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Wiltshire Council

Review of Domestic Abuse and Sexual Violence Support Services

Rapid Research Review

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1 Introduction

This rapid research review is prepared by the Institute of Public Care (IPC) at Oxford Brookes University for Wiltshire Council to inform the overall review of local domestic abuse and sexual violence support services. Alongside the other elements of the service review, such as case file analysis and interviews with staff, stakeholders and service users the rapid research review will inform the final analysis of the findings and will be used as part of the basis for final recommendations.

The key areas of focus for the rapid research review are informed by themes articulated by stakeholders in the earlier stages of this project and includes the following key sections:

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2 National Context

2.1 Definition of domestic abuse and violence

In April 2013, the cross-government definition of domestic violence and abuse was broadened and amended to include violence between young people aged 16-17 years in a relationship, and to include a focus on coercive control. This new definition encompasses non-physical abusive behaviour. In full, 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
> - Emotional

At the same time, the Home Office (2013) defined controlling behaviour and coercive control as follows:

> 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.

2.2 Prevalence and incidence

On the day the Domestic Abuse Bill was announced in the Queen's Speech on 19 December 2019, Victoria Atkins MP, Minister for Safeguarding, described domestic abuse as "an abhorrent crime" but it is also a complex societal problem that is widespread and spans from chronic lower-level abuse to homicide. In most years, domestic violence accounts for around one-half of all UK female homicides, for example 48% in 2018/19 (ONS). In addition to the human cost, domestic abuse was estimated (in the Domestic Abuse Bill 2019) to be a financial cost of "approximately £66 billion for victims of domestic abuse in England and Wales for the year ending March 2017".

In the year ending March 2019, using data from the crime survey of England and Wales, the Office for National Statistics estimated that 2.4 million adults aged between 16 to 74 years had experienced some form of domestic abuse in that year. Although this means that the prevalence of domestic abuse looks to have reduced over the preceding 14 years (from 8.9% of 16 to 74 year olds in the year ending March 2005 to 6.3% in the

year ending March 2019) it remains a ubiquitous crime in all communities. One recent study (Guy 2016) has estimated that approximately 25% of the adult population (defined as 16 to 59 year olds) have experienced domestic violence and abuse at some time in their lives since the age of 16, and 25% of young people have had this experience by the time they reach the age of 18.

Domestic abuse is a category of crime with low levels of success in contested trials. In 2018, domestic abuse accounted for 17% of all prosecutions. Where the accused perpetrator enters a guilty plea, 91% of prosecutions were successful. However, where the case went to trial with the accused perpetrator contesting the charge, the conviction rate was only 7% (ONS 2019).

The inherent complexities of domestic abuse mean that service responses need to span immediate safeguarding interventions through to dealing with historic abuse. Safe Lives (2015) published a research review which concluded that, on average, high-risk victims live with domestic abuse for 2.3 years and medium risk victims for 3 years before seeking help. Victims of all kinds of abuse experience on average 50 incidents of abuse before getting effective help.

Prevalence is reported to vary greatly by victim gender and age. Regarding prevalence rates per year Guy (2016) found that: “prevalence is highest among young women aged 20-24 years (12.5%) and young women aged 16-19 years (11.3%). The rate then decreases with age; 7.0% of women aged 25-34 years old, 6.9% of women aged 35-44 years old, 4.7% of women aged 45-49 years old and 2.7% of women age 55-59 years old reported being subject to domestic abuse”.

2.3 The Domestic Abuse Bill 2020

To help address the persistent problem of domestic abuse and the changing nature of the way the crime manifests itself (such as coercive control, financial abuse etc.), UK Government has drafted a new Domestic Abuse Bill. It was introduced in July 2019 and was given a second reading in October of the same year, but then fell with the dissolution of Parliament. The new UK Government of December 2019 has committed to making the Bill law in 2020. However, this timetable is likely to be delayed by the unprecedented disruption of the CoVid-19 pandemic. The Bill is highly relevant to the context in Wiltshire as it may resolve, clarify or strengthen some of the areas of key concern for stakeholders. The Bill applies to individuals over the age of 16 years[1] and has three main aims:

- Raise awareness and understanding about the devastating impact of domestic abuse on victims and their families.
- Further improve the effectiveness of the justice system in providing protection for victims of domestic abuse and bringing perpetrators to justice.
- Strengthen the support available to victims of abuse by statutory agencies.

[1] Abusive behaviour directed at a person under 16 would be dealt with as child abuse not domestic abuse.

If it becomes law in its current form, the Bill will:

- Create for the first time, a cross-government statutory definition of domestic abuse.
- Establish a Domestic Abuse Commissioner to stand up for victims and survivors; raise public awareness; monitor the response of local authorities, the justice system and other statutory agencies; and hold them to account in tackling domestic abuse[2].
- Provide for a new Domestic Abuse Protection 'Notice' and Domestic Abuse Protection Order[3].
- Place a duty on local authorities in England to provide support to victims of domestic abuse and their children in refuges and other safe accommodation.
- Place the guidance supporting the Domestic Violence Disclosure Scheme ("Clare's law") on a statutory footing.
- Ensure that where a local authority, for reasons connected with domestic abuse, grants a new secure tenancy to a social tenant who had or has a secure lifetime or assured tenancy this must be a secure lifetime tenancy.

The Bill also lists non-statutory Government commitments. If the Bill passes into law in its current form these would include:

- Introducing regulations and statutory guidance on Relationship Education, Relationship and Sex Education, and Health Education in schools.
- Government investment in domestic abuse training for responding agencies and professionals.
- A commitment to develop national guidance for police on serial and repeat perpetrators.
- A commitment to improve awareness and understanding of the offence of coercive control and review effectiveness of the offence.
- A commitment to continue to develop a means to collect, report and track domestic abuse data.

Some of these measures have the potential to bring clarity and some the potential to address issues that have been identified as part of the solution to achieve long-term trend reduction such as relationship education. To implement new duties alongside current service provision, all statutory and voluntary agencies will need to know what evidence exists for interventions and "what works" in terms of service provision.

[2] One of the key functions of the Domestic Abuse Commissioner will be to encourage good practice in the identification of children affected by domestic abuse and the provision of protection and support for these children.
[3] Domestic Violence Protection Orders (DVPOs) and Domestic Violence Protection Notices (DVPNs) were rolled out across all 43 police forces in England and Wales from 8 March 2014 as a trial. DVPOs are a civil order that fills a 'gap' in providing protection to victims by enabling the police and magistrates' courts to put in place protective measures in the immediate aftermath of a domestic violence incident where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions. A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to a perpetrator. Because the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support they require in such a situation.

3 Key Findings from Existing Research: Domestic Abuse

3.1 What works? Generalised conclusions from key areas of research

Published research regarding 'what works' in response to the issues generated by domestic abuse focuses on three tenets:

- A risk-based approach.
- A needs-based response.
- A 'continuum' approach to service provision, usually based on a chronology of support that victims require from first identification to recovery but recognising that it is not always a linear journey.

For example, Safe Lives in their Impact Report (2018) recommend the "risk-led approach" to domestic abuse services. This approach has effectively been codified in England via the widespread adoption and use of the 'DASH Risk Checklist' (Safe Lives 2019) that converts multiple complex risks into a value that enables professionals to categorise victims as standard risk, medium risk, medium/high risk and high risk and response accordingly. In terms of a needs-based response, research published by British Columbia Centre of Excellence for Women's Health (2013) building on work by the Council of Europe (2008) identified the main needs of victims as:

- Helplines.
- Outreach work.
- Trauma care.
- Advocacy.
- Safe refuge accommodation for adults and children.
- Short-term counselling.
- Long-term support.

The report notes that meeting these needs effectively requires coordination with a breadth of public and voluntary services dependent on individual circumstances and could include legal aid, children's social care, mental health services and perpetrator programmes. The British Columbia research also reviewed 90 domestic abuse programmes and reported that victims "primary needs" were for:

- Information.
- Support.
- Safety.
- Legal advocacy.
- Help with economic issues.
- Help related to their children.

