ISLINGTON

Chief Executive Department
Town Hall, Upper Street, London N1 2UD

Report of: Community Safety Partnership

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	3 July 2013		All

SUBJECT: Domestic Violence

1 Synopsis

1.1 The purpose of this report is to provide an overview of domestic violence and abuse in Islington and role of Health in tackling domestic violence and abuse.

1.2 Domestic violence (also known as intimate partner violence) is a major public health problem. Domestic violence is responsible for more ill health and premature death among women under age of 45 than other risk factors such as high blood pressure, obesity and smoking. Its effects extend beyond the many physical, psychological and chromic health problems that affect an individual.

1.3 Domestic violence and abuse is closely associated with child abuse and neglect, as well as a range of other issues including homelessness and substance misuse. Furthermore, it impacts on employers and the local economy by limiting a victim's ability to access education, training and employment and decreases the productivity of employees.

1.4 The World Health Authority identified a strong association between gender inequality and gender based violence and mental, physical and health problems; and that gender inequality exacerbates the harmful effects that violence has on a women's health (WHO 2009, Gender Strategy).

1.5 Domestic violence has always been a challenging area for commissioners to address and it affects many different policy agendas and requires the cooperation of multiple agencies to resolve.

1.6 The Department of Health has identified closer collaboration between Community Safety Partnerships and Health providers to improve violence prevention and that violence prevention is a critical element in tackling other public health issues (DH Protecting people Promoting health: A public health approach to violence prevention for England, 2012)

2 Recommendations

2.1 Ensure domestic and sexual violence is a named priority on Health and Wellbeing Board Strategy and the JSNA.

2.2 Health services to implement the findings of Islington's domestic homicide review.

2.3 Health agencies sign up to Islington's MARAC Operating Protocol.

2.4 Health departments ensure that clinical services are aware of their roles in preventing, identifying and recording violence.

2.5 That all forms of domestic and sexual violence be included in outcomes and performance monitoring (e.g. MARAC).

2.6 Use of routine enquiry to establish whether domestic or sexual has occurred.

2.7 Health professionals trained on identification and referral processes and on how to talk to patients about domestic and sexual violence.

2.8 Ensure that young victims and victims linked to gang associated domestic violence are recognised when they present in health agencies (i.e. sexual health)

2.9 Engagement through common assessment framework for children to identify domestic violence as a risk factor.

2.10 Recognise the link between high risk domestic violence and substance use and mainstream the response to domestic violence in substance use treatment services.

2.11 To consider locating additional resources in Health settings: to include advocacy support in A&E and maternity units and the Identification and Referral to improve Safety (IRIS) across GP services to create a platform of provision. This additional provision would tackle the health Inequalities associated with domestic violence and start to address the abuse experienced by victims who are currently hidden from the criminal justice system and receive no support.

3 Background

3.1 Definition

The revised definition of domestic violence and abuse came into effect on 1st April 2013 and states:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

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

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

* This definition, which is not a legal definition, includes so called 'honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

3.2. Local and national data highlights that the majority of victims are women aged 21 to 40 with young children; on average these victims live with abuse for five years before finding effective help. Three quarters of victims experience multiple types of abuse and 70% experience at least one form of severe abuse such as strangulation, rape or threats to kill. Domestic violence is underpinned by coercive control, and this is evidenced by the 79% of victims who experience jealous and controlling behaviour (CAADA Insights: A Place of Greater Safety, 2012).

4 The Level of DV in Islington

4.1 During 2012/2013, there were 3,852 reports of domestic violence to Islington Police. Although this represented a 2% decrease in numbers of incidents reported over the past three years, the total number of offences (13.4%) and VWI offences (14%) increased over the same period. Repeat victimisation accounted for 39% of all incidents compared with 25% with 61% of reports were first time reports to Police compared with the previous year.

4.2 It is widely accepted that the numbers of police reports do not reflect the true extent of the problem. An analysis of ten domestic violence prevalence studies by the Council of Europe in 2002 concluded that one in ten women are affected by domestic abuse at any give time.

