



Domestic Abuse JSNA Technical Report 4

Good Practice

**June 2013
Community Safety Intelligence (CSI)**

Purpose

This document examines good practice examples of and guidance relating to multi-agency domestic abuse interventions focused on victims, children and young people and perpetrators.

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Authors/Contributors

Farhat Abbas (Lancashire Public Health), Andrew Cass (Lancashire Probation Trust), Helene Cooper (Lancashire County Council), Jackie Dunning (Lancashire County Council), Mel Greenslade (Lancashire County Council), Sarah McCarthy (Lancashire County Council) Mel Ormesher (Lancashire County Council), Lesley Tiffen (Lancashire County Council), Anna Waugh (Lancashire County Council), Gareth Winstanley (Lancashire County Council).

Victim Focus

Victims need access to a range of advocacy, support and other interventions that relate to their specific and current situation (Hester and Westmarland, 2005).

Early Intervention and Referral Services

- An evaluation in Hammersmith and Fulham in 2009 found that:
 - A routine enquiry into domestic abuse can be an effective tool for early intervention and carried out by trained healthcare professionals that are supported by multi-agency referral systems (Zenner, 2009).
 - Advocacy and support for domestic abuse victims should be holistic and preferably based in a one-stop-shop to help victims to navigate the justice systems and support agencies (*Ibid*).
 - Early intervention services, particularly those provided by advocacy services can decrease the escalation of violence and improve support for the victims at an earlier stage (*Ibid*).
- An evaluation of nine UK National Screening Committee Criteria in 2009 found that there was insufficient evidence to implement a screening programme for partner violence against women either in health services generally or in specific clinical setting (Feder *et al*, 2009).
- The UK Identification and Referral to Improve Safety (IRIS) controlled randomised trial in 2012 (Devine *et al*, 2012) tested the effectiveness of training for clinicians; a computer prompt to ask about domestic abuse within the medical record; and a referral pathway to a named domestic violence advocate - an earlier systematic review having shown the effectiveness of advocacy services (Feder *et al*, 2011; MacMillan *et al*, 2009).
- The study found that the intervention is likely to be cost saving from a societal perspective and showed an increased referral to an advocate (Devine *et al*, 2012).

A routine enquiry into domestic abuse can be an effective tool for early intervention undertaken by all frontline services.

Training for Frontline Professionals

- Practitioners need to be trained to recognise the signs of domestic abuse and to understand the link between domestic abuse and the forms of maltreatment (neglect, emotional, physical, and sexual) and the possible impact on the child or young person (eg physical and social developmental, self-esteem, behavioural, self-harming).
- Domestic abuse training is included in frontline practitioner training programmes for police officers, health professionals, social workers and employees in schools and children's centres. These professional groups are most likely to come into contact with victims of domestic abuse and to be in a position where they can offer advice and support to victims.

- Taket (2012) found that primary care clinicians (including GPs, midwives and health visitors) only have basic domestic abuse knowledge and more comprehensive training on assessment and intervention, including the availability of local domestic abuse services is required (Taft, 2011).
- According to the National Institute for Health and Clinical Excellence (NICE, 2010), midwives and health visitors who are in contact with pregnant women need to be appropriately skilled to recognise domestic abuse, respond to the issue when raised, provide support and to signpost them to other services.
- The growing evidence of the effectiveness of interventions accessed from primary care indicates that a strategy of routine inquiry about intimate partner violence in primary care should be more widely adopted (NICE, 2010; Taft, 2011).
- The *Beyond Violence Report* (Farmer and Callan, 2012) recommended that NHS trusts mandate skill-based group training of at least one day for the health professional groups most likely to come into contact with victims of domestic abuse: midwives, health visitors, GPs and clinical staff, in substance misuse, community mental health and emergency department services.
- (Ibid) found that local commissioners should specify that refuges model themselves along the principles of therapeutic communities with all refuge workers given training, both at the start of their work and at regular intervals, that enables them to understand the social and psychological influences on domestic abuse, its interpersonal dynamics and its impact upon victims and children.

All frontline staff should receive training, as a minimum requirement, to ensure that they have at least a basic common understanding the workforce and that this training should be regularly reviewed and updated (*Common Core of Knowledge and Skills - CWDC, 2010*).