The Journal of Family Violence (2018) has published research into how domestic violence support services promote survivor wellbeing. It is a description of current common practice, for example; 'increase access to community resources' as opposed

to innovative best practice; for example priority access to adult mental health support. The research concluded that:

> "*Domestic violence programs engage in a wide range of activities designed to positively impact the social and emotional well-being of both survivors and their children. Specifically, they work to 1) increase survivors' and their children's sense of self-efficacy as well as their hope for the future, and 2) directly increase their access to community resources, opportunities, and supports (including social support)".*

The report also noted that, although actual programs offered may differ across agencies, services for both survivors and their children tend to share eight key features. These are listed as:

- Providing information about adult and child survivors' rights, options and experiences.
- Safety planning.
- Building skills.
- Offering encouragement, empathy, and respect.
- Supportive counselling.
- Increasing access to community resources and opportunities.
- Increasing social support and community connections.
- Community change and systems change work.

In terms of a service continuum, The British Columbia Centre of Excellence for Women's Health (2013) / Council of Europe (2008) research noted that: *"There has emerged a common understanding of the continuum of services required to provide support"* referring to the breadth of services required to meet what are often sequential needs, (for example: information, risk assessment, target hardening, refuge, mental health support etc.). The report also recommended that, *"A continuum approach to service provision recognizes that victims of violence need services matched to the risks to which they are exposed, and that those at high risk of repeat violence and serious injury need a tailored and highly coordinated response".*

In conclusion the published research regarding 'what works' is reflected in the typical configuration of UK services:

- A risk based approach that aims to identify those at highest risk and provide a multi-agency response.
- "Emergency" interventions; forensic, medical attention, safe refuge etc.
- Delivery models centred on improving individual and family safety.
- Specialist advocacy.
- A continuum of services from helplines to counselling for historic abuse.

Services are generally orientated towards safeguarding and intervening when high risk individuals are identified. A lot of resources have to be directed at interventions once abuse has become serious; legal advocacy, safe refuge, involvement of child social

services etc. Services are not typically orientated towards prevention, earliest possible intervention and maximising disclosure opportunities.

3.2 Facilitating disclosure and identifying need

Identification is the first step in supporting victims but often requires some form of disclosure. Enabling disclosure is the pivotal step in assessing risks, safety planning and needs assessment and is recognised as a central challenge for domestic abuse support providers. Research undertaken by Stanley et al (2012) found that*: "Adult as well as child victims of domestic violence are likely to experience feelings of guilt and shame that can act as barriers to disclosure"*.

A Department of Justice Northern Ireland study (DoJNI 2016) found that disclosure is inhibited by the main concerns which are familiar to professionals supporting victims. The evidence was gathered by speaking to victims regarding their experiences of giving a statement to the police. A number of participants expressed concern about the consequences of making the statement. Their concerns related to such things as:

- Their own physical safety
- The potential involvement of Social Services where the victim had children.
- Embarrassment of others finding out.

The Home Office Hester report (2005) found that "routine enquiry" was particularly effective, especially in health care settings when implemented by health visitors, practice nurses and Accident and Emergency departments. Training was important (and should last more than one day), as were good multi-agency relationships and referral systems to specialist domestic violence agencies. Routine enquiry is most effectively implemented where practitioners find ways to incorporate it into their existing patterns of work.

3.2.1 Identification via Multi-Agency Risk Assessment Conference (MARAC) for higher risk victims

A review of domestic abuse impacts and interventions by Office for Police and Crime Commissioner Merseyside (2014) found that MARACs were very cost effective:

> *"Early identification through effective multi-agency risk management to ensure safety is crucial. For high risk victims, Multi-Agency Risk Assessment Conferences (MARAC's) which provide an enhanced, systematic, coordinated response by sharing intelligence between agencies are effective in improving victim safety and reducing re-victimisation (Steel et al., 2011)."*

The review found the MARAC process was highly cost effective with estimates that public services save *"...around £6,000 per case in direct costs, with 20% of this a saving to the NHS, 32% police and 40% to the wider criminal justice system." (DOH, 2011).*

3.3 The need for advocacy and safety planning

Once a victim is in contact with a domestic abuse support service *a key* modus operandi is considered to be advocacy. The Battered Women's Justice Project (2020) summarised that:

> *"Advocacy forms the backbone of interventions to support victims of intimate partner violence and end the violence in their lives… Advocates can help to restore victims' agency".*

It is worth noting that safety planning always covers safety within the home and careful assessment of which victims in which circumstances will require refuge accommodation. However, research conducted by Levison and Harwin (2000) found that *"leaving the family home is usually a last resort for people experiencing domestic violence. It is possible that some who do leave would have stayed if improvements to the security of their current home [often referred to as 'target hardening'] had been made, and measures had been available to improve their personal safety".*

3.4 The role of individual versus group work for adult survivors

Overall individual and groupwork are both seen as important elements of support for adult survivors. For example, The Home Office Hester (2005) research supports both individual and groupwork with victims:

> *"Individual work which incorporated 'emotional' and 'general' support was difficult to conceptualise and evaluate. However, it played a large role in the work of advocates and outreach workers. Individual work and groupwork both helped women become more self-aware and recognise their experiences as abuse; and groupwork was also useful to help women 'move on' with their lives".*

Considerable attention has been paid to the particular value of manualised groupwork programmes. For example a review of domestic abuse impacts and interventions by Office for Police and Crime Commissioner Merseyside (2014) identified the key benefit of group programmes over one to one supports as being that they enabled interactions between survivors:

> "*It is well documented that women often draw strength and benefit from such specialist services, due both to their interaction with other survivors of abuse, and to the one-to-one support from trained staff or volunteers*".

The report cites Jacobson and Gottma (1998) who claimed that "*Support groups have been described as; a place where women can explore alternatives in lifestyle and life goals amongst an atmosphere of respect, safety, and empathy, which rekindles their resiliency, strength, and inventiveness"*.

Women's Aid, in their 2020 domestic abuse report, define their group therapeutic work as "defined groups facilitated by trained staff". Women's Aid primarily use the *Freedom Programme* and, in 2019, such groups were operated from 218 locations in England. Humphries et al (2000) noted that *"The Freedom Programme is open to people living with or separated from violent partners and aiming to provide an educational support, to understand the reasons for domestic violence, dispense with guilt, protect themselves*

and their children in the future, and reduce isolation". However, published research regarding the efficacy of this Programme is limited and criticisms of it from some quarters have included:

- That it represents a 'reductionist approach' (over-simplifies) to human behaviour.
- That places too much focus on the perpetrator (and his beliefs and actions) which may not be useful to empowering women and helping them to realise the role played by themselves in the relationship.
- Linked with the above, that a programme of this nature should place more focus on empowering women and helping them to develop problem-focused coping skills.
- The content lacks an empirical research base (it is based rather on the creator's experience in practice).
- The Freedom Programme offers the opportunity for victims to meet each other and therefore the potential for mutual support but it does require getting to a venue regularly once a week for at least 8 weeks. Recognising that some victims can not travel to venues for group work has driven demand for the course material to be available online.

Group programmes that at their core are based on Cognitive Behavioural Therapy (CBT) have been cited in studies as being at least partially successful in helping victims (it is also worth noting the CBT is also associated with success in some perpetrator programme intervention, see section 3.6). These studies often focus on victims diagnosed as having Post-Traumatic Stress Disorder (PTSD) as a result of domestic abuse. For example, Condino in 'Therapeutic Interventions in Intimate Partner Violence: An Overview (2016)' cites two USA studies; Cognitive Trauma Therapy for Battered Women (CTT-BW) and Helping to Overcome PTSD through Empowerment (HOPE) program. The HOPE program is a CBT-based intervention for women in shelter that addresses safety issues, PTSD symptoms, quality-of-life concerns, and post-shelter goals. The model includes 'educational groups' of survivors who receive a maximum of 12 sessions of HOPE while in shelter over a maximum of 8-weeks.

Condino notes that groups utilising CBT and interpersonal therapy (IPT) *were "mostly conducted within the context of shelter or after discharge of women from it"*. Within the first study, CTT-BW was cited as a cognitive trauma therapy for women with PTSD incorporating many features from standard CBT therapies for PTSD, including education, stress management, exposure therapy, and restructuring of guilt and shame-related cognitions.

