Walsall Council

Public Health Walsall 2015

Domestic Abuse Needs Assessment

This needs assessment is part of the Walsall Joint Strategic Needs Assessment process

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Executive Summary

Domestic Violence and Abuse (DV&A) is an important cause of long term problems for Children, families and communities. It has intergenerational consequences in terms of the repetition of abusive and violent behaviours. It can also have the most significant impact on the outcomes for children and young people, ultimately resulting in children entering the looked after system.

The Partnership in Walsall is committed to ensuring that DV&A are not tolerated in Walsall. The Domestic Abuse Strategy (2014-16) and accompanying Action Plan set out key priorities for tackling DV&A locally. This needs assessment is a refresh of the work done in 2013 to inform the strategy, it includes a review of the evidence, mapping of current services, data on need and demand and consultation with stakeholders. A number of recommendations have been drawn up which reflect both local need and the evidence of what works (see section 6.0). These recommendations are summarised below.

1. Primary Prevention

Unless work is done to reduce the incidence and prevalence of DV&A we will always be faced with dealing with the consequences of it. We need to develop a strategy for primary prevention which includes parenting and relationship skills, life skills for children and young people, and working with those at high risk of DV&A. The strategy needs to recognise the wider workforce who deliver primary prevention and seek opportunities to integrate DV&A prevention into mainstream frontline services.

2. Workforce development

There is some local workforce development but it is inconsistent and not joined up. We need to develop a multi-agency multi-professional system-wide approach to training which includes awareness raising, supporting disclosure, risk identification and assessment and delivery of support to those experiencing DV&A.

3. Support for victims

There are insufficient support services available for victims of DV&A, with particular gaps earlier in the pathway (to prevent escalation), for key groups and longer term support for individuals and high risk. We need to commission evidence-based specialist advice, advocacy and support across the whole pathway, and ensure this is integrated with mental health and addiction support services where necessary.

4. Support for children

There is very limited provision for children who are affected by DV&A. We need to commission more local services to support children to meet their needs, across the whole pathway. This needs to include consideration of their mental health and emotional wellbeing.

5. Work with perpetrators

There are insufficient services for perpetrators with notable gaps (eg female perpetrators). We need to commission additional capacity in evidence-based programmes for perpetrators and monitor the effectiveness and outcomes of these programmes.

6. System-based approach

6.1 Strategic leadership

Current structures lack the authority to hold people accountable for delivering the DV&A Action Plan. We need to have clear accountability for the partnership responsible for DV&A communicated and implemented.

6.2 Co-ordination

The current DV&A system is not well joined up. We need to take a more holistic approach to meeting the needs of the family and commission a whole-system approach rather than separate elements.

6.3 Data, intelligence and information sharing

There are many gaps in data and a lack of information and intelligence sharing across agencies – of both family needs and service delivery. This is particularly apparent for families with lower level concerns before they escalate. We need to improve information sharing across agencies for victims, families and perpetrators. We also need to share information and intelligence across providers to enable a whole system approach to work.

1. Introduction and background

1.1 Background

Walsall Council carried out a needs assessment in 2013 and produced a Domestic Abuse Strategy 2014-16 with the following vision:

> We are committed to ensuring that domestic abuse is not tolerated in Walsall. We want to realise our aims of prevention, protection and accountability and ensure that we do so collaboratively with partner agencies taking a systematic approach to dealing with domestic abuse.

The aims of the Domestic Abuse Strategy are:

- Prevention: To improve early identification and prevention of domestic abuse
- Protection: To ensure that victims of domestic abuse and their children are adequately protected and supported
- Accountability: To hold perpetrators accountable through effective and early interventions

An action plan was developed from the strategy which includes reviewing the needs assessment and analysing gaps. The needs assessment presented here is in response to this action.

1.2 Definition of domestic abuse

On 31st March 2013, Government implemented a new definition of domestic abuse which extends our understanding because it captures the experiences of young people aged 16 and 17 as well as the issue of coercive control within domestic abusive relationships.
The definition is:

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

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

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

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

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

1.3 Aim and Objectives

1.3.1 Aim

To complete a rapid domestic abuse needs assessment for Walsall to inform a commissioning strategy to be implemented in April 2016.

1.3.2 Objectives

- To review current levels of need (based on national and local data)
- To understand current levels of demand for services
- To include information from a variety of sources including: Police, Children's services, hospital data, local intelligence from providers
- To map local services and pathways
- To review the evidence of what works
- To identify gaps in services
- To specifically consider vulnerable groups eg pregnant women to ensure that this work links with wider work on violence, toxic trio and vulnerability
- To develop recommendations for commissioners to consider
- To finish the first draft needs assessment by 30th September 2015

1.4 Local strategic and governance structures

The primary governance structure for the 2014-16 DV&A strategy is through the Safer Walsall Partnership with agreement for 6 monthly reporting to the Adult's and Children and Young People's Safeguarding Boards. DV&A remains a relevant agenda item for all local Strategic Boards:

- Walsall Safer Partnership
- Health and Wellbeing Board (HWB)
- Walsall Safeguarding Children Board (SCB)
- Walsall Safeguarding Adult Board (SAB)
- Walsall Children and Young People Trust Board
- Youth Justice Board

1.5 Links to the current programme of work on the "Toxic trio"

The term 'Toxic Trio' has been used to describe the issues of domestic abuse, mental ill health and substance misuse which have been identified as common features of families where harm to women and children has occurred. They are viewed as indicators of increased risk of harm to children and young people.

There is a programme of work locally to look at the impact of the toxic trio and what can be done to reduce this impact to improve the outcomes for children and young people in Walsall through invest to save. The needs assessment presented here contributes to this work.

2. Evidence base and expert opinion

2.1 National Context

NICE (PH50) included data on domestic abuse in England and Wales, a summary is included here (see NICE PH50 guidance for source references).

- At least 1.2 million women and 784,000 men aged 16 to 59 in England and Wales experienced domestic abuse in 2010/11 – 7.4% of women and 4.8% of men. (Domestic violence and abuse here is defined as: physical abuse, threats, non-physical abuse, sexual assault or stalking perpetrated by a partner, ex-partner or family member.) At least 29.9% of women and 17.0% of men in England and Wales have, at some point, experienced it.
- These figures are likely to be an underestimate, because all types of domestic violence and abuse are under-reported in health and social research, to the police and other services.
- Both men and women may perpetrate or experience domestic violence and abuse. However, it is more commonly inflicted on women by men. This is particularly true for severe and repeated violence and sexual assault.
- Lesbian and bisexual women experience domestic violence and abuse at a similar rate to women in general (1 in 4), although a third of this is associated with male perpetrators. Compared with 17% of men in general, 49% of gay and bisexual men have experienced at least 1 incident of domestic violence and abuse since the age of 16. This includes domestic violence and abuse within same-sex relationships.

2.2 Associated risk factors

The risk of experiencing domestic violence or abuse is increased if someone:

- is female
- is aged 16–24 (women) or 16–19 (men)
- has a long-term illness or disability – this almost doubles the risk
- has a mental health problem
- is a woman who is separated – there is an elevated risk of abuse around the time of separation.
- Is a woman who is pregnant or has recently given birth. In addition, there is a strong correlation between postnatal depression and domestic violence and abuse.
- The majority of trans people (80%) experience emotional, physical or sexual abuse from a partner or ex-partner.
- Just under 40% of bisexual, gay and lesbian people class themselves as having experienced domestic violence and abuse. However, many more respondents reported behaviours that could be classed as domestic violence and abuse.
- The role played by alcohol or drug misuse in domestic violence and abuse is poorly understood. Research has indicated that 21% of people experiencing partner abuse in the past year thought the perpetrator was under the influence of alcohol and 8% under the influence of illicit drugs. People are thought to be at increased risk of substance dependency as a consequence of being the victim of domestic violence

(see NICE PH50 for further detail and references)

In addition to groups who experience increased levels of domestic abuse there are groups and communities who need particular consideration because of other issues such as: poorer recognition of domestic abuse; cultural differences and problems accessing mainstream services. These include:

- Black and minority ethnic groups and refugees
- Older people
- Teenagers under the age of 16
- People with diabilities

2.3 Abusive relationships

(see NICE PH50 for further detail and key references)

2.3.1 Partner abuse among adults

- Partner abuse is the most prevalent form of domestic abuse. At least 26.6% of women and 14% of men have, at some point, experienced this since they were 16. The prevalence is consistently higher among people in healthcare settings
- Women are more likely than men to experience repeated partner abuse, partner abuse over a longer period of time, violence and more severe abuse. Women's reports of partner abuse are also more likely to indicate that it is part of a system of fear and coercive control.
- Men are less likely to report abuse to the police, and more likely to say this is because they consider it too trivial or not worth reporting.
- Each year since 1995, approximately half of all women aged 16 or older murdered in England and Wales were killed by their partner or ex-partner. Around 12% of men murdered each year from 1995 were killed by their partner or ex-partner.