4.3 During 2012/13, Islington’s Multi Agency Risk Assessment Conference (MARAC) heard 196 cases of high risk victims which involved 238 children. (For a full performance break down and CAADA recommendations see *Appendix C).*

4.4 **MARAC Engagement**: Although there is good agency representation at MARAC, data highlights that there are key gaps in agency referrals with several agencies not routinely identifying high risk victims. During 2012-13, there were no referrals were received from Adult Services, Health, Housing or Probation (See full break down of referrals *Appendix D).*

4.5 Domestic violence is a significant child protection issue and, during 2011-2012, 39% (124 out of 320) cases were because of domestic violence. Comparative information for 2012- 2013 is not yet available. Of the cases heard during March 2013, domestic violence was a contributing factor in 33%.

4.6 Antecedent research on young people involved in murders in Islington as well as the young people known to Bronze list indicates that a significant proportion of young people involved in gangs and serious youth violence have been affected by domestic violence in their childhood.

4.7 **Health:** A sample of data from the Whittington hospital A & E from 2010, showed that of the 870 victims of domestic violence who accessed the Victims of Violence Pilot, 53% (459) arrived by ambulance, 40% (348) were categorised as urgent and 2% (21) as very urgent, 39% (339) were categorised as assault with another 38% (332) as head/face injuries.

4.8 Data available from the African Women's Clinic based at the Whittington, which provides medical interventions to women who have undergone Female Genital Mutilation (ante – natal, midwifery and de-infibulation) shows a year on year increase in the numbers of women accessing the service.

4.9 In Islington, treatment services confirm that up to 80% of service users have experienced domestic violence.

5 Islington's approach to tackling domestic violence

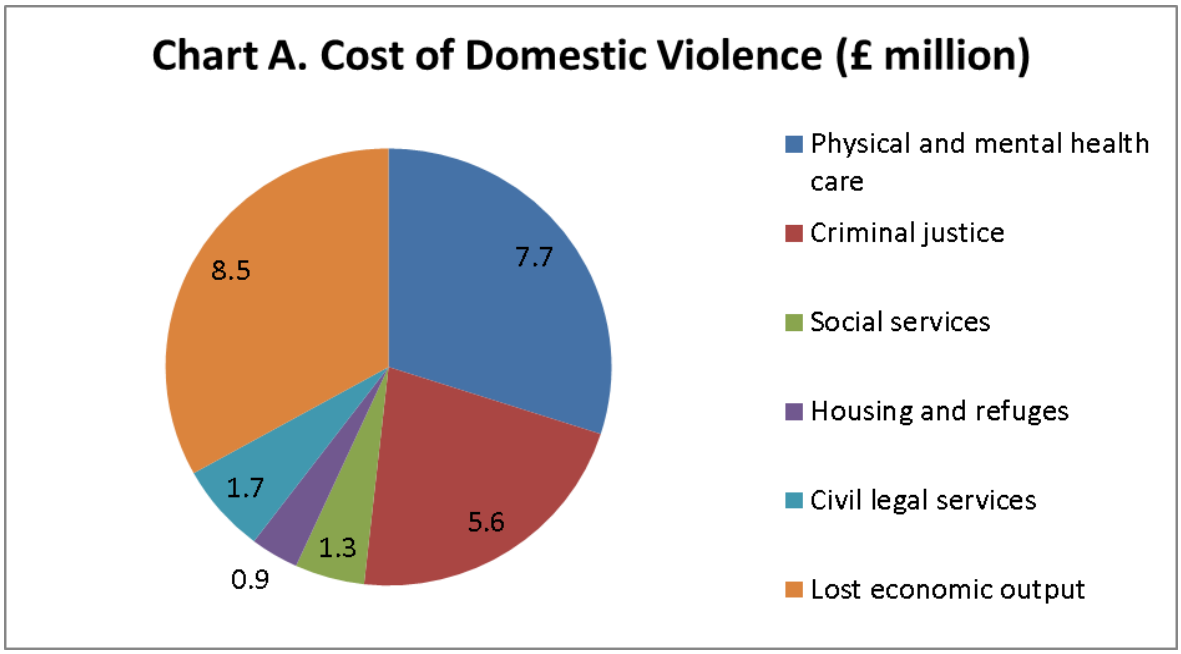
5.1 The overarching objective of Islington's Violence Against Women and Girls' (VAWG) Strategy, 2011-2015, which was signed off by the Safer Islington Partnership in November 2011 is to reduce the impact of all forms of VAWG on Islington residents. The partnership aims to achieve this through an integrated approach of prevention; provision and protection (see *Appendices B and E for detail on the co-ordinated response to domestic violence)*.