Condino concluded that, in some clinical trials (in particular Iverson 2011), CTT-BW has had excellent effects, leading to *'very substantial and significant reductions in PTSD diagnosis, PTSD symptoms, depressive symptoms, and trauma-related guilt'* and that the HOPE's effects showed meaningful decrease of depression level and an increase of social support. Johnson's 2011 study was also positive but caveated the results:

> *"This study represents the first randomised control trial of residents of battered women shelters with PTSD or subthreshold PTSD. Results suggest that HOPE may be a promising treatment for recent IPV victims in shelter, but that some modifications may be required to improve HOPE's impact on PTSD. Results support the initial feasibility and acceptability of a first-stage, present-centered, structured, CBT for sheltered women with IPV-related PTSD. Participants in*

> *HOPE found the treatment credible, expressed a high degree of satisfaction with treatment, and the treatment drop-out rate was low (6.67%). However, most participants left shelter prior to completing HOPE (62.9%), with many participants leaving before receiving a minimal dose (33.3%)".*

In Wiltshire, Splitz described the 'Making Changes' group intervention they operate to IPC. It was devised by Splitz and is delivered over 6 weeks with each session lasting 2 hours. One of the objectives of the intervention is to enable victims of domestic abuse to meet others and potentially form peer support. The programme covers:

- What is domestic abuse.
- Who is responsible.
- Why women stay.
- The impact on children.
- Assertive communication.
- Healthy boundaries.
- Understanding feelings.
- Having your say.
- Healthy relationships.

Making Changes has not yet been formally evaluated. Group Programmes often form part of a wider support offer to victims and the evidence for how such programmes should be structured is mixed. At the very least, all group programmes offer participants the opportunity for reflection and the potential for peer support. Well-structured programmes can improve the relationship between victims who are mothers and their children and for the most traumatised victims' programmes should consider elements of CBT. All groups require professional specialist facilitation.

3.5 Support for children and young people affected by domestic abuse

The Early Intervention Foundation (2014) study into early intervention in domestic abuse underlined the negative effects on children of domestic abuse, in particular quoting a meta-analysis (Kitzmann) of 118 published and unpublished studies, dating from 1978 to 2000. The study examined associations between exposure to domestic violence and childhood outcomes, including social problems and internalizing and externalising symptoms and concluded:

> *"The study indicates the very broad finding that children exposed to domestic violence without suffering physical harm themselves display similar psychological and social outcomes as children who have been abused but not exposed to violence between parents - increased fear, inhibition and other internalising behaviours, and are more anxious and more depressed than other children".*

Hester's Home Office report (2005) quotes Mullender (2000) and suggests that meeting the needs of children exposed to domestic abuse requires work at three levels:

- Primary prevention (to prevent it happening at all).
- Secondary prevention (stopping it once it has started).
- Tertiary prevention (reducing harm after it has occurred).

3.5.1 Primary Prevention

Primary prevention aims to raise awareness and challenge attitudes among young people. Primary prevention for children and young people in schools was found by a Home Office study to be particularly valued when it was student-centred; interactive lessons on relationships and abuse with visual input such as drama. In addition, they were seen be most useful as part of a longer-term intervention:

> *"There were indications that pupils had increased their awareness of factual information regarding domestic violence, but some teachers were concerned that such one-off interventions led to short-term impacts. Training for teachers and multi-agency support were important, and cross-curricular approaches reinforced the positive programme impacts".* Home Office Research Study 290. (2005) Tackling Domestic Violence: effective interventions and approaches.

Individual and group work for children and young people should include sessions on being safe, self-esteem, feelings and past experiences, school and family, as well as use of video input and discussion. Group work may be preceded by one-to-one (or individual work) work and be more appropriate for those students already in a safe environment.

It is noteworthy that national guidance from NICE (2013) concludes:

> *"While there is weak evidence on primary prevention programs for young people, there is modest evidence that prevention programs that target young people at risk for partner violence may improve knowledge, attitudinal and interpersonal outcomes."*

3.5.2 Secondary / Tertiary Prevention – targeted 'early help'

Available evidence indicates overwhelmingly that children and young people want and need to talk about the domestic violence they have experienced. In order to do this, they need to feel safe, be respected, listened to and helped to understand what is happening in their families.

Effective direct work with children and young people either individually or in groups is designed to facilitate the expression of feelings, to reassure children that they are not at fault, to help re-build self-esteem and to develop safety plans for the future (SCIE 2008).

The evidence indicates that all children living with domestic violence or its aftermath can benefit from individual and group work to help them understand what has happened to them and their families, to overcome the negative impact of living with abuse, and to move forward in their lives (Mullender 2004). Support needs to be provided sooner rather than later. Involvement of the child's mother (or other supportive parent or carer) in this work has been found to be helpful, although this should usually be undertaken in parallel with individual work for the adult victim in their own right (Mullender 2004). A large review of the international evidence base relating to child domestic abuse interventions (British Columbia Centre of Excellence for Women's Health. 2013) identified:

- Moderate to strong evidence that single-component therapeutic interventions aimed at both mother and child are effective including in:

  - Improving child behaviour.
  - Improving mother-child attachment.
  - Reducing stress and trauma-related symptoms in mothers and children.
- Moderate evidence that single-component psycho-educational interventions aimed at children are effective including in:
  - Improving children's coping skills.
  - Improving children's behaviour and emotional regulation.
  - Improving children's conflict resolution skills and knowledge about violence.
  - Reducing the trauma symptoms and stress in both children and families.
  - Improving child aggression behaviours.
- Inconsistent evidence that single-component psycho-educational interventions aimed at mothers and children are effective. (Such as community-based psycho-educational and support groups, home-based group parenting sessions, and 'activity packs' designed to build self-esteem and promote communication between children and mothers living in refuges)
- **Weak evidence** regarding the efficacy of single component (child only) therapeutic interventions (such as individual play therapy and sibling group play therapy).

This suggests that therapeutic or psycho-educational interventions are most likely to be effective alongside other additional support. An example of such a 'trauma informed' intervention is 'Opening Closed Doors', a Barnardo's Programme funded by a grant from the Home Office. The programme was established to support children and families who have experienced domestic abuse including help to recover and build sustainable change in their lives. Opening Closed Doors was established in March 2019 in five local authorities in South East Wales a component of which is the Star Programme[4] (STAR is an acronym for Safety, Trust and Respect in relationships). STAR is a 10-week programme which can be delivered in group or via one to ones. The programme is for children to explore their feelings around domestic abuse, enabling children to understand what has happened and provide them with skills needed to express their emotions and keep themselves safe. It is structured according to the age of the child often one to one for over 14-year olds and for children aged 4 to 11 years of age aimed at both mother and child.

A recent report by Barnardo's, 'Not just Collateral Damage' (2020) emphasises the need for targeted early support from specialist professionals once child exposure to domestic abuse has been identified:

> "*The trauma these [domestic abuse] children and young people face is compounded by the ineffective and inconsistent approach of early intervention support services. Early interventions can break the cycle of domestic abuse and are far more cost effective than dealing with the consequences of future domestic abuse in adulthood. All children and young people need to be able to access specialist, trauma informed domestic abuse support. This support must be available for those who are living in a household where there is domestic abuse and for those young people experiencing abuse within their intimate relationships*".

[4] S.T.A.R (Safety, Trust and Respect) suite of services is available from Welsh Women's Aid: https://www.welshwomensaid.org.uk/what-we-do/children-and-young-people/

A key feature of the 'Opening Closed Doors' Programme is that it takes a whole family approach that includes:

- Women accessing Integrated Women's Support (IWS)
- Children and young people accessing the STAR Programme (Safety, Trust and Respect in relationships)
- Men accessing the Domestic Abuse Perpetrator Programme (DAPP).

Both IWS and DAPP are lengthy interventions lasting a minimum of 20 weeks, STAR is a 10-week programme, it can be delivered in group sessions or one to one. The time spent working with an individual often includes early engagement, support to prepare them and the intervention can be prolonged due to missed sessions, time to catch up, and at the end of the intervention the need for some form of ongoing support.

3.5.3 Secondary / Tertiary Prevention for Children involved with Social Care Services

Because of the significant prevalence of families referred to Children's social care services with a domestic abuse 'component', many local authorities in the UK have attempted to build into their offer either dedicated or 'easy access' domestic abuse specialists.