2.3.2 Partner abuse among young people

- Partner violence is also prevalent in young people's relationships. In the UK in 2009, 72% of girls and 51% of boys aged 13 to 16 reported experiencing emotional violence in an intimate partner relationship, 31% of girls and 16% of boys reported sexual violence, and 25% of girls and 18% of boys experienced physical violence. Some form of severe domestic violence and abuse inflicted on them by a partner was reported by 1 in 6 girls.
- In line with research among adults, girls described more abuse, and more severe abuse, more direct intimidation and control, and more negative impacts.
- Young people in same sex relationships were at greater risk than those in heterosexual relationships.

2.3.3 Domestic violence and abuse between parents

- 3.16 Domestic violence and abuse between parents is the most frequently reported form of trauma for children. In the UK, 24.8% of those aged 18 to 24 reported that they experienced domestic violence and abuse during their childhood. Around 3% of those aged under 17 reported exposure to it in the past 12 months.
- The impact of living in a household where there is a regime of intimidation, control and violence differs by children's developmental age. However, whatever their age, it has an impact on their mental, emotional and psychological health and their social and educational development. It also affects their likelihood of experiencing or becoming a perpetrator of domestic violence and abuse as an adult, as well as exposing them directly to physical harm.
- There is a strong association between domestic violence and abuse and other forms of child maltreatment: it was a feature of family life in 63% of the serious case reviews carried out between 2009 and 2011.

2.3.4 'Honour'-based violence and forced marriage

- It is difficult to estimate the prevalence of so-called 'honour'-based violence and forced marriage, but we do know that the incidences of both are under-reported. Both can occur in Christian, Jewish, Sikh, Hindu, Muslim and other communities. They are probably more common in some groups, for example, some Pakistani, Kurdish, and Gypsy and Traveller communities, reflecting a more oppressive patriarchal ideology.
- Both often involve wider family members and affect men, as well as women: 22% of the 1468 cases looked at by the Forced Marriage Unit involved a male being forced to marry. It is estimated that between 5000 and 8000 cases of forced marriage were reported to local and national organisations in England in 2008. In 41% of cases reported to local organisations the person forced to marry was younger than 18.

2.3.5 Abuse of older people

- More than 250,000 older people (aged 66 and older) living in England in private households reported experiencing maltreatment from a family member, close friend or care workers in the past year. Maltreatment included neglect and psychological, physical, sexual and financial abuse.
- Of those experiencing maltreatment, 51% experienced it from a partner, 49% from another family member, 5% from a close friend and 13% from a care worker. Women were more likely to experience maltreatment than men (3.8% of women and 1.1% of men in the past year), and men were more often the perpetrators.

2.3.6 Abuse of parents by children

- The prevalence of abuse of parents by their children is very difficult to ascertain and 'still lies in a veil of secrecy' (Kennair and Mellor 2012, found within NICE PH50). It is 'a pattern of behaviour that uses verbal, financial, physical or emotional means to practise power and exert control over a parent'. It is more commonly experienced by mothers than fathers – and is more common among single parents.
- It can bring stress, fear, shame and guilt, as well as physical, emotional and psychological harm to the person who experiences it. Those inflicting the abuse may feel inadequate, hopeless and alone. A large proportion of those inflicting the abuse will themselves have been physically or sexually abused or have witnessed abuse.

2.4 Impact of domestic abuse

The information on the impact of domestic abuse has been taken from the SafeLives website http://safelives.org.uk/policy-evidence/about-domestic-abuse (please refer to website for source references)

2.4.1 Death due to domestic abuse

- In 2013-14, 85 women were murdered by their partner or ex-partner in England and Wales. This accounted for just under half (46%) of all murders of women aged 16 or over. In comparison, 7% of men murdered were killed by their partner or ex-partner

- This means 1.6 women a week – or 7 a month – are killed by a current or ex-partner in England and Wales
- It is estimated many more take their own lives as a result of domestic abuse: every day almost 30 women attempt suicide as a result of experiencing domestic abuse and every week three women take their own lives

2.4.2 Forms of domestic abuse

- 88% of high-risk victims experience multiple forms of abuse, including physical and sexual abuse, harassment and stalking and coercive control (jealous and controlling behaviours)
- In 8 in 10 (79%) high-risk cases, the abuse is escalating in either frequency or severity, or both
- Approximately 42% of domestic violence victims have been victimised more than once. Victims experience an average of 20 incidents of domestic violence in a year, which can often increase in severity each time
- Over 80% of high-risk victims report experiencing physical abuse
- Nearly 90% of high-risk victims report experiencing emotional abuse and/or coercive control (jealous and controlling behaviours)
- 79% of teenage victims of domestic abuse experienced physical abuse, and 19% sexual abuse

2.4.3 Physical health impacts of domestic abuse

- 1 in 5 high-risk victims reported attending A&E as a result of their injuries in the year before getting effective help
- As well as short term injuries, victims of abuse suffer long-term physical health consequences. Health conditions associated with abuse include: asthma, bladder and kidney infections, cardiovascular disease, fibromyalgia, chronic pain syndromes, central nervous system disorders, gastrointestinal disorders, migraines/headaches
- Domestic abuse often leaves victims with reproductive consequences too, including gynaecological disorders, sexually transmitted infections, pre-term difficulties and pregnancy difficulties
- At least a fifth (18%) of children in domestic abuse households are injured as a result of the abuse

2.4.4 Mental health impacts of domestic abuse

- 40% of high-risk victims report having mental health issues
- 16% of victims report that they have considered or attempted suicide as a result of the abuse, and 13% report self-harming
- Domestic abuse has significant psychological consequences for victims, including anxiety, depression, suicidal behaviour, low self-esteem, inability to trust others, flashbacks, sleep disturbances and emotional detachment
- Domestic abuse victims are at risk of post-traumatic stress disorder (PTSD) – as many as two-thirds of victims of abuse (64%) developed PTSD in one study
- Between 30 and 60% of psychiatric in-patients had experienced severe domestic abuse

2.5 Financial costs

- The public service burden of domestic abuse is considerable. A high proportion of women attending accident and emergency departments, primary care, family planning, reproductive and sexual health settings are likely to have experienced domestic violence and abuse at some point. In addition, between 25 and 56% of female psychiatric patients report experiencing domestic violence and abuse in their lifetime (NICE PH50).
- Domestic violence and abuse cost the UK an estimated £15.7 billion in 2008 (Walby 2009). This included:

Organisation/system	Costs incurred (England and Wales 2008)	Estimated costs incurred for Walsall (based on 2013 population and 2008 costs)
Criminal Justice system	£1,261m	£5.15m
Health care	£1,173m	£7.07m
Social services	£283m	£1.16m
Housing and refuges	£196m	£0.81m
Civil legal services	£387m	£1.58m
Economic output	£1,920m	£7.84m
Human and emotional costs	£9,954m	£40.66m
TOTAL	£15,720m	£64.26m

2.6 Return on investment

Some information has been found demonstrating return on investment for elements of domestic violence services.

2.6.1 Domestic violence perpetrator programmes

Respect commissioning guidance on domestic violence perpetrator interventions (2015) states that for every man who received the DVPP intervention the estimated saving to the public purse was:

- £63,937 per man
- £35,058 per partner/ex-partner
- £1,172 per child

Overall, this means that for every £1 invested in a DVPP, the return is:

- £2.24 in reduced criminality (excluding set-up costs)
- £2.57 in net savings to the Health Service
- £10 in savings to all public agencies
- £14 in total savings when Human & Emotional costs are included (including all set-up costs5).
- Given the average cost of taking one child into care is £130,000 per year, if a DVPP averts just one care proceeding, it will have recovered its entire annual staffing costs.

2.6.2 Specialist domestic violence support

Nef (New Economics Foundation) consulting carried out a social valuation for Refuge of services they provide to survivors of domestic abuse (2013). The study focused on 3 elements of the service

provided: Refuge housing, community outreach and IDVAs. It looked at outcomes for three stakeholder groups (women, their children and the State) and translated these into monetary values. The overall social return on investment ratio was found to be 3.54:1 (£3.54 for every £1 spent). The social return on investment ratios by service is shown below:

- Refuges 1.99:1 (this increases to 2.69:1 when adjusted for women who were already in receipt of housing benefit)
- Outreach 5.28:1
- IDVAs 9.88:1

NB These ratios are not intended to imply the relative value of one service over another – each service works with clients in different situations and the supports are not substitutable.

2.7 Evidence base

A review of the evidence on prevention, support and interventions for domestic violence and abuse was carried out (Sept 2015). The key results from this are presented below.

2.7.1 NICE guidance

"Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively" [PH50] Published date: February 2014

This guidance set out NICE's recommendations for local authorities and partner organisations on domestic violence and abuse. It does not include recommendations directly relevant to female genital mutilation, primary prevention or the content of programmes for perpetrators.