Publicity Campaigns

- The pan-Lancashire *Handled with Care Campaign* (Safer Lancashire, 2012) aimed to raise awareness of what constitutes domestic abuse and signpost people to the national domestic abuse helpline or where required, local support services.
- The campaigns main objectives were to:
 - develop a creative campaign with strong branding which was based on sound research with domestic abuse support services and markedly different from previous campaigns;
 - demonstrate the different types of domestic abuse eg: physical, emotional, psychological, financial or sexual;
 - demonstrate that tackling domestic abuse is a priority for agencies in Lancashire;
 - specifically target female victims, given research shows that the vast majority of domestic abuse in Lancashire is carried out by men and experienced by women;
 - encourage women to access services and report incidents in order to break the cycle of abuse;

- challenge the myths and perceptions that some people may hold in relation to victims of domestic abuse; and
- highlight the impact that domestic abuse can have on women and their families.
- An evaluation of the campaign showed:
 - reporting of domestic abuse incidents across Lancashire was higher in June 2012 than in any of the previous six years including those where football tournaments had taken place. Figures for 2012, compared to 2011 show a 12% increase in reporting;
 - four local domestic abuse service providers localised the posters by including their own helpline numbers. Three of these providers report increases in the number of calls to their helplines over the evaluation period.

Publicity campaigns are a primary prevention measure that can form part of a long term strategy to prevent abuse by changing the attitudes, values and structures that sustain domestic abuse.

Independent Domestic violence Advocates (IDVAs)

- IDVAs are trained specialist case workers who provide a service to victims who are at high risk (those most at risk of homicide or serious harm) from intimate partners, ex-partners or family members, with the aim of securing their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis:
 - to assess the level of risk, support the range of suitable options and develop safety plans;
 - represent their clients at the Multi Agency Risk Assessment Conference (MARAC) taking a lead role in coordinated activity to reduce risk of the victim and their family with other attending organisations such as the Police, Probation, Children's Services, Health and Housing;
 - support the victim through any criminal justice proceedings; and
 - are independent of any single agency to ensure a victim focus to the support.
- In Lancashire, there are over 15 full-time equivalent IDVA posts which have received over 3,800 referrals between April and December 2012. In Lancashire IDVAs are hosted by VCFS organisations.
- CAADA *Safety in Numbers* (Howarth et al, 2009) evaluation report highlights the reality of living with high-risk domestic abuse and the impact of IDVA services on victim safety. Howarth et al (2009) findings advance the understanding of 'what works' in improving the safety of victims of domestic abuse and their children.
- Howarth et al (2009) found:
 - IDVAs that worked with victims had a direct bearing on the chance of achieving improved safety and well-being;
 - victims who received intensive support and multiple types of intervention were approximately twice as likely to experience a cessation in abuse compared to those victims receiving less intensive intervention, or only a single type of intervention;
 - the range of choices offered to victims to address their safety was also critical. By this, is meant action relating to safety planning, housing, the family courts, the criminal courts, support with children, substance misuse services and benefits;

- IDVA services must be structurally part of a multi agency response and need to be commissioned as an independent service, working closely in partnership with voluntary and statutory sector agencies both within and outside the MARAC.

CAADA focuses on maintaining and strengthening existing services with increased involvement from primary healthcare providers through:

- **Funding four IDVAs and one MARAC for every 100,000 adult females;**
- **locating additional IDVAs in accident and emergency and maternity units; and**
- **funding specialist support for children and young people.**