For example, **Hampshire** used part of their DfE Innovation Programme funding to develop 'Family Intervention Teams' (FITs) working alongside social work teams and incorporating domestic abuse, substance misuse and, to a certain extent, adult mental health specialists. An evaluation of the innovation for DfE (Burch et al, 2017) was unable to establish a clear link between an early implementation of the scheme and better outcomes for children, although social workers and other staff working with families considered the innovation to be very positive.

Since the ending of the Innovation Programme, Hampshire has drawn back from this model to a certain extent, preferring to develop 'Multi-Disciplinary Hubs' for 'priority cohort families' that include mainly more generic 'Intensive Family Support Workers' who understand domestic abuse (as well as substance misuse, parenting programmes and other key aspects of the work with families). These workers and hubs now provide what is essentially a 'bridging' role with families – to undertake some direct work with them around domestic abuse, enough to enable them, where appropriate, to continue to access more specialist domestic abuse services – mainly group programmes, but also sometimes one to one support from the local provider that is negotiated via the Public Health-held contract. However, it is anticipated that the Multi-Disciplinary Hubs will incorporate some domestic abuse (and substance misuse / mental health) specialists again in time.

In summary, the research studies regarding support for children and young people affected by domestic abuse identify the following key points:

- Domestic abuse has a profoundly negative affect on children regardless of whether the abuse is direct or indirect.

- Meeting the needs of children exposed to domestic abuse requires work at three levels; prevention, cessation, mitigation (reducing harm after it has occurred).
- Primary prevention for children and young people needs to take place in schools.
- Secondary and tertiary prevention models should be centred on targeted early help delivered by specialist professionals.
- Children and young people want and need to talk about the domestic abuse they have experienced and the evidence indicates that all children living with domestic violence or its aftermath can benefit from individual and group work.
- Single-component therapeutic interventions aimed at both mother and child are most effective when combined with additional support.
- Children's social care services delivery model should either have 'easy access' to domestic abuse specialists or build such specialists into their offer.

3.6 Perpetrator Programmes

The evidence base for effective interventions with perpetrators is not yet strong. The primary reason for perpetrator intervention programmes is to reduce recidivism. Perpetrator programmes are operated in prison and in the community for this reason. Interventions have progressively tried to measure an increasing number of facets of perpetrator behaviour to gauge improvements but the aim of reducing reoffending remains.

Much of the debate concerning perpetrator interventions for many years has centred on the proposition that 'nothing works'. The Early Intervention Foundation looked at the changing approaches to perpetrator 'treatment' in their report 'Early Intervention in Domestic Violence and Abuse' (2016). The report noted that much of the debate on the effectiveness of these programmes has focused on the 'Duluth Model' of perpetrator intervention which tends to assume that domestic violence and abuse is a gender-specific behaviour which is socially and historically constructed. Men are socialised to take control and to use physical force when necessary to maintain dominance.

The ineffectiveness of the Duluth Model is quantified in the 2016 report:

> *"Two recent reviews of [Duluth] programmes delivered in the US showed no benefit to reoffending rates from existing perpetrator programmes. Men who commit domestic violence and abuse and are treated after arrest have only slightly lower recidivism rates (36%) than men not treated after arrest (39%)"*.

The 2016 report suggests that more is now known regarding what interventions *can* help perpetrators and reduce recidivism and that there are examples of good practice and 'early evidence of emerging promising models' including in particular those that:

- Are 'non-Duluth' based models "(namely CBT, relationship enhancement, substance abuse treatment and couples counselling), where an average reduction in recidivism of 33% (statistically significant) from baseline was observed".
- Are culturally attuned (target domestic abuse in a culturally specific context)
- Simultaneously tackle other issues such as mental health or substance misuse.

However, the report also notes that interventions for perpetrators of sexual violence are still proving particularly ineffective. *"There is more promising evidence of effectiveness for interventions for perpetrators of other forms of domestic violence and abuse. Although, these distinctions can sometimes be hard to draw in practice".* A 2013 National Institute for Health and Care Excellence (NICE) report and separate guidance also contain useful findings regarding the effectiveness of group or individual interventions including:

- 'Moderate' evidence that programmes delivered 1:1 with individual perpetrators (including case management, an individual level intervention combined with community outreach services, solution focused therapy, educational interventions, and motivational interviewing approaches) may reduce aggressive feelings towards partners, increase understandings of violence and accountability, and increase short-term help seeking. However, NICE also found the evidence on these programmes to be "mixed and inconsistent", with some interventions leading to improvements in violent behaviours or recidivism, while other similar programmes show no effect. Overall, individually delivered interventions appeared to have a greater effect on 'attitudinal outcomes' than actual recidivism/ violence outcomes, which, when measured improved in some but not all studies.
- Mixed and inconsistent evidence for reducing recidivism amongst both short and longer duration group-based approaches[5]. Some studies reported a reduction in recidivism or other abuse measures, and a few studies reported improvements in some, but not all abuse measures or no improvement at all. However, NICE did find moderate evidence that short (16 weeks or less) group interventions improved attitudinal outcomes (as above), including: motivation / readiness to change, accountability for abuse, and demonstrating empathy.

The 2016 Early Intervention Foundation report describes an example of a promising approach; 'Strength to Change' which is described as an innovative programme for male domestic violence and abuse perpetrators designed in the UK and operating in Hull since 2009. It is a self-referral service which in itself is noteworthy. Men self-refer to the service after exposure to a marketing campaign and receive a minimum of 10 weekly hour-long individual sessions followed by group sessions over 40 weeks.

The programme has undergone preliminary evaluation after 18 months of operation based on case file reviews, in depth interviews with 47 men and their partners and analysis of police data. Hull Police data indicates that men are involved in substantially fewer domestic violence and abuse call outs than prior to their involvement with the scheme (66% reductions in call outs for those who have finished involvement with the scheme, and a 76% reduction for men who are still involved with the scheme when compared to call out levels two years prior to engagement with the programme). Without a control group for comparison the results should be interpreted cautiously.

[5] The group approaches for perpetrators considered by NICE included "family of origin group therapy, a solution and goal focused group treatment programme, Cognitive Behavioural Therapy (CBT), unstructured supportive group therapy, group counselling, and group sessions based on the narrow Duluth model. Both short (16 weeks or less) and longer duration group approaches were assessed.

In Wiltshire, Splitz operate a perpetrator programme that is based on behavioural change and is delivered via one-to-one sessions with a behavioural change IDVA. The service is available to both male and female perpetrators over 16 years of age. The service works with standard to medium risk perpetrators who recognise that they have been abusive and want to positively change.

Interaction with the perpetrator begins with a 24 question 'risk assessment' similar to the DASH risk assessment for victims. The service consists of 6 sessions of 1 hour duration. The programme is structured and covers: exploring the impact of their behaviour on others, how feelings and perceptions (e.g. jealousy) can drive behaviour, what equality means and what a healthy relationship looks like. A "Control log" approach may be used to look at a specific abusive incident. After 6 sessions, there is a review of key issues and triggers for the individual. Individuals can self-refer and a small number do. However, most are referred into the service which can cause issues 'as the individual has to be genuinely motivated to want to change'. Most perpetrators using the service are known to social services and the behavioural change IDVA does attend Child in Need and Child Protection conferences.

The key points from the existing research regarding perpetrator programmes and emerging best practice are:

- The reason for perpetrator programmes is to reduce recidivism, they are therefore a necessary element worthy of effort and investment.
- Much of the criticism of perpetrator programmes is in fact a criticism of the 'Duluth Model' which has been shown to be ineffective.
- Interventions for perpetrators of sexual violence are still proving particularly ineffective.
- Domestic abuse perpetrator programmes should simultaneously tackle other issues such as substance misuse.
- Consideration should be given to delivering perpetrator programmes one to one as this may have greater success and facilitates interventions being available to both men and women.
- Actively encouraging men to self-refer via marketing campaigns is likely to be more successful than referring individuals into interventions.

3.7 What works in 'Toxic Trio' households or where there are complex needs?

Many victims of domestic abuse have complex needs. Of particular concern in recent years is the problem of meeting the needs the victims in "Toxic Trio" households, where domestic violence is present in the household alongside parent substance misuse and or alcohol misuse as well as parent mental health problems. The All-Party Parliamentary Group on Complex Needs and Dual Diagnosis (2013) defined a person with 'complex needs' as someone with two or more needs affecting their physical, mental, social or financial wellbeing. The Group noted that complex needs:

- Interact and exacerbate one another, leading to an individual often experiencing several problems simultaneously.