5.2 Legislation provides a framework with obligations, through Community Safety Partnerships and set up by the Crime and Disorder Act 1998, for public bodies to work together to reduce violent crime including domestic violence. This also gives a legal framework for information sharing to protect and prosecute in domestic violence and abuse cases. The Community Safety Partnership co-ordiantes the response to domestic violence and delivery of the strategy via relevant working groups.

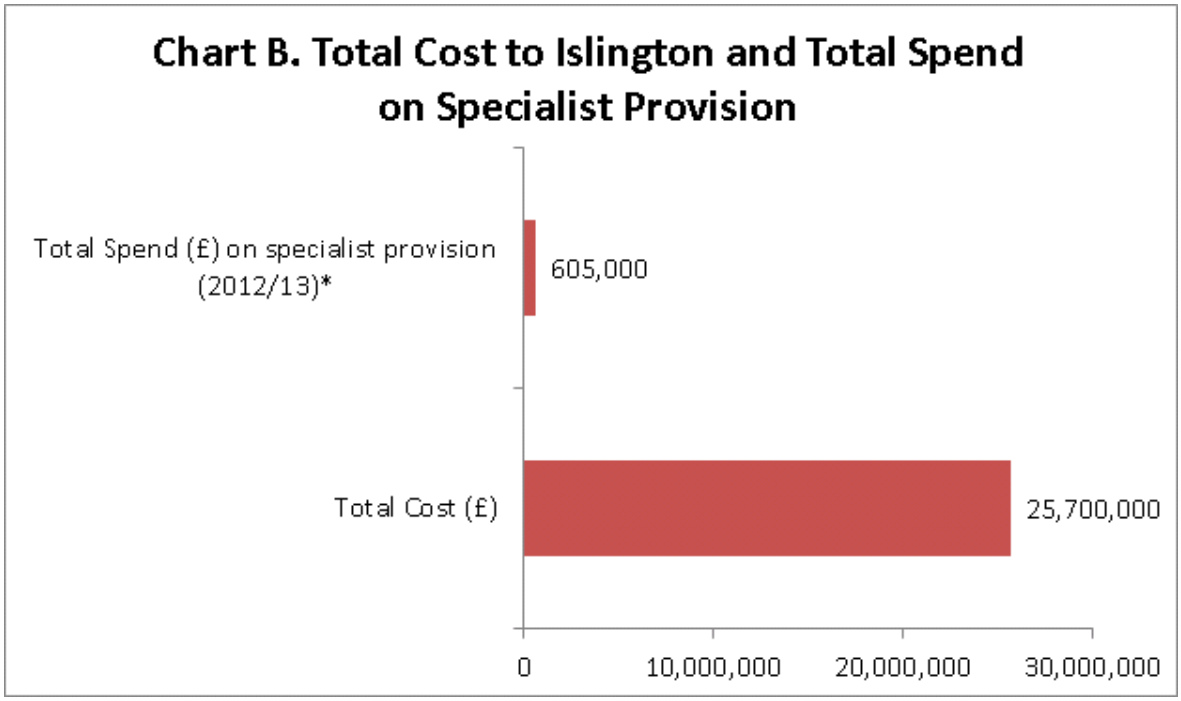
6 The Cost of Domestic Violence to Islington

6.1 The estimated cost of domestic violence to the borough is £25.7 million per year, with Health having the highest costs per service at £7.7 million. In terms of sexual violence, there is an overall cost of £76,000 for each rape that results in full multi agency response.[1] The reliable research on the costs of domestic violence (Professor Sylvia Walby, 2009) calculated an estimated cost for each local authority area, based on the size of the 16- 59 year old population (this is the age range that is targeted in the British Crime Survey, from which national estimates of domestic violence prevalence are obtained). It uses the Office of National Statistics 2009 mid year population estimates.