- Currently, no IDVAs are based within any health setting. At St Mary's Maternity Hospital in Manchester every woman due to give birth is screened by a midwife about domestic abuse as part of routine enquiry. Between April 2009 and March 2011 an IDVA was seconded to work in the hospital five days a week.
- Granville and Bridge (2010) found that the PATHway IDVA pilot:
 - Increased the number of referrals, between April 2009 and June 2010 the PATHway IDVA completed 697 actions with a range of agencies on behalf of clients; spoke with 160 of the 196 women referred to the pilot and referred 28 cases to MARAC. A cost 'saving to the public sector of £170,800' (*ibid. p4*) for the 28 cases referred to MARAC, with the IDVA costing just over £50,000.
 - Developed specialist skills working in a health setting, work that was differentiated from other IDVA colleagues on the basis that only pregnant women are referred; women are often in the acute phase of abuse; and the women are seen and assessed within far shorter timescales. 82 of 160 women were seen and assessed within hours and 16 of 160 women were seen and assessed within minutes.
 - Improved safety for women and their children with 116 women reporting they felt safer.
 - Enhanced the response of midwives through routine enquiry with the presence of the IDVA and the ability to refer women immediately.
 - Developed 'institutional advocacy' (Robinson, 2009) a process by which partners in multi-agency initiatives learn and improve their practice through the transfer of knowledge, exemplified by the IDVA providing midwives brief training sessions and informal advice.
- Granville and Bridge (2010: p4) recommended that the:
 - IDVA service at St Mary's should continue part of joint commissioning across Manchester;
 - clear patient pathways should be developed that link with safeguarding procedures and track the individual journey of a woman from routine enquiry to specialist services;
 - a team of specialist IDVAs should be developed to work in health organisations with other patient groups;
 - midwives should be trained and supported to carry out the CAADA-DASH Risk Indicator Checklist to help them identify those who are at high-risk of harm and who should be referred to a MARAC meeting in order to manage their risk.

Multi Agency Risk Assessment Conferences (MARACs)

- MARACs were introduced in England and Wales as a non-statutory meeting where information about high risk domestic abuse victims is shared between agencies and a risk-focused coordinated safety plan is produced to support the victim.
- MARACs are attended by local authorities, health services, housing authorities, criminal justice agencies, specialist domestic violence services (refuges and outreach services) and many other statutory and voluntary sector agencies to improve service provision.
- In Lancashire 10 MARACs operate, managing over 1,800 cases between April and December 2012. Across England, Wales and Northern Ireland over 260 MARACs operate, managing over 55,000 cases a year.
- Robinsons (2004) evaluation in Cardiff found MARACs:
 - increased information sharing and trust between agencies;
 - provided a setting where children's needs could be raised and discussed; and
 - prevented revictimisation (6 in 19 women experienced no further threats of violence in the six months following the MARAC).
- The *Supporting High-risk Victims of Domestic violence: A Review of MARACs* (2011) found that MARACs have the 'potential to improve victim safety and reduce re-victimisation therefore may be a highly cost-effective measure. However, the available evidence on MARAC outcomes is limited, and a more robust evaluation would be required to strengthen this conclusion' (Steel *et al*, 2011: p24).

Specialist Domestic violence Courts (SDVCs)

- SDVCs were introduced in England and Wales by the *Domestic violence Crime and Victims Act 2004* to enhance victim safety and provide a more coordinated response to domestic abuse by bringing together both civil and criminal cases; and establishing fast-track routes into perpetrator programmes (Eley, 2005).
- Pan-Lancashire eight SDVCs operate, presiding over 1,454 cases in 2011. Across England and Wales 143 SDVCs operate.
- An evaluation of the first five SDVCs in England and Wales found that multiagency partnership approaches were a crucial element in their success; by enhancing the effectiveness of court and support services for victims; making support for victims and information sharing easier; improving victim participation and satisfaction; and increasing public confidence in the criminal justice system (Cook *et al*, 2004).
- Victim withdrawal is a key factor in court proceedings but evidence indicates it to be lower in cases where victims are supported with the criminal justice system (Robinson 2004), specialist domestic violence courts are in operation and prosecutors and judges or magistrates have domestic violence training (Cook *et al*, 2004).