- Are severe and/or long standing, difficult to ascertain, diagnose or treat.
- Often involved people at, or vulnerable to reaching crisis point and experience barriers to accessing services, requiring support from multiple services/agencies.

Someone described as having complex needs will have co-morbidity of at least two or more of the following:

Mental ill health	**Substance or alcohol misuse issues**
Dual diagnosis (mental health and substance misuse	Domestic Abuse
Physical health condition	Learning disability
History of offending behaviour	Physical disability
Employment problems	Homeless or housing issues
Family or relationship difficulties	Social Isolation
Poverty	Trauma (physical, psychological, social)

List is not exhaustive

The Toxic Trio is a sub-set of complex needs of particular significance due to both the negative interactions between domestic violence, mental health and substance misuse and the difficulties it presents in supporting victims. Concerns regarding Toxic Trio households are now well documented with regard to increased risk not only for the primary adult victim but also for children living in such households: Ofsted (2010) cites Cleaver et al (2007):

> "*Time and again, it seems that the combination of problems is much more likely to have a detrimental impact on children than a parental disorder which exists in isolation*". Cleaver et al (2011)

An innovation programme study for the Department for Education (Burch et al, 2017) also identifies how, although the prevalence or incidence of individual toxic trio issues in the overall adult population is relatively low, their incidence increases significantly within the 'social care intervention' population and in tandem with the seriousness of the social care intervention, as illustrated in the table below. In other words, it is highly likely that families with a Child in Need or Child Protection Plan will be experiencing not only domestic abuse but the other 2 key toxic trio items known to increase risk to children.

Toxic Trio 'issue'	Prevalence in the overall population	Prevalence in 'child protection' cohorts overall	Prevalence in families subject to care proceedings	Prevalence in families whose children are the subject of a serious case review
Parent Mental illness	Between 3 – 13% (excluding post-natal depression)	25%	43%	63%
Parent Substance/Alcohol Misuse	Alcohol abuse = 5% for women and 7% for men Drug abuse = 3%	25 – 60%		33%
Domestic Violence	Approximately 200,000 households with a known risk of domestic violence	40 – 50%	51%	52%

This table includes research evidence summarised in Cleaver et al (2011)

Specific frameworks for the assessment of risk to children affected by domestic violence have also been developed, for example the Domestic Violence Risk Assessment Model originating from Canada and developed in the UK by Barnardo's. This model encourages practitioners to examine nine 'key' areas:

- The nature of the abuse.
- Risks to the children posed by the perpetrator.
- Risks of lethality.
- The perpetrator's pattern of assault and coercive behaviours.
- The impact of the abuse on the woman.
- Impact of the abuse on the children.
- Impact of the abuse on parenting roles.
- Protective factors.
- The outcome of the woman's past help-seeking.

The NSPCC (2014) report Assessing Parenting Capacity, describes a number of barriers to carrying out effective parenting assessments where a parent has a substance misuse problem, including the 'denial and stigma' of addiction and also that assessments must focus on children's needs and the ways in which parents are able or unable to meet these needs due to their addiction. Stanley et al (2010) suggest that

social workers should liaise at least with adult substance misuse workers to undertake an assessment. The NSPCC recommend tools to help practitioners assess the extent of alcohol use and how big a risk it poses to child welfare including:

- The Alcohol Use Questionnaire (Department of Health, Cox and Bentovim. 2000)
- Screening Questionnaires T-ACE and TWEAK (BMA, 2007) for assessing risk.

For families involved in care proceedings, Family Drug and Alcohol Courts have proven to be more successful than conventional interventions, including in relation to:

- Substance misuse cessation.
- Family reunification.
- Reduction in neglect and abuse.
- A timely offer of support from other agencies (Harwin, J et al 2014).

For the mental health element with reference to research undertaken by Cassell and Coleman (1995), the NSPCC have recommended that, during the assessment, social work practitioners should:

- Focus on how mental health issues affect day to day parenting capacity.
- Remember that mental health problems can fluctuate over time – sometimes during the course of a day. For example, a depressed mother may function better in the evening than in the morning. This suggests that visits should take place more than once and at different times of the day.
- Seek information and advice from mental health practitioners involved in the parents' care.

However, the complexity of the issues regarding Toxic Trio households means that a multi-agency and nuanced approach will likely be necessary to resolve all of the presenting needs, as listed above this includes safeguarding and both therapies and advocacy simultaneously.

The Department for Education publication 'Rethinking Social Work' (2014) recommends that service delivery shapes team structure so that teams are either interdisciplinary (for example with embedded specialists), and/or social workers have easy access to clinical and therapeutic support for families. Similarly; the NSPCC (2014) suggests that a 'risks and resilience approach' should be taken including identifying and then reducing risks posed by substance misuse and promoting protective factors for example, by working to reduce family conflict whilst at the same time building family and social support networks. Practitioners should also seek to connect family members with specialist services able to provide intensive help with the addiction (Forrester, 2014).

Regarding how teams operate, a SCIE report: Analysis of statutory reviews of homicides and violent incidents in London (2020) suggests that Children's social care in particular regard 'Toxic Trio' as "multiple risk" in their support planning and it is important not to make "over-optimistic assumptions". "In a small number of cases, children's social care appeared to make over-optimistic assumptions about victims' ability to safeguard children and that the perpetrator would not harm their child. In one

instance, the review highlighted that children's social care wrongly assumed that the victim could safeguard both herself and the children from the abuser".

A research study by Maybery et al (2015) also suggests that, even where there is a dual diagnosis of parental mental health and substance misuse problems, outcomes for children are rarely recognised in recovery models. The research proposes a greater role for holistic 'goal setting' incorporating these elements as well as those relating to the parent 'issue(s)'.

Templeton (2014) has evaluated 'Moving Parents and Children Together' (MPACT), a structured educational programme strongly influenced by the 'Strengthening Families Programme' but tailored to meet the multiple and complex needs of children and families affected by parental substance misuse. The model draws upon a range of child and family-focused approaches including systemic theory; group theory; attachment theory; motivational interviewing; cognitive behavioural therapy. Much of the content is focused on improving relationships between parents and children; parenting (boundaries and consistency); and supporting families to develop a 'toolbox' of strategies and activities to draw upon in difficult times. The programme is delivered by a team of professional facilitators supported sometimes by volunteers. Following a comprehensive family assessment, the programme runs for eight consecutive weeks with each weekly session covering a different topic such as 'making sense of addiction'; 'communication'; 'feelings and beliefs'. It combines separate work with children and adults with work with family units or the whole group together. In summary, the key points from these research studies regarding working with Toxic Trio households are:

- Team structure matters. Teams need embedded specialists or easy access to the correct specialist services.
- Toxic Trio households should always be regarded as multiple risk.
- 'Risks and resilience approach' should be taken to identifying and then reducing risks.
- Holistic 'goal setting'.
- Don't make over-optimistic assumptions in the ability of victims to safeguard themselves or any children.
- Support should include improving relationships between parents and children.

3.8 What works for repeat victimisation?

Repeat victimisation makes domestic abuse a chronic problem and is widely recognised by professionals supporting victims as a sometimes intractable problem. Women's Aid (2017) cite the statistics and evidence around repeat victimisation to assert that domestic violence is a "gendered crime", essentially that the majority of repeat abuse is male perpetrator against female victim:

> "*Whilst both men and women may experience incidents of inter-personal violence and abuse, women are considerably more likely to experience repeated and severe forms of abuse, including sexual violence. They are also more likely to have experienced sustained physical, psychological or emotional abuse, or violence which results in injury or death".*

Women not only experience higher rates of repeated victimisation but are also much more likely to be seriously hurt (Walby & Towers, 2017; Walby & Allen, 2004) or killed than male victims of domestic abuse (ONS, 2017). Further to that, women are more likely to experience higher levels of fear and are more likely to be subjected to coercive and controlling behaviours (Dobash & Dobash, 2004; Hester, 2013; Myhill, 2015; Myhill, 2017). The Hester and Westmarland Home Office Research Study Tackling Domestic Violence: effective interventions and approaches (2005) suggests that schemes aiming to reduce repeat victimisation should incorporate:

- Advocacy.
- Tailored support.
- "Target hardening"[6].
- Support to report incidents to the police.