[1] Produced by Trust for London and the Henry Smith Charity from the Professor Sylvia Walby, (2009) update of her earlier work for government (2004) Calculating the cost of domestic violence".



6.2 The level of investment into VAWG prevention, early intervention and into the provision of specialist VAWG services locally is relatively low compared to the cost of dealing with its aftermath. The majority of investment into dedicated services comes from Supporting People and Community Safety Partnership funding. Conversely, money is spent across universal and mainstream services on crisis intervention and responding to cases deemed to be "high risk" with limited investment into early intervention, prevention and work with perpetrators.



7 Health and tackling domestic violence and abuse

7.1. The Royal College of General Practitioners has made domestic violence a strategic priority and produced guidelines for GP's practices in association with CAADA and IRIS. In addition, the National Institute of Clinical Excellence is also producing guidelines for domestic abuse and these will be published in February 2014.

7.2. Health's role in tackling domestic and sexual violence is to recognise the need and risk for victims and perpetrators, signpost to support and safety, address health issues, protect children and mitigate impact. Improving the quality of care for victims of domestic violence requires more than ensuring they get effective and timely clinical treatment.

7.3. Evidence shows that victims identified thorough health agencies are more likely to reflect vulnerable, hard to reach groups. These include pregnant victims, those still living with the perpetrator, the young, those with mental health and substance use issues, and victims from black and minority ethnic communities (*CAADA: Insights to a place of greater safety, 2012)*

7.4. Evidence also suggests that those victims who are identified through health professionals and referred to support from a domestic violence specialist also experience a shorter length of abuse than those who are identified by the criminal justice system or who self refer*.*

7.5. **Implications of earlier Intervention:** Domestic violence is a common problem that is almost invisible in primary healthcare. Only around 15% of women with a history of domestic violence have any reference to domestic violence in their medical record in primary care. NHS services work with significant number of people affected by domestic violence who present with physical and mental health problems attributable to violence, often over a sustained period, without ever being asked the cause. In this regard, the IRIS problem enables primary care professionals to not only treat the immediate health needs of the women in front of them but also to refer them to recognised experts, on the basis that this can have a lasting and transformative effect on that persons life as well as reduce repeat presentations in Health services (*The Health Foundation. Improvement in Practice: The IRIS Case Study, 2011*).

7.6. **Reaching victims earlier:** National data shows that 39% of hospital clients/victims are still living with their abuser, compared to only 26% of non-hospital clients/victims. Some 54% of hospital clients/victims are still in the intimate relationship compared to 33 % of non –hospital clients accessing dv support services. Health services may therefore, be the best opportunity for identifying victims early. Maternity health services are a key point of identification and engagement for pregnant victims.

7.7. **Identifying perpetrators:** The co- existence of substance misuse and mental health is a key risk factor in relation to serious harm in domestic violence. Mental Health and substance use treatment services are well placed to identify victims and perpetrators.

8 Support for victims of domestic violence and abuse

8.1. Over the last seven years, services for victims of domestic abuse have been transformed. At the centre of this change is a national model which prioritises victims at high risk of harm or murder. The model depends upon specialist support from trained advisors called Independent Domestic violence Advisors (IDVA). IDVAs are independent and provide emotional and practical support.. They engage with adult victims from the point of crisis and mobilise the resources of other agencies to keep the victim and children safe. The effective co-ordination of other public services now happens through the work of Multi – agency Risk Assessment Conferences (MARAC).

8.2. The importance of specialist services cannot be overstated. Many agencies can give advice on debt, benefits which domestic violence clients can utilise. What distinguish the specialist services is their understanding of risk management, knowledge of civil and criminal justice systems and the dynamics of domestic violence and its risk, (risk encompassing risk of harm (physical/emotional), lethality and vulnerability of the victim). They also understand support needs identified around personal safety and home security, will link people into specific support services and understand that support needs vary between victims and different levels of risk. They are able to assess whether risk is low, medium or high and assess the nature of the abuse, the risk to victim and children, risk of homicide, pattern of assaults and coercive behaviour and the impact of the abuse on victim and children. As crisis recedes the level of support directly attributable to abuse reduces.

8.3. Victims of domestic violence often have multiple presenting needs. The table below highlights the complexity of victim needs.