NICE recommendations:

- Recommendation 1: Plan services based on an assessment of need and service mapping
- Recommendation 2: Participate in a local strategic multi-agency partnership to prevent domestic violence and abuse
- Recommendation 3: Develop an integrated commissioning strategy
- Recommendation 4: Commission integrated care pathways
- Recommendation 5: Create an environment for disclosing domestic violence and abuse
- Recommendation 6: Ensure trained staff ask people about domestic violence and abuse
- Recommendation 7: Adopt clear protocols and methods for information sharing
- Recommendation 8: Tailor support to meet people's needs
- Recommendation 9: Help people who find it difficult to access services
- Recommendation 10: Identify and, where necessary, refer children and young people affected by domestic violence and abuse
- Recommendation 11: Provide specialist domestic violence and abuse services for children and young people
- Recommendation 12: Provide specialist advice, advocacy and support as part of a comprehensive referral pathway
- Recommendation 13: Provide people who experience domestic violence and abuse and have a mental health condition with evidence-based treatment for that condition
- Recommendation 14: Commission and evaluate tailored interventions for people who perpetrate domestic violence and abuse
- Recommendation 15: Provide specific training for health and social care professionals in how to respond to domestic violence and abuse

- Recommendation 16: GP practices and other agencies should include training on, and a referral pathway for, domestic violence and abuse
- Recommendation 17: Pre-qualifying training and continuing professional development for health and social care professionals should include domestic violence and abuse

A summary of evidence from the NICE guidance can be found at appendix 1.

2.7.2 Systematic reviews

The Cochrane, HMIC and NHS Evidence databases were searched to identify systematic reviews (2010-15). A small number of reviews were identified:

- Effectiveness of home visiting in reducing partner violence for families experiencing abuse : a systematic review. (Prosman et al 2015).
  Key points: Home visiting interventions that support abused women explicit to stop IPV seem to be effective in reducing IPV. However, it is not known whether these results are effective in the long term

- Interventions to reduce domestic abuse in pregnancy : a qualitative systematic review (Leneghan 2012)
  Key points: Counselling was found to be significant in reducing domestic abuse in two of the four studies, which used the Dutton's 1992 empowerment model as the basis for their counselling intervention. Tthe strength of evidence for the effectiveness of counselling is promising. Interventions based on mentoring appear to be beneficial. Further research is recommended.

- Interventions for preventing or reducing domestic violence against pregnant women (Jahanfar et al 2014)
  Key points: There was insufficient evidence to assess the effectiveness for domestic violence on pregnancy outcomes

- Intimate partners violence and pregnancy: a systematic review of interventions (Van Parys, 2014)
  Key points: There was not strong evidence that certain interventions are effective but home visitation programs and some multifaceted counselling interventions did produce promising results including a reduction in partner violence.

- Preventing domestic abuse for children and young people (PEACH): a mixed knowledge scoping review (Stanley et al, 2015)
  Key points: The review carried out a mapping of current practice, systematic literature review, review of the UK grey literature and a consultation. From this a series of conclusions were developed which could be used to help inform any commissioning of prevention programmes for children and young people. The conclusions can be found in appendix 2.

2.7.3 Protecting People Promoting Health : a public health approach to violence prevention for England (DH 2012)

This is a report covering various forms of violence, including domestic violence. The report draws on the latest evidence to show that many of the key risk factors that make individuals, families and communities vulnerable to violence are changeable. The Department of Health commissioned the North West Public Health Observatory (NWPHO) to produce the high level report to provide information and evidence for policy makers and commissioners to use in developing preventative approaches with strategic partners.

Violence and abuse can be prevented. There are a wide range of strategies that can be used to address risk factors for violence and promote protective factors across the life course. Some can be implemented universally and others are targeted specifically towards at risk groups. Evidence is presented on the effectiveness of violence prevention interventions, focusing particularly on primary prevention approaches and the role of health services.

1. Supporting parents and families
   Interventions that develop parenting skills, support families and strengthen relationships between parents, carers and children can have long lasting violence prevention benefits. They can prevent child abuse and improve child behaviour, reducing children's risks of involvement in violence in later life. They can also be cost-effective.

2. Developing life skills in children and young people
   Programmes that develop life and social skills in young people can help protect them from violence by building their social and emotional competencies, teaching conflict avoidance skills and providing broader skills to help them find employment and avoid poverty and crime. They can prevent violence and other health risk behaviours among young people, particularly when targeted towards at-risk children early in life.

3. Working with high risk youth and gangs
   Delinquent behaviour, criminal activity and gang membership in youth are key risk factors for involvement in violence. Interventions that work with high risk youth to change their behaviour can be important in preventing future violence.

4. Reducing the availability and harmful use of alcohol
   The consumption of alcohol is strongly associated with violence. Measures to limit access to alcohol and reduce alcohol consumption among hazardous and harmful drinkers can have important violence prevention impacts.

5. Community interventions
   Community interventions can bring together multi-agency partnerships at a local level to identify and address risk factors for violence. They typically implement a range of co-ordinated enforcement and preventive approaches, often focusing on youth or alcohol-related violence.

6. Changing social norms that support violence
   Social and cultural norms – behavioural rules or expectations within a social group - can strongly influence violent behaviours, including child maltreatment, violence towards women and elder abuse. Interventions that challenge social norms aim to prevent violence

by making it less socially acceptable.

7. Identification, care and support
   Programmes that identify victims of violence and provide effective care and support are critical for protecting the health and wellbeing of victims and breaking cycles of violence. Health settings can be ideal places to identify and support victims of violence

2.7.4 Protecting people and promoting healthy lives in the West Midlands: An evidence based public health response to support violence reduction across West Midlands police force area (June 2015)

This report presents evidence on violence prevention. It is not specific to domestic abuse but the following may be considered relevant:

- Home visiting programmes – intensive early years support for vulnerable parents whose children are at risk of poor outcomes
- Life skills programmes eg Safe Dates (USA) which targets 12-18 year olds and aims to develop relationship skills, address social norms and raise awareness of support services
- Emergency department information sharing (Cardiff model) -Emergency department sharing information with the police, enabling them to target their resources more effectively

2.7.4.1 West Midlands Domestic Violence and Abuse Standards Sept 2015

These standards are intended to identify and promote evidence-based, safe and effective practice in working with adult and child victims of domestic violence and abuse, and to ensure perpetrators are held to account increasingly effectively. The standards apply to all statutory organisations and specialist domestic abuse services in the West Midlands

2.7.5 Report from the domestic violence sub-group: responding to violence against women and children - the role of the NHS (DH 2010)

This report examines the impact of domestic violence against women, girls and children in England and how it can damage them and their families, with long-lasting wider repercussions for society. The findings and recommendations from this report have fed into the overarching report from the Taskforce on the health aspects of violence against women and children. The recommendations are detailed in Appendix 3.

2.7.6 Early intervention in domestic violence and abuse (Early Intervention Foundation 2014)

This report assesses the evidence of existing services aimed at the prevention of domestic violence and abuse, and also whether broader Early Intervention services can also help address DV&A.

Key findings are presented on prevalence, impact, costs and policy effectiveness. The evidence for policy effectiveness can be summarised as:

- Universal services (primary prevention) – there is little UK evidence on the capacity of universal primary prevention programmes delivered through schools to achieve behavioural, as opposed to attitudinal, change. However there are approaches to sex and relationship education that have shown promise (eg “Safe Dates”)

- Early intervention – young people at risk – there is modest evidence that programmes can improve knowledge, attitudinal and interpersonal outcomes, and drive modest reductions in violent behaviours. The report includes details of potential approaches
- Late intervention (the review does not cover safeguarding children or service provision for victims) – there is good evidence about differences in effectiveness of perpetrator programmes that indicate a need for approaches to be carefully personalised to the individual
- Workforce – a lack of professional confidence among the Early Intervention workforce is a primary barrier to addressing domestic violence and abuse. Core training on domestic violence and abuse should be available for all professionals working with children and families including midwives, health visitors and primary care staff

2.7.7 Domestic Violence Perpetrator Programmes: Steps towards change (project Mirabal RESPECT final report London and Durham 2015)

Project Mirabal considered how effective programmes are in changing the behaviour of individual perpetrators, and how much they contribute to a CCR (co-ordinated community response). RESPECT-accredited DVPPs were analysed through quantitative and qualitative measures. There were positive changes in all 6 measures of success:

- Respectful communication
- Expanded “space for action”
- Safety and freedom from violence and abuse for women and children
- Shared parenting
- Awareness of self and others
- Safer, healthier childhoods

The inclusion of DVPPs within CCRs was variable, and further work needs to be done to ensure DVPPs are seen as an integral part of the local response to DV&A.

2.7.8 Commissioning services for women and children who experience violence or abuse – a guide for health commissioners (DH 2011)

This document is designed to improve the commissioning of services for women and children who are victims of violence or abuse. It includes useful detail on measuring effectiveness, including suggested patient-reported outcome measures (PROMs). It also cites some case examples with information on how data are collected and used.

2.7.9 Preventing Domestic Violence and Abuse: common themes lessons learned from West Midlands’ domestic homicide reviews (DHRs) 2014

This report was commissioned by the 7 Community Safety Partnerships across the West Midlands Police Force Area. It is a collation of findings from 13 DHRs and stakeholder interviews.

