including the children, siblings or elderly relatives. Consider HBV.)<br>Children ☐ Another family member ☐<br>Someone from a previous relationship ☐ Other (please specify) ☐ | ☐ | ☐ | ☐ | |
| 19. Has (.....) ever mistreated an animal or the family pet? | ☐ | ☐ | ☐ | |
| 20. Are there any financial issues? For example, are you dependent on (.....) for money/have they recently lost their job/other financial issues? | ☐ | ☐ | ☐ | |
| 21. Has (.....) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? (If yes, please specify which and give relevant details if known.)<br>Drugs ☐ Alcohol ☐ Mental Health ☐ | ☐ | ☐ | ☐ | |
| 22. Has (.....) ever threatened or attempted suicide? | ☐ | ☐ | ☐ | |
| 23. Has (.....) ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? (You may wish to consider this in relation to an ex-partner of the perpetrator if relevant.)<br>Bail conditions ☐ Non Molestation/Occupation Order ☐<br>Child Contact arrangements ☐ Forced Marriage Protection Order ☐<br>Other ☐ | ☐ | ☐ | ☐ | |
| 24. Do you know if (.....) has ever been in trouble with the police or has a criminal history? (If yes, please specify.)<br>DV ☐ Sexual violence ☐ Other violence ☐ Other ☐ | ☐ | ☐ | ☐ | |
| Total 'yes' responses | | | | |



3

**Name of victim:** **Date:** **Restricted when completed**

| |
|---|
| **For consideration by professional:** Is there any other relevant information (from victim or professional) which may increase risk levels? Consider victim's situation in relation to disability, substance misuse, mental health issues, cultural/language barriers, 'honour'- based systems, geographic isolation and minimisation. Are they willing to engage with your service? Describe:<br><br>Consider abuser's occupation/interests - could this give them unique access to weapons? Describe: |
| What are the victim's greatest priorities to address their safety? |
| **Do you believe that there are reasonable grounds for referring this case to MARAC? Yes / No**<br>If yes, have you made a referral? Yes/No<br><br>**Signed:** **Date:** |
| **Do you believe that there are risks facing the children in the family? Yes / No**<br>If yes, please confirm if you have made a referral to safeguard the children: Yes / No<br>Date referral made ..... |

| | |
|---|---|
| **Signed:**<br><br>**Name:** | **Date:** |

Practitioner's Notes

| |
|---|
| |

[i] This checklist reflects work undertaken by CAADA in partnership with Laura Richards, Consultant Violence Adviser to ACPO. We would like to thank Advance, Blackburn with Darwen Women's Aid and Berkshire East Family Safety Unit and all the partners of the Blackpool MARAC for their contribution in piloting the revised checklist without which we could not have amended the original CAADA risk identification checklist. We are very grateful to Elizabeth Hall of Cafcass and Neil Blacklock of Respect for their advice and encouragement and for the expert input we received from Jan Pickles, Dr Amanda Robinson and Jasvinder Sanghera.

## Appendix 5 Survey results

As part of the HNA, opinions and information were sought from a number of stakeholders, including healthcare commissioners and providers and specialist DA/SV providers.

The following themes frequently surfaced in stakeholder responses:

- Healthcare view of DA/SV
    - DA/SV viewed as safeguarding issue by healthcare professionals and providers
    - Uncertainty about referral pathways among primary and secondary healthcare professionals
    - Training around DA/SV for healthcare professionals often as small part of safeguarding training
    - Lack of DA/SV trigger question that can be used by professionals to invite disclosure
    - Confusion among healthcare professionals about 'capacity' – feeling that there is nothing they can do/offer if someone chooses not to leave an abusive relationship / does not want to pursue criminal justice routes
    - Lack of knowledge/awareness about services available amongst professionals and public
- Service provision
    - Poor integration/excessive complexity of service provision and funding
    - Lack of places to refer perpetrators
    - 'On the whole I think that Derbyshire are one of the better areas. However I feel any more cuts will put us at breaking point'.
    - Difficulties linking in to on-going healthcare support, particularly mental health
- Barriers to accessing services:
    - Lack of / difficulty of accessing interpreter services for people affected by DA/SV who do not speak English