The needs of the victims				
Advocacy	Housing Advice	Immigration	Referral to legal advice	Support Group
Counselling	Homeless application	Injunction	Rape Crisis	Support at Court
Divorce	Housing Transfer	MARAC	Safety Planning	Welfare benefits
Family Support	Information on options	Mental Health Referral	Safe child contacts advise	Urgent move to place of safety

8.4. Specialist services report the majority of victims require between 6 – 39 interventions to achieve safety. The higher levels of intervention are typical of high risk victims and those from BAMER groups or with complex needs.

8.5. National domestic violence service standards have been developed by Women's Aid in partnership with the Department for Communities and Local Government

and the Home Office, and followed extensive consultation. The national standards form part of a wider quality framework which include National Occupation Standards and a national accredited training programme that supports the implementation of both. Refuge and housing related support services, funded under the Supporting People programme, are also subject to the national Quality Assessment Framework.

8.6. The national standards have been developed in partnership with accompanying standards and accreditation systems for perpetrator programmes of women's safety work and accreditation systems for Independent Domestic Violence Advocates services, to ensure an integrated set of standards with core principles that reflect the needs and work of the whole sector.

9 Implications

9.1**. Financial implications**

The high cost of domestic violence to Islington Health is in estimated to be in the region of £7.7 million. Cost benefit analysis highlights that through investment in early intervention significant savings can be achieved. CAADA state that for every £1 spent on IDVA services £3.40 is saved, whilst investment in the Strength to Change perpetrator intervention by Hull NHS confirmed a £10 saving for every £1 investment. Similarly, the savings associated with the IRIS system are £37 for every women registered at GP's.

9.2. **Legal Implications**

None identified

9.3. **Equalities Impact Assessment**

Equalities Issues: There is a lack of identification of disabled, LGBT and male victims. This is evidenced across data sets including MARAC data. There is also the issue of victims with complex needs who may be affected by multiple forms of VAWG and include those with and BAMER victims, where the increased risks associated with access to services, immigration status and/or ability to communicate in English.

9.4**. Environmental Implications**

None identified

10 Conclusion and reasons for recommendations

10.1. Domestic violence is a high volume crime and is a significant factor in health inequality and health deprivation. Many victims of domestic violence present in health settings but not in the criminal justice system. Therefore, prevention work in health would reach a different group of victims to reduce repeat victimisation. In addition, domestic violence is extremely costly to health and there is a sound financial case for investment in prevention and early intervention. Locating resources in the health sector would enable early identification and intervention

and reduce the human and financial cost of domestic violence whilst improving health and well- being.

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Appendix A:

The National legislative framework for addressing Domestic Violence

The Domestic Violence Crime and Victims Act 2004 forms part of a wider framework of legislation applicable to victims of VAWG including, the Family Law Act 1996, the protection from Harassment Act and homeless legislation from 2002 onwards. The Act also introduced a range of measures including extending the scope of domestic violence legislation to include survivors within same sex relationships, cohabiting couples and those in intimate non-cohabiting relationships to apply for non-molestation orders, and introduced domestic violence homicides reviews as a means of learning from past cases to improve support for future survivors.

More recently, the Forced Marriage (Civil Protection) Act 2007 introduced civil measures to enable a person (who may be an adult or a chid) who is being forced into marriage, or a relevant third party, to apply to the court for a Forced Marriage Protection Order. The court can order the behaviour or conduct of those forcing the person into marriage to change or to stop or impose particular requirements on them.

All public bodies have statutory and legislative obligations under the Children's Acts 1989 and 2004 to safeguard children and young people, to embed safeguarding children into the daily functioning of their services and so to co-operate to provide protection for children and promote their welfare. The Adoption and Children Act 2002 also extended the legal definition of significant harm suffered by seeing or hearing ill treatment of others, especially in cases of domestic violence.

Appendix B:

Objectives and delivery Islington Violence against Women and Girls (VAWG) Strategy, 2011- 2015.

The overarching objective of Islington's VAWG Strategy is to reduce the impact of all the VAWG crime types on Islington residents. The partnership aims to achieve this through an integrated approach of prevention, provision and protection. This approach is outlined briefly below.