Summary of Local Recommendations:

1. Improving health services
    - Implement RCGP national guidance on the role of GPs in understanding and responding to DV&A.
    - Training for health visitors
    - Assessment tools and referral pathways for addiction services and mental health services

- Mental health support for patients and their families in primary care

2. Engaging carers
    - Assessment and referral pathways for carers to ensure proper support is provided

3. Assessment tools
    - Ensure clear MARAC procedures are in place for risk assessment and coordination
    - Introduce longer term interventions for repeat MARAC cases
    - Development of a tactical toolkit for staff called to DV&A incidents

4. Sharing information
    - Specific services that target the needs of perpetrators
    - Increased awareness of Clare's Law

5. Funding for services
    - Provide adequate and sustained funding to DV&A coordinators, and ensure all DV&A posts are filled. Investment into IDVA services must be a priority

6. Equalities issues
    - Access to police services and public campaigns to encourage new entrants to communities to disclose concerns around DV&A

7. Child protection issues
    - Training across different sectors for any agency dealing with children and young people
    - Clear policies, procedures and training in place for any agencies that work with children and young people
    - Clear information sharing protocols across agencies

8. Preventing domestic violence
    - Sharing of information and evaluation of any prevention services, pilots and interventions

2.7.10 Coordinated community response model

The Coordinated Community Response to domestic violence (CCRM) was developed by AVA for the Home Office (http://www.ccrm.org.uk/) . It is designed as a blueprint against which local services could map their provision for domestic violence services in order to assess their current response and identify any gaps. The toolkit is designed for strategic planners, and provides guidance, research and examples of projects and initiatives to assist in creating a more comprehensive and stronger interagency response (see appendix 4 for model).

The Coordinated Community Response Model to domestic violence acknowledges that, while each agency maintains its independence, all agencies involved must work in an integrated and coordinated way with each other to achieve:

- An increase in the safety of domestic violence survivors
- An increase in the safety of children who live with domestic violence
- Holding abusers accountable for their actions
- Effective prevention strategies
- A system where the onus of holding abusers accountable lies with service providers, and the wider community, rather than the survivor.

3.0 Need and demand for services

3.1 Local estimates (need)

National figures for domestic abuse are shown in section 2.1. The "Violence against women and girls home office ready reckoner" has been used to estimate the local prevalence of domestic abuse (using a local population of 153,178 males and females aged 16-59).
http://webarchive.nationalarchives.gov.uk/20100104215220/http:/crimereduction.homeoffice.gov.uk/domesticviolence/domesticviolence072.htm

Based on regional data from the British Crime Survey, the estimate for an area this size would be that:

5,131	women and girls aged 16-59 have been a victim of **domestic abuse** in the past year	(Margin of error: +/- 1238)
2,144	women and girls aged 16-59 have been a victim of a **sexual assault** in the past year	(Margin of error: +/- 890)
6,102	women and girls aged 16-59 have been a victim of **stalking** in the past year	(Margin of error: +/- 1362)

These figures are estimates based on the population size specified for your area and the BCS prevalence rate for the region your area is in. As such they are only indicative of the level of VAWG, and should serve as one of several sources on which to assess the need for VAWG services in the area.

It should be noted that these figures do not include elder abuse or male victims so will be an underestimate of the size of the problem.

3.2 Local Data (demand)

Local data are obtained from local services so reflect demand for these services rather than need. A number of sources of data are presented here to give as complete a picture as possible for Walsall. Data were not available from all providers at this time.

3.2.1 Police

A Domestic Abuse Profile for Walsall has been provided by West Midlands Police and is included in Appendix 5. Key points from this profile:
Domestic incidents (police called but no crime recorded)

- In the period 1.7.13 – 30.6.15 there were an average of 305 Domestic Incidents per month. This equates to 5% of the Brorough's total demand for service
- 55% of these had Domestic Abuse recorded as a qualifier, 37% did not have a qualifier so no further conclusions can be made.
- Peak days are weekends (Saturday and Sunday), peak times are during the evening (up to 23:00h)

Domestic Abuse: Crimes

- Domestic Abuse Committed Crimes decreased from 2007-early 2014 (average of 105/month July 13-Apr14) but showed a sharp increase in April 2014. This effect was seen across the West Midlands Police Force area and was not specific to Walsall. These higher levels have been maintained (average of 149/month May14-June15). This increase may be due to improved data quality and the launch of Operation Sentinel (long running initiative aimed at enhancing the service provided by West Midlands police and its partners to vulnerable victims across the area)

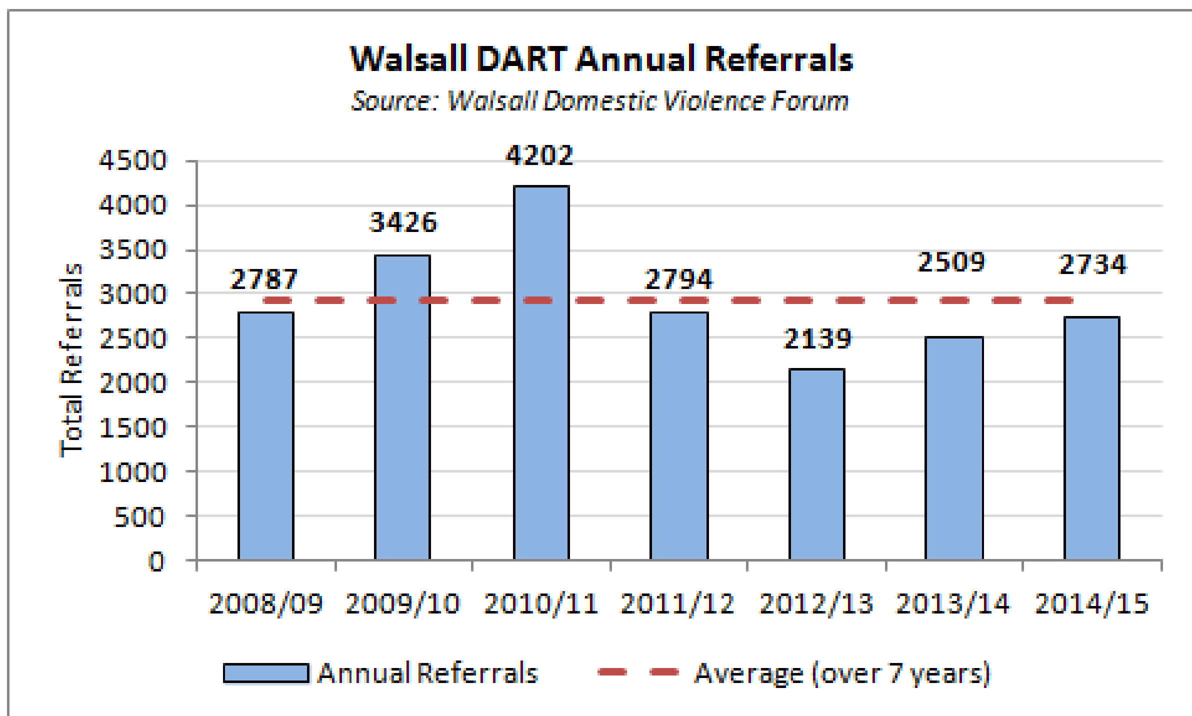
- Assault accounts for over 50% of Domestic Abuse crimes
- 24% of Domestic Abuse crimes were classified as high risk, 76% as medium or standard
- The highest intensity of crimes occurred within Caldmore and Chuckery, there is also high intensity within Blakenall Heath
- 78% of offences relate to dwellings.
- The majority of victims were female (84%), white-skinned European (80%), peak age range 21-30 (38%) and unemployed (57% where data were available)
- The majority of offenders were male (91%), white-skinned European (79%), peak age range 20-29 (41%) and unemployed (66% where data were available)
- Between July 2013 and June 2015 there were 2329 arrests for domestic abuse where the offender was taken to a Walsall custody station. 32% were charged but 60% were "no further action".