Hester and Westmarland conclude that:

> "*The approach most effective was the tailoring of advocacy and support to the specific needs of the victim. This occurred where women described feeling more empowered to report to the police; identified what was happening as criminal; and/or where the abuse was particularly chronic. Overall, target hardening measures reduced repeat victimisation and also increased women's confidence and sense of safety. Having both a panic alarm and home security had the most impact, but it is important that target hardening measures are offered within a wider framework of support and alongside regular risk assessments*".

A further problem of repeat victimisation occurs when the victim is disempowered to the point that police attendances at the victim's home do not result in a complaint being made, this could be related to the reasons listed in 3.1 (fear of assault, concern over "losing" children, shame). Wiltshire Police commented to IPC researchers that some repeat victims are discussed at MARAC but don't engage with support services due to these concerns and additional complex needs.

One potential solution to non-engagement with MARAC is a *Community MARAC* or *Risk Enablement Panel.* Community MARACs operate in addition to the local MARAC not instead of. The experience of sites where they have been trialled suggest that they may be particularly useful for cases that have been discussed at MARAC showing repeat victimisation alongside complex needs, most frequently mental health issues. *Empowering Communities* (2019) describe common factors for referrals to Community MARACs including where a victim is also a perpetrator and victims with unmet mental health needs who refuse to engage with support services.

"*Community MARACs are a Multi-agency Risk Assessment comprised of those public service agencies best suited to help resolve community concerns. There are no fixed*

[6] Target hardening primarily focuses on measures around the victims home. High quality door and window locks, panic alarms and cameras. These measures are available via the local authority or specialist third sector organisations. Newer innovations aim to increase security outside of the home such as TecSOS software on the victim's mobile phone and "sweeping" the phone for perpetrator spyware. This is important as coercive behaviour can continue and extend victim harassment via cyber means even after separation.

risk thresholds for referral and complex cases which do not fall immediately or easily into established categories are welcomed".

Their purpose is to create an environment for experts and specialists to collaborate with a range of partners to design a personalised risk reduction plan to address the problem at hand. Frequent attendees at CMARACs include Fire, Ambulance, Local Authority, housing, social services, troubled families, drug and alcohol services, mediation, police, community teams, mental health services, as well as third-sector organisations, such as Victim Support, Registered Social Landlords, and various charities (membership therefore tends to be broader than a MARAC). The exact membership of a CMARAC depends on the specific needs of a particular local area and can include other specialist agencies. Any organisation who sits at this broad CMARAC table can refer a case into the process.

The effectiveness of Community MARACs has not yet been the subject of research but Empowering Communities.org (2018) article: Community MARACs – sharing and solving complex risk makes the following observation:

> "*At present, 60% of London boroughs have adopted the concept [of Community MARACs] with growing interest elsewhere. The process has already started to evidence cost and time efficiency and recorded case studies have confirmed a sustainable and measurable success in managing complex individuals. Initial benefits also include a consistent approach for cross boundary concerns, identifying gaps in service and responsibilities of care"*

Empowering Communities (2018) Community MARACs – sharing and solving complex risk cites the National Police Chiefs' Council as documenting Community MARACs as an area of good practice and one pilot is currently being evaluated by the College of Policing. Following a recommendation from a domestic homicide review Swindon (Public Health Swindon 2019) has developed a Community MARAC and Risk Enablement Panel (REP).

3.9 Whole system supports – speed of court proceedings

The longer a domestic abuse case takes between charging the defendant and a court trial date the more likely a case will fail, often due to the victim feeling unable to support the case and give evidence. To tackle this issue, a project has been established (since 2017) in the Thames Valley Police Force area based on Aylesbury Crown Court. The project has developed a protocol to decrease the average time for domestic abuse cases to be sent from magistrates' court to Crown Court for a pre-trial hearing from 28 days to 10 days.

The Crown Court worked closely with police and other agencies to develop the fast-track system reducing the trauma for victims and helping ensure that they receive justice. Researchers from the University of Huddersfield (Synott J and Ioannou M. 2019) carried out a detailed appraisal of the scheme and were convinced of its efficacy to the point of recommending that it could be rolled out nationally. Their report also praises the "full support and flexibility" of the judge who backed the initiative, adding that "to implement this nationally it will require similar commitment from judges around the country".

They commented that the approach had a "considerable positive impact with regard to improving how cases of domestic abuse are managed and run". And that "The system can lessen the likelihood of repeat victimisation and a boost in the efficiency of evidence gathering leads to an increase in guilty pleas. It also has the potential to bring about significant savings". The average time for domestic abuse cases to be sent from magistrates' court to Crown Court for a pre-trial hearing could therefore be a useful benchmark and Police forces will have access to this data via the CPS.

3.10 The role of benchmarking

As with any important topic that requires public sector resources it is appropriate to consider benchmarking and wider sense checking regarding priorities and key areas of performance. Very little benchmarking work exists in the area of domestic abuse and sexual violence (There is data from the Crime Survey of England and Wales, police recorded crime data [by police force areas] and annual Office for National Statistics Crime in England and Wales statistical bulletins). The Crown Prosecution Service also compiles data that it shares with police forces. All use different data methodologies and are not directly comparable. However, some national indicators can help inform local understanding and service provision planning, for example:

- The ONS prevalence figure for percentage of population experiencing domestic abuse per annum. Year ending March 2019 = 6.3%. Analysis using this figure combined with the number of domestic abuse incidents and crimes recorded within a police force area (e.g. Wiltshire 2019 = 12,000 + 6,000 giving 18,000) gives an indication of unmet need which can assist with targeted publicity campaigns and efforts regarding "routine enquiry".
- The average time for domestic abuse cases to be sent from magistrates' court to Crown Court for a pre-trial hearing, with perhaps a common standard such as 28 days.

One recent report makes some helpful suggestions about ways in which whole systems can undertake regular joint performance management activity, it is the Auditor General for Wales' report on Progress in implementing the Violence Against Women, Domestic Abuse and Sexual Violence Act (2019). The areas that the auditor chose to concentrate on could act as a broad guide to areas of service provision and best practice approaches for multi-agency working. The three key areas identified are:

- Victims find it difficult to navigate a fragmented support system (because no single agency has responsibility).
  - Do local authorities and their partners have a complete picture of all support services in their area?
- Have public bodies shifted from reactive services to a preventative model which balances the short and long-term needs of victims and survivors?
  - Is there sufficient training of relevant front-line workers to increase awareness?
  - Is there effective collaboration between the necessary public bodies, voluntary sector and including criminal justice?
  - Is there effective data sharing between the necessary public bodies, voluntary sector and including criminal justice?

  - Do social housing landlords support victims and act against perpetrators?
- The complexities of funding do not allow public bodies to assess value for money in service provision.
  - Is funding of services generally fragmented? Overly complex? Short term?
  - Is the quality of commissioning good enough to measure public value for money?
  - Are commissioners able to evaluate performance and impact?

4 Key Findings from Existing Research: Sexual Violence

4.1 Sexual Violence

Sexual violence is criminalised in England under the Sexual Offences Act 2003. This Act makes many forms of sexual violence criminal acts including: rape, sexual assault, causing a person to engage in sexual activity without consent, and voyeurism. Offences are defined as non-consensual and intentional. Charities working in the area summarise sexual violence as non-consensual sexual contact. (For example see *Safe Lives* (2017) Insight Sexual Violence pilot with Victim Support Services).

Rape (and assault by penetration) are two of the most serious criminal offences in English law and each carries a potential punishment of life imprisonment. Sexual assault covers a wide range of possible conduct and can be punished with anything from a fine to imprisonment for 10 years. Sexual assault is any non-consensual touching of a victim that is sexual. Refuge (2020) suggest a broader definition of sexual violence incorporating:

- Pressuring or forcing someone to do something sexual.
- Touching someone sexually without their permission.
- Unwanted sexting – sending sexually explicit texts and images to someone without their consent.
- Unwanted sexual attention – for example ‘wolf-whistling’ and making sexualised comments about women’s bodies.
- Watching a sexual act take place without permission.
- Engaging in sexual acts with someone who is too drunk, or too intoxicated, to give consent.
- Engaging in a sexual act with someone who is asleep or unconscious.
- Having sex with someone who cannot legally consent – for example, a boy or girl under the age of 16, or someone with disability who does not have the capacity to understand the situation.
- Making someone watch or appear in pornography against their will.
- Preventing someone from using contraception.