Refuges

- Refuges provide specialist secure short-term housing for survivors of domestic abuse and their families.
- There are seven refuges in the pan-Lancashire area. In 2011/12 they accommodated over 500 women and 700 children. Many of the refuges offer additional services, in addition to safe housing, such as recovery programmes and financial advice.
- The *Beyond Violence Report* (Farmer and Callan, 2012) found that:
 - social housing shortages ensure women and children remain in refuge crisis accommodation for long periods of time;
 - the implementation of eligibility criteria restricts women with substance misuse or mental health problems, and those without children, or recourse to public funds; and
 - the crisis model on which many refuges operate prevent the 'necessary mechanisms that would help workers provide therapeutic and wraparound support are typically missing, such as reflective supervision, peer support, training in managing stress, and hands-on and receptive management' (*Ibid* p59).
- To overcome such barriers, Farmer and Callan (2012) found that the Berkshire and South Buckinghamshire Women's Aid:
 - employs a psychotherapist who specialises in domestic abuse. They undertake psychological assessments on every resident which inform referrals to other agencies and determines the support the resident and their children are given in the refuge; she also provides therapeutic space for the workers to make sense of their experiences as helpers (*Ibid* p59);
 - employs male and female workers, so that residents can move beyond limiting stereotypes of men that may otherwise affect their children and their future relationships (or lack thereof) (*Ibid* p59); and
 - offers a 'woman and child-centred' service (rather than 'woman-centred' with children seen as 'add-ons'). The director of services has her background in children's services, refuge workers are trained to provide support groups to children (rather than simply offering childcare), and local authority child protection is accessed to gain necessary input rather being viewed as 'anti-mother' and therefore best avoided (*Ibid* p59).
- Nationally, unlike IDVAs and MARACs, refuges are not subject to 'rigorous standardisation, accreditation or evaluation' (Farmer and Callan, 2012: p59).

The *Beyond Violence Report* (Farmer and Callan, 2012) recommended that refuges model themselves along the principles of therapeutic communities.

- An evaluation of refuge services by the Department for Communities and Local Government (Quiggars and Pleace, 2010) found that there were insufficient services for some users, including victims with complex needs (such as mental health issues or substance misuse), victims with older children, victims from minority groups (such as Lesbian Gay Bisexual Transgender or Black Minority Ethnic communities).

- The same study found that flexibility in funding arrangements and joint commissioning were most commonly identified as factors that enabled new service development.

Refuges and Floating Support Services (Supporting People)

A number of local authorities, including Lancashire County Council, Blackpool and Blackburn Councils, contract with the Centre for Housing Research at St Andrew's University to collect outcome data for housing related support/supporting people services which enables performance to be compared on a regional and national basis. Data is collected for the following outcome indicators that sit under each of the five high-level outcome domains:

- **Economic Wellbeing:** maximisation of income, reduction of overall debt, participation in paid work.
- **Enjoy and Achieve:** participation in chosen training and/ or education, participation in chosen leisure/ cultural / faith/ informal learning activities; participation in chosen work like/ voluntary/ unpaid work activities; established contact with external services/ family/friends.
- **Be Healthy:** better management of physical health, mental health, substance misuse issues, and better management of independent living as a result of assistive technology / aids and adaptations.
- **Stay Safe:** maintenance of accommodation, secured settled accommodation, compliance with statutory orders and processes (in relation to offending behaviour); better management of self-harm, avoided causing harm to others, minimise harm/risk of harm from others.
- **Make a Positive Contribution:** greater choice and/or involvement and/or control at service level and within the wider community.

The full data set is available from the Supporting People Teams at Lancashire County Council, Blackburn and Blackpool Councils.

Examples of outcomes for people who received a service from refuges and floating/visiting support services, during 2012/13, in the Lancashire County Council are as follows:

- 327 of 663 people using services identified a need for support to better manage their mental health. 270 of the 327 people with an identified need (83%) had a positive outcome. This was marginally above the North West performance of 80%.
- 436 of 663 people using services identified a need for support to contact external services/ groups. 405 of the 436 people with an identified need (93%) had a positive outcome. This was marginally above the North West performance of 89%.
- 179 of 663 people using services identified a need for support to access education and training. 118 of the 179 people with an identified need (66%) had a positive outcome. This was marginally above the North West performance of 62%.

Domestic Homicide Reviews (DHRs)

In 2011 the coalition government enacted on the duty of the Community Safety Partnership to conduct domestic homicide reviews. The aim of introducing a review when a domestic abuse homicide occurs is for all agencies involved (police, local authorities, probation services, health services and voluntary partners) to identify the lessons that can be learned with a view to improving policies and practice at a local and national level. It is hoped that this will help improve approaches to tackling domestic abuse and by looking into the circumstances of the case, lessons are learned and future homicide and incidents of domestic abuse are prevented.