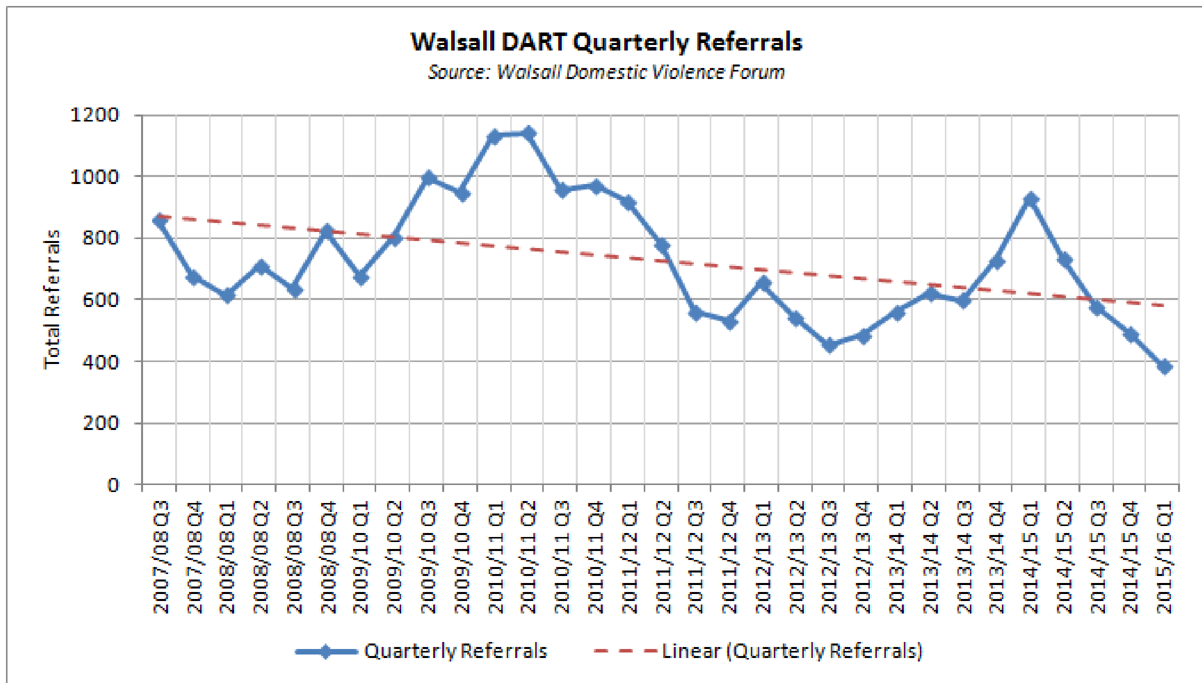
Domestic Abuse: Non-crime

- Non-crime reports are where review is needed, particularly in relation to safeguarding
- During the 2 year period 1.7.13-30.6.15 there were 5,875 non-crimes recorded. This has increased from 193/month ((July13-mar14) to 276/month (Apr14-June15).

3.2.2 DART (Domestic Abuse Response Team)

Data supplied by the Walsall Domestic Violence Forum (WDVF) were used to plot the number of referrals onto the two charts below. These show the number of referrals by financial year and also by quarter. Although the first chart indicates a gradual annual increase since 2012/13, the second chart shows that the number of DART referrals is in fact falling with each quarter since April 2014. It is the high number of referrals (n=930) is Q1 2014/15 which is making the annual total high in 2014/15.





The linear trend in the above chart shows that the number of referrals are reducing and is currently at the lowest level (n=384) since 2007/08.

DART Referrals Mapping

All DART referrals from April 2014 to September 2015 were grouped into wards and split by financial year. The number of referrals by ward were provided. A full year of data was available for 2014/15, but only 6 months were available for 2015/16 i.e. from April to September. This 6 months of data was multiplied by 2 to provide an estimated annual figure. This would then allow 2015/16 data to be compared with 2014/15.

Before mapping the data, the number of referrals for each Ward were converted into a crude rate. This was done by dividing the referral numbers by the ward population and then multiplying the result by 10,000. The result is a value per 10,000 population. The population figures used for the calculation were derived from mid 2013 population estimates by ward as supplied by the Office for National Statistics (ONS).

Calculation can be seen in the tables below, followed by the maps.

2014/15 Referrals

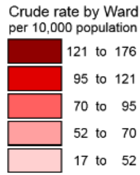
Ward	Referral Numbers	Ward population 2013	Crude rate (per 10,000)
Aldridge Central and South	61	13726	44
Aldridge North and Walsall Wood	72	13298	54
Bentley and Darlaston North	129	13584	95
Birchills Leamore	261	15158	172
Blakenall	246	14027	175
Bloxwich East	145	12235	119
Bloxwich West	160	13468	119
Brownhills	117	12789	91
Darlaston South	176	14625	120
Paddock	82	13009	63
Palfrey	116	16791	69
Pelsall	92	11506	80
Pheasey Park Farm	51	11280	45
Pleck	207	15512	133
Rushall-Shelfield	82	11903	69
Short Heath	58	11339	51
St Matthews	179	15290	117
Streetly	24	14007	17
Willenhall North	113	12628	89
Willenhall South	217	15986	136

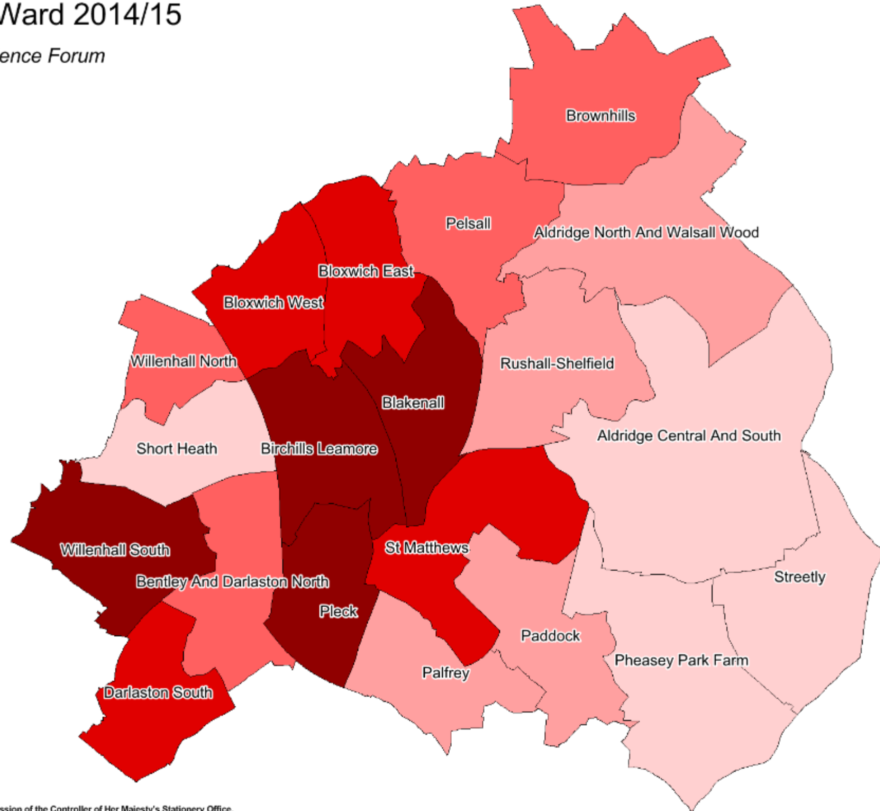
2015/16 Referrals

Ward	Referral Numbers (Estimated 12 months)	Ward population 2013	Crude rate (per 10,000)
Aldridge Central and South	20	13726	15
Aldridge North and Walsall Wood	46	13298	35
Bentley and Darlaston North	92	13584	68
Birchills Leamore	152	15158	100
Blakenall	168	14027	120
Bloxwich East	108	12235	88
Bloxwich West	106	13468	79
Brownhills	64	12789	50
Darlaston South	94	14625	64
Paddock	30	13009	23
Palfrey	58	16791	35
Pelsall	26	11506	23
Pheasey Park Farm	28	11280	25
Pleck	112	15512	72
Rushall-Shelfield	30	11903	25
Short Heath	78	11339	69
St Matthews	72	15290	47
Streetly	16	14007	11
Willenhall North	32	12628	25
Willenhall South	118	15986	74

DART Referrals by Ward 2014/15

Source: Walsall Domestic Violence Forum





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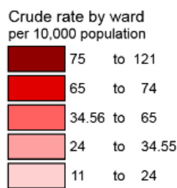
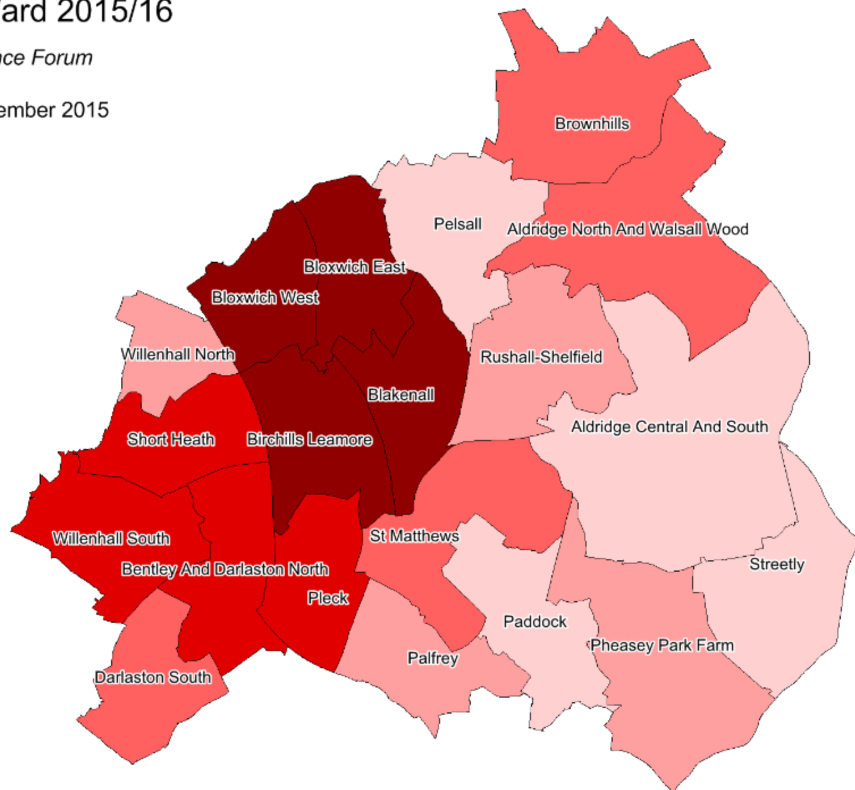
DART Referrals by Ward 2015/16