4.2 Consent

Central to sexual violence offences is the concept of ‘consent’. Consent is pivotal to an act being an offence. The acts described in the offences are only criminal if they are done to a person who does not consent. According to sections 74 to 76 of the Sexual

Offences Act 2003: *"a person consents if he agrees by choice and has the freedom and capacity to make that choice."* The age of consent in the UK is 16 years of age. It is presumed that a person does not have the freedom to consent if *violence* is used against them or threatened at the time of or just prior to the sexual act. Consent should be:

- Affirmative (not the absence of a no but the presences of a yes).
- Active (silence is not consent, and mere participation may not be consent).
- Freely given (not something you can be pressured into giving).
- It can be revoked at any time and is never implied.
- And people can't give consent if they're unconscious or incapacitated by drugs or alcohol.

4.3 Prevalence of sexual violence

The Office for National Statistics report 'Domestic Abuse in England and Wales year ending March 2017' (2018) provides one of the most comprehensive analysis of the prevalence of sexual violence in the UK. The report uses Crime Survey data and police recorded crime statistics. However, the data and analysis is heavily caveated:

> "*Police recorded crime statistics must be interpreted with caution. The police can only record crimes that are brought to their attention and for many types of offence these data cannot provide a reliable measure of levels or trends as they can be affected by varying policing priorities, activity and changes in crime-recording practices. This is particularly the case with sexual offences and recent trends have been driven by a number of these factors".* The report states that, in the year ending March 2017:

- There were 121,187 sexual offences recorded by the police in England and Wales.
- 121,187 offences equate to 2.1 sexual offences per 1,000 population.

This looks to be an under-estimate of the actual prevalence of sexual offences. For example, the England and Wales Crime Survey ending March 2017 (2018) suggests a figure of 646,000 sexual offences just affecting the age group 16 to 59. The 2018 report summarises the key prevalence data for sexual assaults as follows.

Prevalence of sexual assault. Adults 16 to 59 in the last year Year ending March 2017. Crime Survey England and Wales	
Any sexual assault (includes attempts)	1.96%
Indecent exposure or unwanted touching	1.74%
Rape [& assault by penetration] (includes attempts)	0.46%
Any domestic sexual assault (includes attempts)	0.27%
Any sexual assault by a partner (includes attempts)	0.25%
Any sexual assault by a family member (includes attempts)	0.04%

In addition to an analysis of data from a single year, the ONS (2018) report also analysed data relating to victims' experiences of sexual violence since the age of 16. It identifies that:

- An estimated 12.1% of adults aged 16 to 59 have experienced sexual assault at some point (including attempts).
- 12.1% equates to an estimated 4 million victims.
- An estimated 11.5% of adults aged 16 to 59 have experienced indecent exposure or unwanted sexual touching at some time.
- 11.5% equates to an estimated 3.8 million victims.
- An estimated 3.4% of adults aged 16 to 59 have experienced rape or assault by penetration at some time.
- 3.4% equates to an estimated 1.1 million victims.

The Ministry of Justice, Office for National Statistics and Home Office have published an 'Overview of Sexual Offending in England and Wales in 2013' including the following key statistics:

- Approximately 85,000 women are raped in England and Wales every year.
- Approximately 90% of those who are raped knew the perpetrator prior to the offence.
- 1 in 5 women aged 16 to 59 has experienced some form of sexual violence since the age of 16.
- Only approximately 15% of those who experience sexual violence choose to report it to the police.

A recent NSPCC and University of Bristol report (2015) finds that 40% of teenage girls have been pressured into having sex. Furthermore, the Office for National Statistics crime survey report (2016) has found that nearly one third of rape victims are girls under 16 years of age.

4.4 What work for victims of sexual violence – an overview

4.4.1 Structuring services around ISVA

Much of the published literature regarding how to best support victims of sexual violence centre on advocacy. Specifically, most studies look at the central importance of Independent Sexual Violence Advisers (ISVAs). Advocacy services based around ISVAs is the current predominate UK service paradigm promoted and practiced by national charitable services such as Women's Aid, Refuge, Rape Crisis and the Survivors Trust.

Safe Lives (2017) Insight Sexual Violence pilot with Victim Support Services describes the role of the ISVA as providing "tailored, holistic and intensive support over long periods of time to survivors of sexual violence to ensure they have the help they need to recover. A critical part of an ISVA's role is providing criminal justice support to victims of sexual violence before and during a trial". The Survivors Trust describe the role with emphasis on the criminal justice system:

"An ISVA is trained to look after your needs, and to ensure that you receive care and understanding. They will help you understand how the criminal justice process works, and will explain things to you, such as what will happen if you report to the police, and the importance and process of forensic DNA retrieval. An ISVA is there to provide you with information only so that you can make the right decision for you. By contacting them, you are not *expected to report any offence to the police".*
Survivors Trust. Org (2020) role of ISVA.

National sexual violence support charities structure their services with ISVA as their core service, Rape Crisis for example have four pillars to their services; a helpline, Independent Sexual Violence Advisers, counselling and advocacy workers. To help ensure that sexual violence response and support services are as effective as possible, Rape Crisis has worked with the Care Quality Commission (CQC) to produce the Rape Crisis (2019) National Service Standards. The standards build on the CQC 'key lines of enquiry' approach and are based around four principles:

- Strong Leadership: Rape Crisis specialist services have strong leadership and governance that ensure services for survivors of sexual violence are inclusive and participatory and delivered to the highest standards.
- Responsive to Need: Rape Crisis specialist services are responsive to the diverse needs of survivors and actively work towards ensuring they are relevant, accessible and survivor led.
- Safe Practice: Rape Crisis specialist services seek to expand the safety and wellbeing of all survivors and work within safe models of practice which facilitate this.
- Effective Provision: Rape Crisis specialist services are effective in promoting a culture of empowerment that supports survivors to regain control in their lives and in actively challenging misperceptions and social tolerance of sexual violence.

Some of the detail under 'response to need', 'safe practice' and 'effective provision' is helpful from an operational perspective of how support might best be delivered:

Responsive to Need

- The organisation monitors and responds to diversity of need within the population it serves and uses this knowledge to inform service planning and delivery.
- Service users are informed about the scope, independence and any limitations of the services being provided.
- Services are informed by the needs of service users and each service user is an active partner in the service they receive.
- The organisation takes positive steps to maximise the accessibility of the services it provides and the settings from which it provides them.

Safe Practice

- The organisation has robust and reliable systems and practices in place to keep people safe and safeguarded from harm.
- The organisation ensures a safe working environment for staff, volunteers, trustees and service users.
- The organisation operates policy and guidance on confidentiality and data protection which is compliant with current legislation and good practice.
- The organisation has processes in place to support the continuous improvement of safety and protection across the service.

Effective Provision

- The organisation identifies outcomes for its service users which are meaningful to those users and to funders and commissioners.
- The organisation ensures that staff and volunteers have the relevant skills, knowledge and experience to deliver effective and high-quality service provision.
- The organisation develops productive partnerships with other services to effectively meet individual needs.
- The organisation promotes awareness of the impact of sexual violence and works to challenge misperceptions and social tolerance of sexual violence.