Whilst responsibility of the domestic homicide reviews sits at a district local authority community safety partnership level, across Lancashire, a single approach has been taken to ensure consistency across the county.

Sanctuary Schemes

- Sanctuary schemes enable victims to remain in their own homes by providing improved security measures and support mechanisms.
- An evaluation of sanctuary services by the Department for Communities and Local Government (Jones et al, 2010) found that sanctuary schemes were a success in that they enabled victims to stay in their own homes thus reducing disruption, provided a safe alternative to refuges where the victim had complex needs or older children, reduced re-victimisation rates and were more cost effective than other interventions. However, they found that victims felt unsafe as soon as they left their home and therefore could become 'prisoners' in their own home.

Children and Young People Focus

Research shows that living with domestic violence between parents is as psychologically harmful to children as when they are victims of physical abuse themselves (Kitzman *et al*, 2003).

The pronounced negative effects of domestic abuse on children and young people can cumulate in anxiety, depression, poor health, failure in education, aggression and repeated patterns of abusive behaviour as they develop and on into adult life with repeated cycles of abuse in families over generations.

The guidance for multi-agency Children's Safeguarding Boards states that: The most effective intervention for ensuring safe and positive outcomes for children living with domestic violence is usually to plan a package of support that incorporates risk assessment, trained domestic violence support, advocacy and safety planning for the non-abusive parent who is experiencing domestic violence in conjunction with protection and support for the child (Local Safeguarding Procedures).

Prevention in Education:

- Schools have a safeguarding duty under the *Education Act* (2004) to protect the welfare of children. The *Tackling Domestic violence: Effective Interventions and Approaches Research Study* (Hester and Westmarland, 2005) recommended that primary domestic abuse prevention programmes should be implemented in both primary and secondary schools and all teachers should be trained and be confident in using the project materials.
- Preventative programmes that are commonly used in schools in England include:
 - Social and Emotional Aspect of Learning (SEAL) in primary and secondary schools;
 - Promoting Alternative Thinking Strategies (PATHS); and
 - Personal, Social, Health Economic and Education Life Skills (PSHE) in secondly schools.

The *Beyond Violence Report* (Farmer and Callan, 2012) recommended that a core cross curricula module focussed on helping adolescents to build equal and non-abusive relationships is included within the PSHE curriculum.

Early Intervention and Referral Services

- Early Intervention for children living with domestic abuse, have lived with it in the past, or are at risk of doing so, means offering them and their families help and support before significant problems develop (Farmer and Callan, 2012).
- Since 2004, police notifications have become the principal means of referral to children's social care and both Cleaver *et al* (2004) and Rivett & Kelly (2006) note that a high volume of referrals has created pressure for children's services in the UK. Jaffe *et al* (2003) found that classifying domestic abuse as grounds for state intervention had led to an improvement in interagency collaboration but has acted to overload child protection services and functioned as a deterrent to disclosure of domestic abuse.
- The Laming Review (2009) recommended the establishment of the National Safeguarding Delivery Unit, which would urgently develop guidance on referral and assessment systems for children affected by domestic abuse.
- The Munro Review (Department for Education, 2010) recommended the government place a statutory duty on local authorities and statutory partners to secure the provision of "early help" services for children, young people and families which:
 - prevents significant mental health problems developing, thereby reducing suffering and costs to society;
 - prevents relationship problems in the present and future, thereby reducing family breakdown and dysfunction in the next generation;
 - reduces the chances of unwanted family separations (for example, between victimised parents and children); and
 - restores confidence in children's services, so that people working with adult victims are more likely to link up with them.
- Examples of early intervention for children who have been affected by domestic abuse:
 - family group conferences - in which strengths within the immediate family, extended family and wider friendship network are drawn upon to develop a plan for keeping the family safe. They act against the secrecy of the abuse by enhancing knowledge and the number of people who know what has been happening;
 - counselling in schools;
 - a trusted adult or peer to turn to for support; and
 - mother-child groups, brief parent-child psychotherapy, parent-focussed support and parenting groups all help parents forge more supportive relationships with their children following domestic abuse.