Source: Walsall Domestic Violence Forum

Uses referrals from April to September 2015
Projected over 12 month period





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On the maps, the darker shades represent a higher referral rate. In order to facilitate comparing both maps, the crude rates have been split into quintiles i.e. there are therefore 5 groups of rates in each map. Care must be taken when interpreting these maps:

- The 2015/16 data is only provisional, as it is based on 6 months data, projected over 12 months

In the 2015/16 map, some of the ranges are very close together in order to create the quintiles for comparison i.e. especially between 24 and 65 per 10,000.3.2.3 MARAC

(data taken from Safe Lives review 2015)

National and Regional Picture

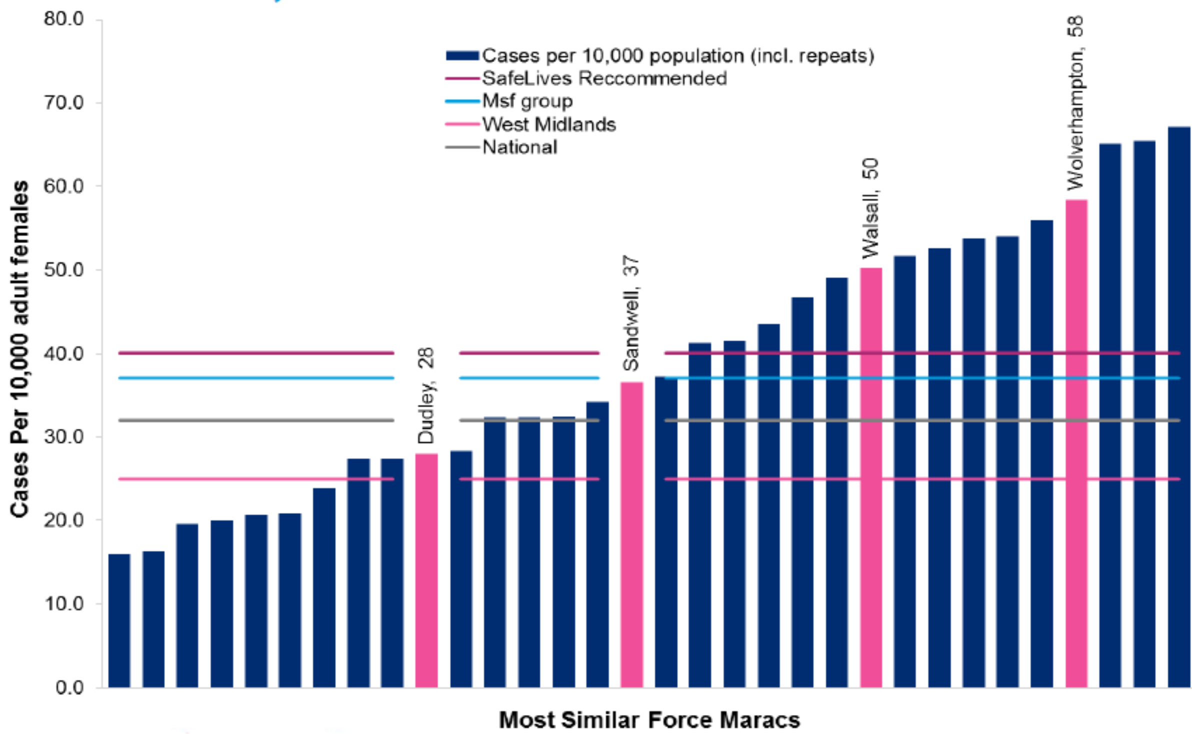
National figures (April 2014 – March 2015)	West Midlands Police Force	Most similar force group	West Midlands	National
Number of Maracs sending in Data	9	33	20	287
Number of cases discussed	3,221	13,124	5,659	78,144
Change in No. of Cases since last year	+20%	+17%	+14%	+17%
Cases per 10,000 of adult female population	29	37	25	32
Number of children in Household associated with cases discussed	4,126	17,497	7,262	99,625
% Marac repeats	34%	27%	26%	24%
% Non-police referrals into Marac	17%	33%	35%	37%

Local Picture

National figures (April 2014 – March 2015)	Dudley	Sandwell	Walsall	Wolver-hampton
Number of cases discussed	363	454	551	595
Change in No. of Cases since last year	+32%	+59%	+15%	+47%
Cases per 10,000 of adult female population	28	37	50	58
Number of children in household associated with cases discussed	459	580	835	738
% Marac repeats	33%	33%	44%	38%
% Non-police referrals into Marac	13%	26%	5%	25%

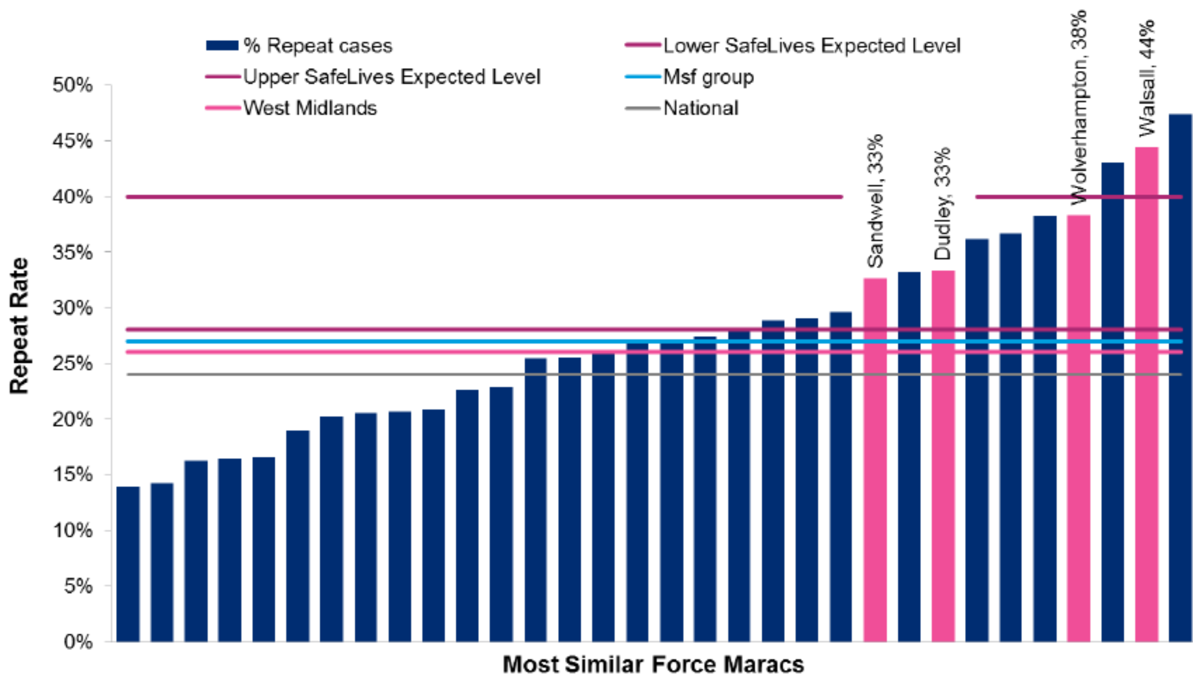
This highlights the size of the issue in Walsall, both the number of victims and the number of children involved. Demand for the MARAC increased in 14/15 compared with the previous year. This may reflect the decrease seen in referrals to the DART – more cases with a higher risk. Of particular note is the number of repeat cases referred to the MARAC for Walsall. This was highlighted as a "healthy" repeat rate in the MARAC review, suggesting there are effective processes in place to identify repeat incidents and refer these back to MARAC. However, consideration should also be given to the action taken to prevent the risk of a repeat occurrence wherever possible.

Cases per 10,000: West Midlands, Most similar forces group and National, Q1 2015



The number of cases referred to the Walsall MARAC is above the national and West Midlands averages, and above the Safe Lives recommended level.