Prevention
Aim: To change attitudes and prevent violence

- Raising awareness with the general public to change attitudes and behaviour and reduce tolerance of VAWG
- Safeguarding and educating children and young people so they are protected from the impacts of violence and less likely to perpetuate a cycle of violence
- Early identification and intervention with potential victims and perpetrators to prevent violence from occurring

Provision
Aim: To assist victims get on with their lives.
Services are:

- Appropriate and responsive to the needs of the community
- Delivered by sensitive, well informed, well trained officers across the Partnership.
- Delivered by a partnership of agencies that share information efficiently and safely about individuals.
- Well supported, coordinated and monitored, continually considering and incorporating good practice from other areas.

Protection
Aim: To provide effective criminal justice system

- Perpetrators are apprehended and held to account for their behaviour.
- Victims in the criminal justice system are appropriately supported and protected from their abuser to give them the strength to report and pursue criminal convictions.
- All information and resources available across the partnership are used to identify and manage offenders/perpetrators to support them to change their behaviour and to protect potential victims.

Appendix C: Islington MARAC Performance Data 2012/13

Indicator (all figures relate to the 12 month period 1st April 2012 – 31st March 2013)	Islington	CAADA's recommendation[1]	Metropolitan Police	Most Similar Forces Group	National Data
Number of MARACs sending in data	1	-	28	56	266
1. Number of cases discussed	196	350	6,758	14,142	58,351
2. Cases per 10,000 of the adult female population[2]	22.1	40	23.2	23.9	24.9
3. Number of children	238	-	7,846	17,181	75,471
4. Referrals from partner agencies	80%	25-40%	67%	50%	39%
5. Referrals from Police (%)	20%	60-75%	33%	50%	61%
6. Repeat referrals (%)	11%	28-40%	21%	25%	24%
7. B & ME referrals (%)	32%	MARAC area B & ME population = 52%			
8. LGBT referrals (%)	<1%	5%	<1%	<1%	<1%
9. Referrals where the victim has a disability (%)	0%	5%	6%	4%	3.2%
10. Referrals with a male victim (%)	<1%	4-10%	4%	3%	4.0%

[1] If data was not submitted or was incomplete this quarter then the previous quarter's data has been used.
[2] For a full explanation of CAADAs recommendations and points to consider please see our website.

The following recommendations for IDVA and administration capacity have been calculated for your MARAC:

Indicator	To support the current number of cases	To support the recommended number of cases
Recommended number of FTE IDVA(s)	2.0	3.5
Recommended number of FTE administrator(s)	0.6	1.0

About this data. The number of cases per 10,000 of the adult female population figure is based on all referrals to the MARAC (including repeat incidents).