4.5 What specific services do victims of sexual violence need and access?

Safe Lives have published reports reflecting their sexual violence research (2017) and a dataset (2015) which gives an accurate picture of what services victims of sexual violence have accessed in practice. Safe Lives services are structured around four ‘Steps’:

- Safety (and immediate needs).
- Health & wellbeing
- Feeling informed and supported
- Reintegration

Safe Lives 2017 pilot analysed data from 487 cases. For 54% of victims the sexual violence was a one-off incident and for 43% it was an on-going pattern of abuse. Victims immediate needs were categorised as:

Forensic examinations	28%
Access to a sexual health clinic	23%
Emergency services	6%
Emergency contraception	5%

After meeting immediate safety needs the Safe Lives 2017 pilot found the following services were utilised by victims:

ISVA support to improve safety	
Needs assessment	88%
Risk assessment	80%
Safety plan	39%
Personal alarm	39%
ISVA support to improve health and wellbeing	
Coping strategies	45%
Support with self-confidence	41%
Support with decision-making	22%
Support with anxiety	15%
Support with and trauma	12%
ISVA help for victims to feel informed and supported	
Providing specialist sexual violence services directly to victim	47%
Providing specialist sexual violence services to their children	18%
Support with applications for compensation from the Criminal Injuries Compensation Authority	15%
ISVA reintegration support	
Support with housing	5%
Support with welfare benefits	1%
Support with employment	1%

In terms of how a service should carry out a sexual violence needs and risk assessment, the process is similar to that for domestic abuse. Safe Lives have produced a MARAC DASH sexual violence toolkit (2015) that utilises the DASH questions familiar to domestic abuse assessments. The Safe Lives report indicates that victims of sexual violence are likely to need intensive help once they have accessed a suitable service, the 2017 insight pilot found that 46% of victims needed between 11 to 20 direct sessions with an ISVA.

4.5.1 Emotional health and wellbeing

Victims of sexual violence come to support services in a traumatised state. The Safe Lives 2017 pilot found that mental health conditions and issues were common:

Anxiety	69%
Depression	65%
Trouble sleeping	53%
Stress	42%
'Flashbacks'	36%
Panic attacks	20%

In addition, the Safe Lives 2017 pilot found a worryingly high percentage of sexual violence victims had self-harm and suicidal behaviours:

Safe Lives 2017 pilot, cohort size 487	
Attempted suicide	29%
Self-harmed	34%

This data relating to suicidal intent and self-harm underlines the vital importance of victims being enabled to access support and for that support to be as effective as possible. Resolution for all victims does not come via the criminal justice system. The Safe Lives (2017) pilot found there were mixed criminal justice outcomes for victims of sexual violence and abuse, with half of cases not proceeding and in only 6% of cases was this due to insufficient evidence for CPS to proceed.

4.6 What is the reported impact of ISVA Services?

The Safe Lives pilot report summarised the improvements to victims lives by measuring self-reported responses to questions at 'intake' to support and at 'exit'. The results appear to demonstrate considerable improvements. What is not clear is the extent to which the improvement is due specifically to the interventions of the IDVA services as opposed to other factors such as for example, the passing of time. Victims' reported responses after support from an ISVA included the following:

Issue	At intake	At exit (case closed)
Confident to deal with 'the situation' on their own	10%	47%
Able to enjoy life	28%	62%
Live life to the fullest	21%	59%
I am coping	26%	65%
Feel safe outside the home	38%	64%
The abuse has prevented me from living life as I used to	44%	27% (the aim is a decrease)

The cited studies suggest that victims of sexual abuse who access well-structured Independent Sexual Violence Adviser services experience multiple benefits ranging from support with mental health issues to support navigating the criminal justice system.

4.7 Services that help meet need: Sexual Assault Referral Centres

England operates 43 Sexual Assault Referral Centres (SARC) one in each Police force area. It is a model promoted by the Home Office. They are designed to offer a range of short, intermediate and longer-term support and assistance to victims of sexual violence. SARCs are formally affiliated with the Police and statutory services.

They are multi-agency partnerships between Police and health services and involve liaison with the voluntary sector. Police input is via specially trained Sexual Offences Liaison Officers (SOLOs). In the Victim's Commissioner's report: What works in supporting victims of crime (2016) SARCs are described as "forensically secure", a crucial aspect for victims wanting to access the criminal justice system.

SARCs may or may not have an ISVA service, depending on the make-up of services of any given SARC. If the local model does not include ISVA it is likely to have counsellors and Case Tracking Co-ordinators (CTC) to cover similar functions to an ISVA.

A report into SARCs: Different yet complementary: Two approaches to supporting victims of sexual violence in the UK (2011) describes two core aims for SARCs: firstly a "one-stop shop model of service provision" to "support and care" for victims and secondly "to improve criminal justice performance"; performance should be improved in evidence gathering, victim support through the processes of the criminal justice system and increased conviction success. Support for victims is a co-ordination of advocacy and access to the correct medical and legal provision to meet the individual victim's need.

The 2011 report states that some notable advantages for victims are:

> *"SARCs provide victims who have self-referred, and who might be considering reporting a rape, the option to talk to specialist police officers anonymously before deciding what to do*". And *"victims accessing SARCs particularly value the automatic provision of female examiners and support staff; proactive follow-up support; case tracking; advocacy; and easy access through the telephone to advice and information".*

Furthermore SARCs "provide an interface between two large, bureaucratic systems: health and criminal justice".

SARCs physical locations vary from anonymous suburban locations to NHS Health sites. The 2011 report noted that being taken to the SARC building by an advocate is the most successful approach;

> *"what works well is if somebody's being referred in through a police process by a SOLO [Sexual Offences Liaison Officer], if that SOLO officer can actually bring them here [SARC building] for that very first appointment, it makes it so much easier for the client as … making that first step is the hardest*".

The SARC approach reflects the findings of the Victim's Commissioner's report: What works in supporting victims of crime (2016). The report reviewed literature on the factors that contribute to developing effective victim services, the report covered 28 papers from UK, USA, Canada, Australia, New Zealand, The Netherlands, Sweden and Slovenia.

The report's main findings were that:

> *"Although the strength of the evidence within the research papers is variable, overall there exists a strong research landscape on what works in supporting victims".*

The following themes emerged:

- **Information and communication**: Timely and accurate information and effective methods of communication with victims, both in delivering information and listening to their needs. The basic provision of timely information can assist victims in coping with the impact of victimisation. A lack of information can only act to aggravate these symptoms and in many cases can result in victims disengaging with the criminal process and withdrawing their co-operation.
- **Procedural justice**: The quality of service that victims get from criminal justice professionals and associated agencies is often a more important factor in victim satisfaction than the final outcome of their case. Perceptions of fair treatment, including knowledge of and access to entitlements, increases victims' perceptions of legitimacy and aids compliance.
- **Multi-agency working**: Co-located multi-agency partnership working across statutory and voluntary sectors can provide effective support for victims in terms of information sharing. It can assist in reducing the duplication of tasks, so that the process is less confusing for victims. Effective communication can encourage victims to remain engaged with the criminal justice process and may assist in reducing the potential for re-victimisation by reducing risk and vulnerability. Collaboration between agencies can also contribute to effective prevention strategies.
- **Professionalisation of victims' services**: A single point of contact or advocate is an effective way to provide victims with the combination of both information and support required to help them regain a sense of autonomy, which the crime has taken from them. Not all victims will require the same levels of information and support, so early identification of a victim's needs means that services can be targeted at those who most want and need them. The literature demonstrates that in order to provide effective support this single point of contact should be undertaken by a trained professional, with sufficient knowledge of the criminal justice system, as well as the compassion and empathy to be a source of moral support".

SARCs meet these four themes and thereby help to meet the needs of victims. By providing advocacy regarding how to navigate through the processes of the criminal justice system and facilitating better evidence gathering SARCs can in particularly help those victims to recover for whom formal justice via the criminal court system is of particular importance.

In summary, some of the key points regarding approaches to sexual violence include:

- Legislatively, sexual violence hinges on consent; acts that are legal between consenting individuals over 16 are illegal in the absence of consent.
- Sexual violence is clearly defined in the Sexual Offences Act 2003. In contrast Domestic abuse is not yet clearly legally defined, this will change if the Domestic Abuse Bill passes into law unchanged. However the distinction between sexual violence and domestic abuse/domestic violence is not always so clear in practice.
- Offences of sexual violence are likely to need medical interventions and forensic services, hence the establishment of Sexual Assault Referral Centres (SARCs).
- Victims of sexual violence require a breadth of services capable of providing immediate medical support, through to legal advocacy and support for dealing with historic offences.
- Support for victims needs to be delivered by specialist professionals; e.g. ISVAs and staff capable of legal advocacy.
- Support services need to be configured to provide intensive support (such as multiple face-to-face sessions with an ISVA).
- Support services must be able to respond to victims immediate post-violence harm and the risk of self-harm and suicide attempts post-trauma.

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