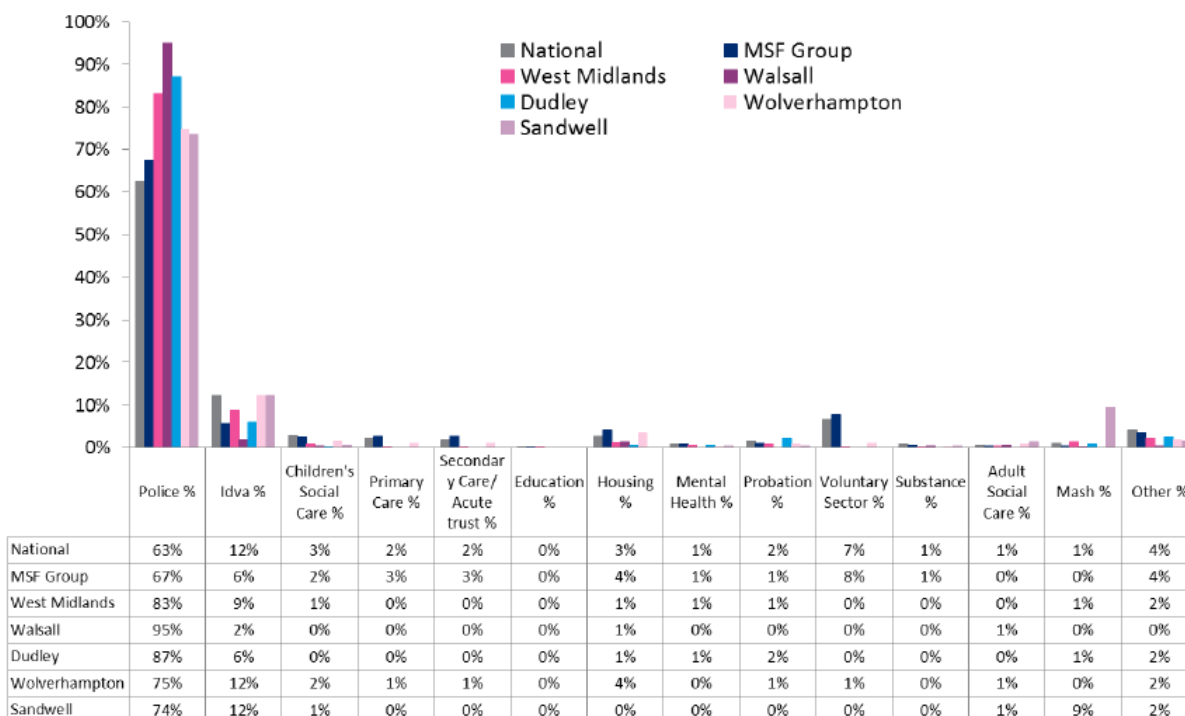
Repeat cases (%): West Midlands, Most similar force group and National, Q1 2015



These data demonstrate the exceptionally high level of re-referrals to the MARAC in Walsall.

Referring agency

Referring agency (%): West Midlands Police, most similar force group and National, Q1 2015



	Police %	Idva %	Children's Social Care %	Primary Care %	Secondary Care/ Acute trust %	Education %	Housing %	Mental Health %	Probation %	Voluntary Sector %	Substance %	Adult Social Care %	Mash %	Other %
National	63%	12%	3%	2%	2%	0%	3%	1%	2%	7%	1%	1%	1%	4%
MSF Group	67%	6%	2%	3%	3%	0%	4%	1%	1%	8%	1%	0%	0%	4%
West Midlands	83%	9%	1%	0%	0%	0%	1%	1%	1%	0%	0%	0%	1%	2%
Walsall	95%	2%	0%	0%	0%	0%	1%	0%	0%	0%	0%	1%	0%	0%
Dudley	87%	6%	0%	0%	0%	0%	1%	1%	2%	0%	0%	0%	1%	2%
Wolverhampton	75%	12%	2%	1%	1%	0%	4%	0%	1%	1%	0%	1%	0%	2%
Sandwell	74%	12%	1%	0%	0%	0%	0%	0%	0%	0%	0%	1%	9%	2%

The majority of referrals to the MARAC are from the police, compared with other areas. Referrals from other agencies are low in the majority of areas, suggesting there is a need for workforce development.

Diversity data

National figures (April 2014 – March 2015)	Dudley	Sandwell	Walsall	Wolver-hampton	SafeLives Recommends
% BME victims	11% (Local BME pop. 11%)	20.5% (Local BME pop.34%)	10% (Local BME pop. 23%)	12% (Local BME pop 35%)	Local BME population
% LGBT victims	0%	0.2%	0.4%	0.7%	5%+
% Victims with Disability	0%	0.4%	0.2%	1.2%	17%+
% Male Victims	1.4%	2.9%	2.0%	3.5%	4% - 10%

There are low levels of referrals from key groups who are affected by DV&A, levels in all groups are well below the Safe Lives recommended level.

Benefits of MARAC – national data

Positive outcomes for victims

65%

65% of victims experienced a reduction in police call outs. 45% had a total cessation of police call outs, 20% reduced from an average of 6 callouts before the Marac to 2 after

21%

21% of victims experienced no change in the number of police call outs. 10% had none before or after the Marac, 11% had an average of 2 before and 2 after

14%

14% of victims experienced an increase in the number of police call outs. 4% went from none before the Marac to 1 afterwards, 10% had an average of 3 before and 6 after

- 63% of adult high risk victims report a cessation of abuse following support from an Idva
- 69% of victims report that their quality of life has improved
- The more intensive the support, the better the victim outcomes

3.2.4 WDVF

Data have been requested from WDVF, in particular data on numbers, services offered and outcomes would be particularly useful.

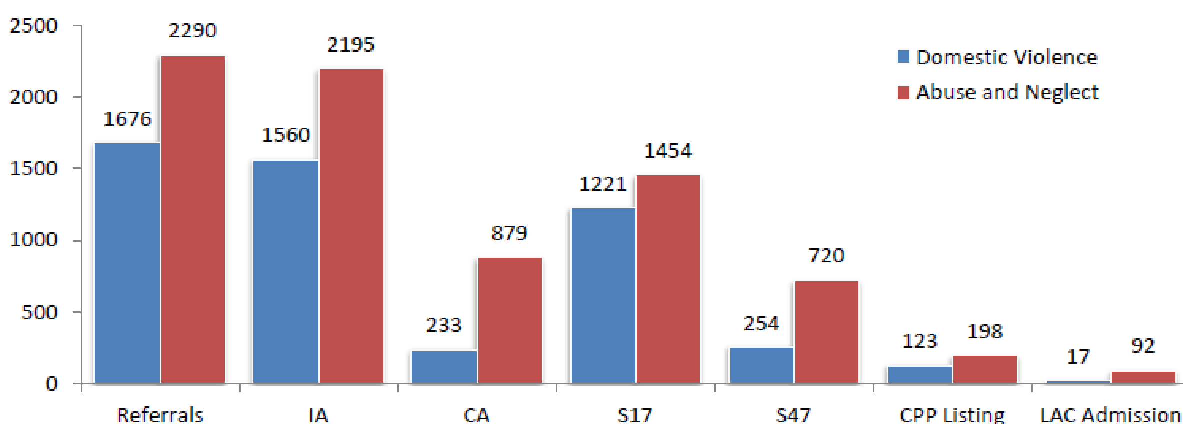
3.2.5 Childrens' services

Referrals to Children's services

The following table and chart show the total referrals to Children's services (through MAST to level 4 services). These are cases referred, so if a child is re-referred they will be counted more than once. Referrals are categorised by referrers, abuse or neglect of a child is often linked to DV&A, although abuse/neglect is the main reason for referral. The key issue here are the numbers of children affected by DV&A, nearly 4000 (70%) are likely to be due to or affected by DV&A.

IA = initial assessment
CA = core assessment (may follow IA or be first assessment)
S17 = Child in need
S47 = Assessment for child protection
CPP = child protection plan
LAC = looked after child
(NB: this is not a linear process)

2014/2015	Domestic Violence		Abuse or Neglect		D.V. & A/N	
	Number	%	Number	%	Number	%
Referrals	1,676	30%	2,290	41%	**3,966**	**70%**
IA	1,560	29%	2,195	41%	**3,755**	**71%**
CA	233	13%	879	48%	**1,112**	**61%**
S17	1,221	25%	1,454	30%	**2,675**	**55%**
S47	254	17%	720	49%	**974**	**66%**
CPP Listing	123	25%	198	40%	**321**	**66%**
LAC Admission	17	9%	92	47%	**109**	**56%**



Domestic Violence & Abuse by Referral Outcome 2014/15

The following tables show the data by referral outcome (compared with referral reason shown above). A key point here are the number of cases with no further action. These are cases that have been closed or stepped down and are not tracked any further. Feedback suggests that these are likely to repeat due to a lack of lower level services specific to DV&A.