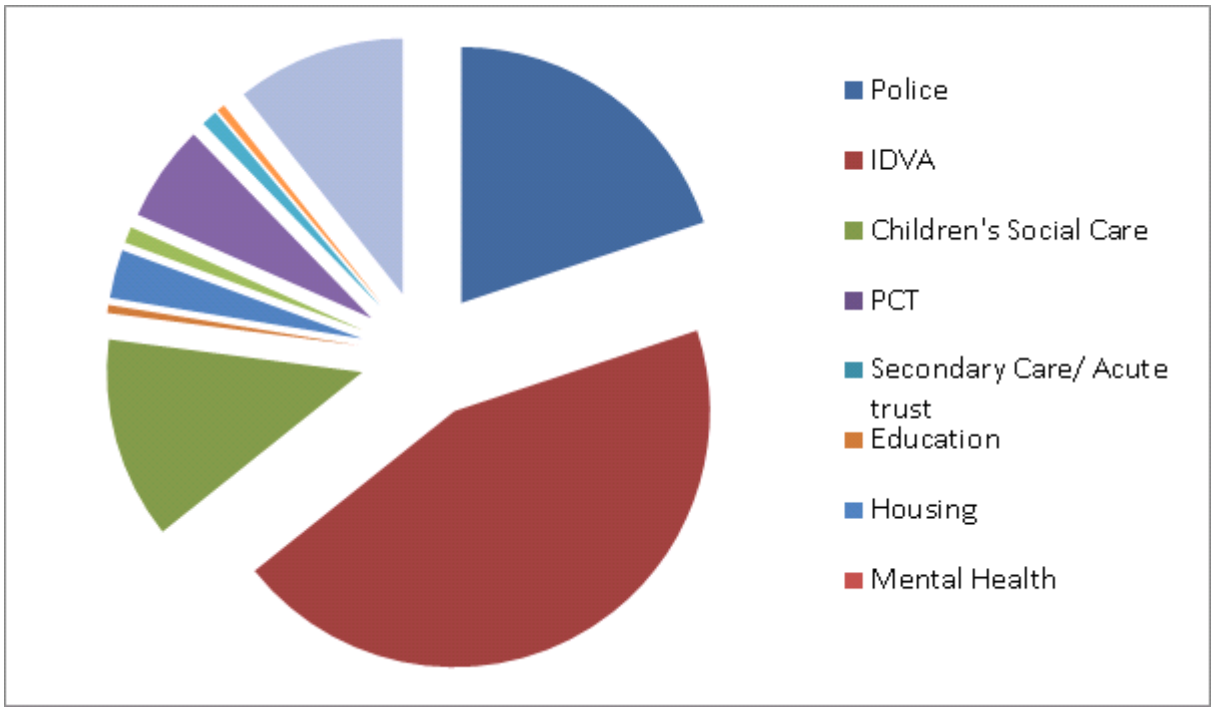
[1] For a full explanation of CAADAs recommendations and points to consider please see our website
[2]This figure has been updated with Census 2011 estimates for adult females aged 16+. If you have any questions on the population estimates used please get in touch via marac_data@caada.org.uk

Appendix D: Referral's to Islington MARAC (April 2012 to March 2013)

Totals for the last 12 months (April 2012 – March 2013)	
Total number of cases referred	196
Number of repeat cases	21
% repeats	11%
Number of children	238

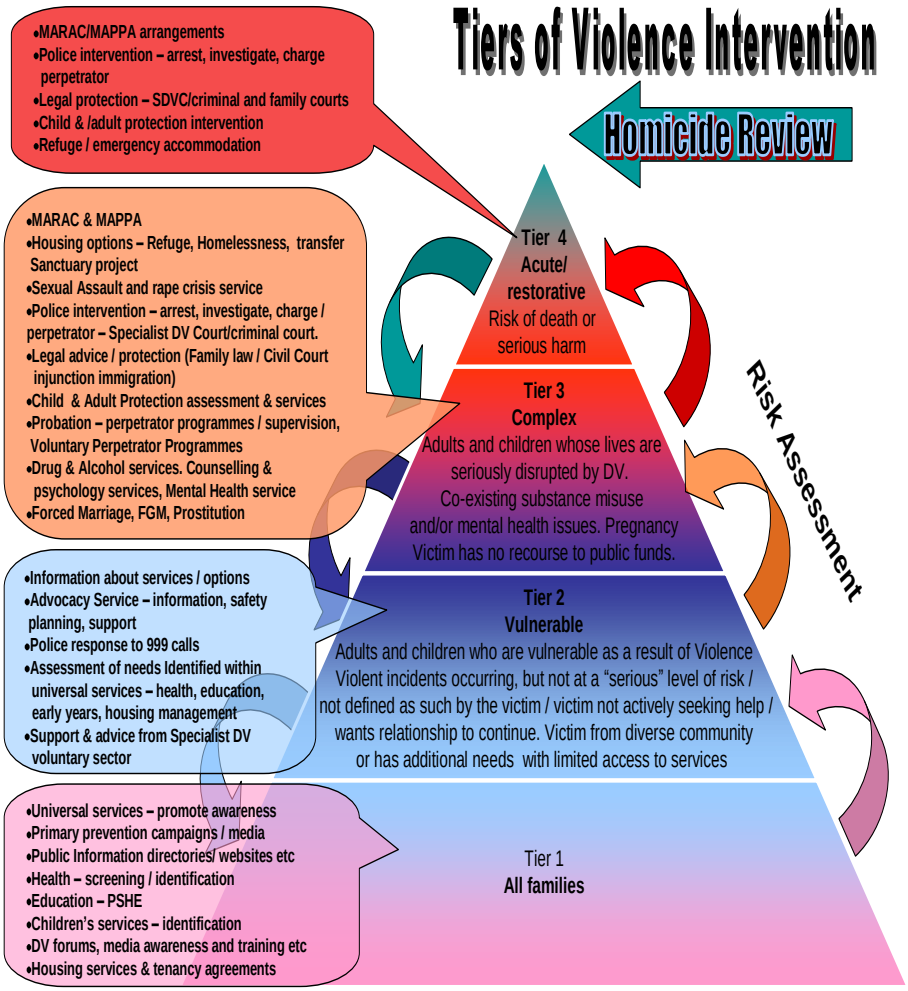
Equalities Profile	
Number of cases from black and minority ethnic community	62 (32%)
Number of LGBT cases	1 (0.5%)
Number of cases where victim has a registered disability	0 (0%)
Number of male victims	1 (0.5%)