"Building their essential social and emotional capabilities means children are less likely to adopt antisocial or violent behaviour throughout life. It means fewer disruptive toddlers, fewer unmanageable school children, fewer young people engaging in crime and antisocial behaviour. Early intervention can forestall the physical and mental health problems that commonly perpetuate a cycle of dysfunction" (Allen, 2011: p7).

The Early Intervention – Next Steps Report (Allen, 2011) outlined a range of programmes to assist children and young people, pertinent to children and young people who have been affected by domestic violence are as follows:

- Functional Family Therapy (FFT) (10 -17) – a structured family-based intervention to enhance protective factors and reduce risk factors in the family. This three-phase programme motivates family change; identifies family problems; and improves problem solving skills.
- Incredible Years (0-12) - a parent-training intervention that provides a series of programmes focused on strengthening parenting competences.
- Parent child interaction therapy (2-7) - aims to improve the quality of the parent child relationship and change interaction patterns. Noticeable changes are improved child behaviour; reduced stress; and reduced abuse and neglect.
- Multidimensional Treatment Foster Care (MTFC) - foster families are trained and supported to provide care for adolescents exhibiting a high level of emotional disturbance and antisocial behaviour. (Trialled as part of the Care Placements Evaluation)
- Multisystemic Therapy (MST) (12-17) - focuses on improving the family's capacity to overcome the known causes of delinquency and promote the parents ability to change their relationship with their child and assist them to reduce their deviant behaviour.
- Nurse Family Partnership/Family Nurse Partnership - for young families with social/medical difficulties the nurse-family partnership provides support and parenting advice during pregnancy and for the first two years after birth.
- Promoting Alternative Thinking Strategies (PATHS) - helps develop self esteem, emotional awareness, self-control and inter-personal problem solving skills. When linked to PSHE it promotes school behaviour policy.
- Safer Choices – is a teenage pregnancy prevention programme that can be implemented in schools.
- Life Skills Training (9-15) - a school-based intervention to develop social skills and reduce behavioural problems including risky sexual behaviour and alcohol and substance misuse.
- Start Taking Alcohol Risks Seriously (STARS) (11-14) for Families - is a health promotion programme to inform young people about the risks associated with alcohol and for the prevention alcohol use. The goal of STARS for Families is to have all young people postpone alcohol use until adulthood. Results have shown a reduction in alcohol use by young people.
- Systemic Family Therapy - at least 15 fortnightly sessions, if child / young person are unresponsive to treatment, then further psychological therapy and /or family therapy should be considered.

The NSPCC commissioned Children and Families Experiencing Domestic violence: Police and Children's Social Services' Responses Report (Stanley et al, 2010) recommended that:

- inter-agency approaches to filtering notifications that involve staff sharing access to police and children's social services information should be further developed and evaluated;
- actuarial risk assessment tools developed for police use with victims should not be assumed to be appropriate for assessing risks to children;
- not all incidents of domestic violence need to be referred to children's social services but social workers should contribute to interagency processes for identifying which families should be referred;
- multi-agency structures need to be more widely developed with the aim of engaging a range of other agencies in delivering early intervention services;
- children's social services should review the practice of sending letters to families following a notified incident of domestic violence in the absence of any further intervention and consider whether such letters act to promote families' engagement with social services;
- supervised contact services that can be accessed by families on a voluntary basis should be developed as an early intervention in children's experience of domestic violence with central government funding made available for third sector agencies to develop these services; and

- services offering therapeutic support to children and young people harmed by domestic violence should be identified as a priority area for development by central government, local authorities and children's trusts.

Mapping the availability of local resources against population needs represents a useful first step in this process at the local level (Stanley et al, 2010).

Partnership Working

- The *Report of the Children and Young People's Health Outcomes Forum* (CYPHOF, 2012) emphasised that professionals working in different care settings need to communicate better with one another on child protection issues, including domestic abuse. *Working Together to Safeguard Children* (DfCSF, 2010*) summarises legislative requirements and sets out how midwives, health visitors, GPs, teachers, police officers and social workers should work together to ensure the safety of children. (* revised document to be published in Spring 2013).
- Partnership working is imperative when talking into account the number of people who return to abusive relationships through a lack of practical support. This includes practical issues such as local support, feeling safe in the community, housing, understanding and accessing benefits, finding work, securing school places for children, managing finance and paying bills, rebuilding self confidence and accessing literacy, numeracy or other training.
- Professionals must understand the devastating impact of domestic violence on victims, the need to develop clear pathways that join up service provision, as seamlessly as possible, whilst empowering the victim to retain their independence, restart their lives and parent their children.
- Good partnership working with children, young people and families with multiple problems is reliant on agreed services providing a range of service interventions, that meet the assessed needs of children, young people and their family (whole family assessment); all of which requires a concerted commitment to working together.

Stop-start patterns of intervention should be avoided and children's social services should work with other organisations and through commissioning to develop opportunities for long-term monitoring and support of families with multiple and complex needs (Stanley et al, 2010).

Training for Frontline Professionals

- Brandon et al (2011) found that case reviews show that children's safety has been improved where front line staff has received training that includes information about domestic violence and the impact on child development as one of the reasons for a child/young person's inability to thrive.
- For example, a review of internal training for Child and Adolescents Mental Health Services (CAMHS) professionals found that the inclusion of underpinning knowledge and skills will enable CAMHS professionals to work effectively with children and young people who are directed to them for mental health support relating to the impact of domestic violence.

Training initiatives can lead to increased awareness of domestic violence among child welfare agencies (Banks et al, 2008).

Family Intervention Projects (FIPs)

- The report *Working Together With Troubled Families* (DCLG, 2012) describes how FIPs were initiated to reduce anti-social behaviour but had an impact on domestic violence with a reduction of 54%. In collating evidence on families who experienced FIPS between 2007 and 2012, DCLG (2012) found that the work carried out had far wider impacts on families' lives, bringing about significant changes.
- Focussing intensively on the whole family meant FIP workers quickly discovered that the anti-social behaviour of these families was related to deeper family dysfunction leading to or stemming from problems such as drug or alcohol misuse, poor mental health, domestic violence or lack of parenting.
- The evidence compiled in *Working Together with Troubled Families* (2012) suggests that much of the success of family intervention work is due to the skills of individual workers, both in building an honest and productive relationship with a family and influencing the actions of other agencies around that family.

The key FIP factors are 'a dedicated family worker, practical 'hands on' support, a persistent, assertive and challenging approach, considering the family as a whole – gathering the intelligence and a common purpose and agreed action' (*Working with Troubled Families*, 2012: p15).

Refuge Services

- A refuge stay can be conceptualised as a key opportunity for a child's need for support to be assessed and the family put in contact with relevant services as key interventions offered include:
 - structured play which may be used to learn and practice coping skills and may include expression through art, Storytelling to offer empathy and demonstrate problem solving;
 - music, dance and drama which also offer opportunities to learn new skills and to express feelings;
 - individual counselling;
 - groups that offer opportunities to learn new skills and express feelings;
 - assistance with transition to new schools; and
 - child advocacy.
- Although the brevity of a child's stay in a refuge may further reduce opportunities for interventions offered to children. Webb *et al* (2001) assessed the health of 147 children in Cardiff refuges and concluded that children had a high level of health needs and that frequent moves had resulted in limited access to services; having found that:
 - 30% of children screened has delayed immunisations;
 - 19% of children were assessed as having delayed or questionable development; and
 - 48% of children had mental health difficulties.

Perpetrator Focus

A high proportion of domestic abuse perpetrators are likely to reoffend thus positive interventions are vital and should be offered. Perpetrators have a wide variety of needs and treatment interventions need to be understood via an individual assessment (Gilchrist *et al*, 2003).