Source of Referrals	
Police	39 (20%)
IDVA	87 (44%)
Children's Social Care	25 (13%)
PCT	0 (0%)
Secondary Care/Acute Trust	0 (0%)
Education	1 (0.5%)
Housing	6 (3%)
Mental Health	0 (0%)
Probation	2 (1%)
Voluntary Sector	12 (6%)
Substance Abuse	2 (1%)
Adult Social Care	1 (0.5%)
Other	21 (11%)



Appendix E: Local Service Model:

Coordinated community response and tiers of need and intervention



This model acknowledges that, while each agency maintains its independence, all agencies involved must work together in an integrated and coordinated way with each other to an increase the safety of domestic violence survivors and the children who live with domestic violence; systems for managing risk and for holding abusers accountable for their actions, which is the responsibility of service providers and the wider community, rather than the survivors; and effective prevention strategies. Responsibility for this coordination must ultimately rest with the Local Strategic Partnership.

An understanding of a tiered approach to intervention is central to good practice in service delivery and to the effectiveness of the CCR. The goal of interventions is to increase the safety and well-being of adult and child survivors and to hold perpetrators accountable for their abusive behaviour. The principle behind the tiers of intervention approach is that at each tier, survivors and perpetrators have access to all the services in the tiers below and additional services relevant to that tier, and that movement up and down the tiers are based on a risk and safety assessment, which recognises that risk is dynamic when dealing with domestic violence.

Tier 1: The first tier involves ensuring services are universal and that any person who enters a service will be directed appropriately if and when they disclose domestic violence, either as adult or child survivors or perpetrators.

Tier 2: The second tier involves working with adults, young people and children who are vulnerable as a result of domestic violence and their access to services should include the police, information and support from the specialist domestic violence services, and an assessment of their needs identified within universal services such as health, education, early years and housing services.

Tier 3: The third tier involves responding to adults and children whose lives have been seriously affected by domestic violence and may have more complex needs such as substance misuse or mental health. This is where integrated services are important such as the MARAC, Courts and perpetrator services. Survivors at this stage usually need considerable support from a variety of agencies which will need to be coordinated and reviewed to ensure their continued safety.

Tier 4: The fourth tier represents those cases with the highest risk, where the utmost care is needed to ensure that the serious risk of harm or of murder posed by the perpetrator is averted.

Statutory homicide reviews: Where multi agency working fails, or where victims may not have come into contact with any agencies, and homicide is the result, the statutory homicide review mechanism should be implemented in order to learn lessons from these reviews, which can in turn influence and further improve the response to domestic violence. This statutory provision came into place on 13th April 2011 and is the responsibility of the Community Safety Partnership.

Glossary

A& E	Accident and Emergency
BAMER	Black Asian Minority Ethnic Refugee
CCR	Co-ordinated Community Response
DHR	Domestic Homicide Review
DV	Domestic Violence
ED	Emergency Department
GP	General Practitioner
IDVA	Independent Domestic Violence Advocate
IRIS	Identification and Referral to Improve Safety
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LGBT	Lesbian, Gay, Bisexual, Transgender
MARAC	Multi Agency Risk Assessment Conference
NHS	National Health Service
VAWG	Violence Against Women and Girls
VWI	Violence With Injury