- Victim and child safety programmes carry out a range of activities designed to intervene and respond to the domestic violence of perpetrators; including, but not confined to:
 - individual assessment of past and current use of abuse, current and likely future risk, treatment suitability, compounding factors and needs;
 - individual or group orientation to the programme (pre-group work);
 - group work with perpetrators of typically 60 hours or more, usually in weekly sessions but not always;
 - individual work with perpetrators who are not suitable for group work;
 - proactive contact with partners, ex-partners and new partners of group work with perpetrators, in order to carry out detailed risk assessment and management with those working with the perpetrators, to provide support and advocacy and information about programme activities and consequences. This is essential in order to ascertain even the most basic information about the safety of the victim and the impact of the programme on victims;
 - group work for supporting survivors;
 - inter-agency working such as child protection case conferences, MARACs, etc.;
 - risk assessment reports for courts such as family courts, child protection cases etc.;
 - evaluation and follow up work; and

- supervision for practitioners.
- Support can also be offered either directly or through service provision and by raising awareness:
 - in parenting programmes designed to improve awareness, self esteem, and improve parenting capacity (the Solihull Parenting programme is up and running in the local authority);
 - in local community support groups both funded and voluntary;
 - in children's centres by children's centre staff and associated health and social care staff. In Lancashire various programmes are delivered that include an increased understanding and awareness of domestic violence related issues and offer support/access to support eg parenting programmes, '*From Bump to Birth and Beyond*';
 - in health care settings; through the changing role of the health visitor, school and the family nurse partnership programme for vulnerable young first time mothers;
 - in cases where there are child in need and child at risk protection concerns through assessment and referral to children's social care;
 - in local domestic violence groups and other commissioned services.
- Improved outcomes are also dependent on:
 - better family court decision making because the courts are provided with specialist information about a perpetrator's level of risk to victim and children;
 - safer parenting on child contact visits because of the work done with the perpetrator on the impact of their behaviour on their children;
 - improved victim safety because the victim is able to make informed choices with greater understanding of the possible consequences of the programme as well as other safety options;
 - victims feeling able to make the choice to end the relationship;
 - victims receiving help who would not otherwise have received any.

Evaluation of Perpetrator Programmes in Scotland

- Dobash *et al* (1999) evaluated two Scottish perpetrator programmes by examining outcomes for men mandated to attend by courts and comparing them with outcomes from men subject to alternative CJS sanctions eg fines, community and custodial sentences.
- Dobash *et al* (1999) found that 12 months after the initial interview:
 - 66% of the men participating in the programmes had remained violence free compared with 30% of those subject to alternative CJS sanctions; and
 - the partners of men participating in the programme were also significantly less likely to report frequent violence.

Evaluation of Perpetrator Programmes in the US

- Gondolf (2002; 2004) undertook a large-scale US evaluation of perpetrator programmes over four sites over seven years, involving 840 men and their partners; finding that:
 - programme participation was more effective in ending men's violence than CJS sanctions;

- majority of men participating in programmes had not re-assaulted their partner after four years after the programme; and
- over two thirds of participants partners reported that their quality of life had improved and 85% felt very safe.
- Men mandated by the courts are more likely to change their behaviour than self-referrals and programme attendance must be monitored with Court sanctions applied if required (*ibid.*)
- Integrating programmes focused on intensity rather than length into a coordinated community response to domestic violence contributes to better outcomes (*Ibid.*)

Evaluation of Perpetrator Programme in Blackpool

- The domestic abuse perpetrator pilot commissioned and evaluated in Blackpool in 2012/13 was run to ascertain if the integrated offender management (IOM) mechanism could be applied to the IOM offender cohort exhibiting domestic abuse, in order to impact on their offending.
- It is recognised that the attitudes, thinking and behaviour pathway is the most challenging to impact upon due to its entrenched nature and therefore when managing domestic violence perpetrators the other six pathways (accommodation, finance, relationships, education and employment, health) need to be managed and in some cases supported with a bespoke programme that addresses the behaviour, attitude and thinking.
- Blackpool CSP funded a 12-week perpetrator programme delivered by Blackburn Women's Aid, which cost £1,000 per perpetrator. The impact of that pilot, six of the eight perpetrators completed the programme against an average 30% take-up.
- The pilot was evaluated by Blackpool CSP and it evidenced the:
 - notable impact on incidents, offences and behaviour;
 - challenges experienced with the initial selection criteria;
 - most effective selection was by partner exercising professional judgement and overlaying an analytical product; and
 - redesign and remodel of MARAC could readily facilitate the effective selection of high risk offenders.

Perpetrator programmes have been shown to be successful in reducing men's violence for the majority of men who attend and improving the quality of life and safety for the majority of participants' partners. However, an evaluation of the long-term effectiveness of perpetrator programmes is required.

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