Referrals by referral outcome:

	Domestic Violence		Abuse or Neglect	
Referral Outcome	**Number**	**% of DV**	**Number**	**% of A/N**
Section 17 Assessment	1,104	66%	1,186	52%
Section 47 Assessment	42	3%	446	19%
No Further Action CSC	345	21%	475	21%
Blank	185	11%	183	8%
Grand Total	**1,676**	**100%**	**2,290**	**100%**

530 cases referred for DV&A and 658 cases referred for abuse/neglect had no further action recorded

IA by referral outcome:

	Domestic Violence		Abuse or Neglect	
IA Outcome	**Number**	**% of DV**	**Number**	**% of A/N**
Child In Need Plan	109	7%	100	5%
CIN Plan & Core Assess	49	3%	75	3%
Strategy Discussion/S47	204	13%	709	32%
No Further Action CSC	1,142	73%	1,203	55%
NFA & Carers Assessment	1	0.1%	2	0.1%
Service Under 17			1	0.0%
Blank	55	4%	105	5%
Grand Total	**1,560**	**100%**	**2,195**	**100%**

1197 cases referred for DV&A and subject to an initial assessment, and 1308 cases referred for abuse/neglect and subject to an initial assessment had no further action recorded.

CA by referral outcome:

	Domestic Violence		Abuse or Neglect	
CA Outcome	**Number**	**% of DV**	**Number**	**% of A/N**
Child In Need Plan	47	20%	111	13%
Strategy Discussion	39	17%	57	6%
Continue Existing Plan	53	23%	196	22%
No Further Action CSC	77	33%	400	46%
Blank	17	7%	115	13%
Grand Total	**233**	**100%**	**879**	**100%**

94 cases referred for DV&A and subject to a core assessment, and 515 cases referred for abuse/neglect and subject to a core assessment had no further action recorded.

S17 by referral outcome:

	Domestic Violence		Abuse or Neglect	
S17 Outcome	**Number**	**% of DV**	**Number**	**% of A/N**
Child In Need Plan	85	7%	85	6%
Cin Plan & Core Assess	38	3%	46	3%
Strategy Discussion/S47	121	10%	247	17%
No Further Action Csc	881	72%	953	66%
Continue Existing Plan			1	0.1%
Service Under 17			1	0.1%
Blank	96	8%	121	8%
Grand Total	**1,221**	**100%**	**1,454**	**100%**

977 cases (80%) referred for DV&A and subject to a section 17, and 1074 (74%) cases referred for abuse/neglect and subject to a section 17 had no further action recorded.

S47 by referral outcome:

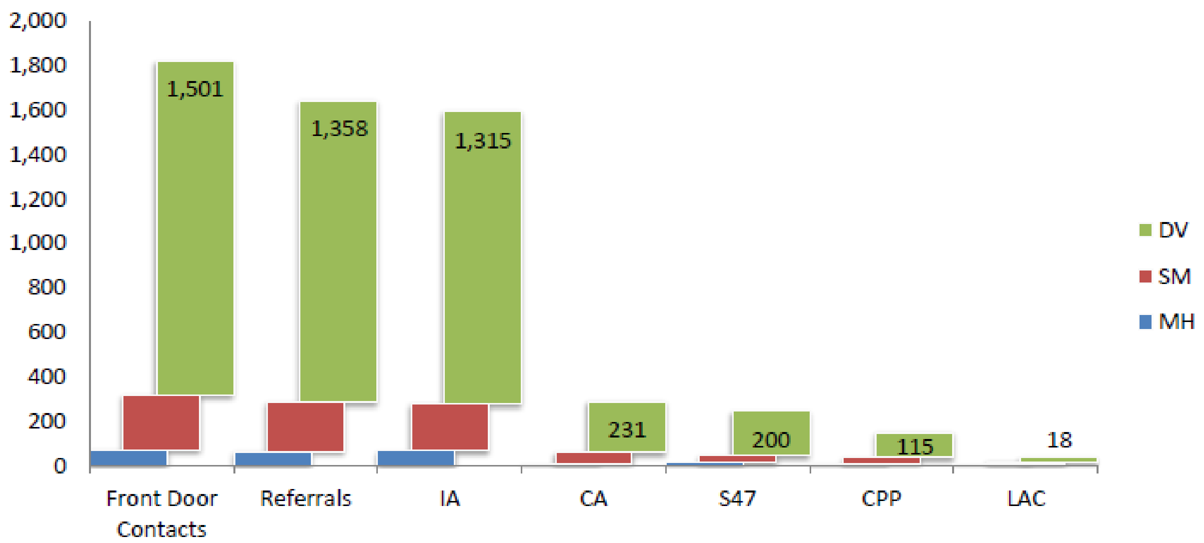
	Domestic Violence		Abuse or Neglect	
S47 Outcome	**Number**	**% of DV**	**Number**	**% of A/N**
Already CPP Listed - Continue	3	1%	4	1%
Child Protection Conference	89	35%	176	24%
No Further CP Action	151	59%	498	69%
Section 47 To Be Completed	3	1%	10	1%
Blank	8	3%	32	4%
Grand Total	**254**	**100%**	**720**	**100%**

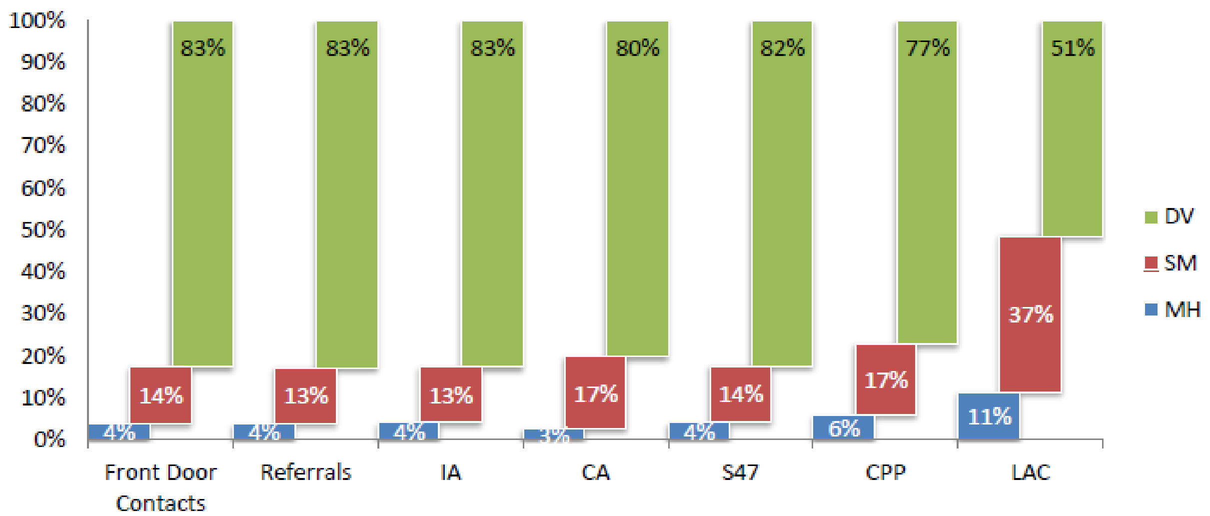
159 cases referred for DV&A and subject to a section 47, and 530 cases referred for abuse/neglect and subject to a section 47 had no further action recorded.

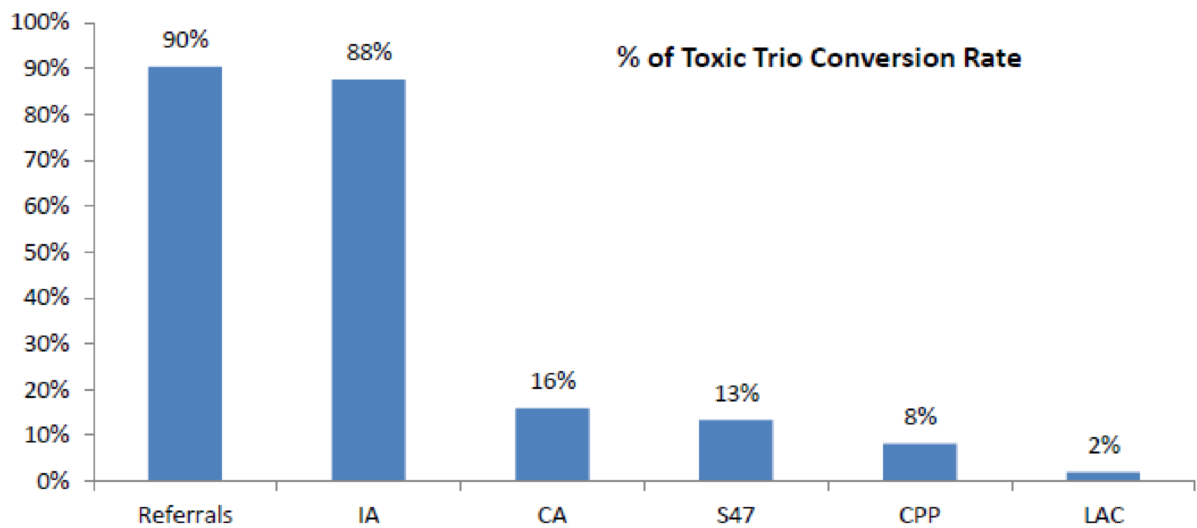
Toxic Trio Needs Mapping 2014-15

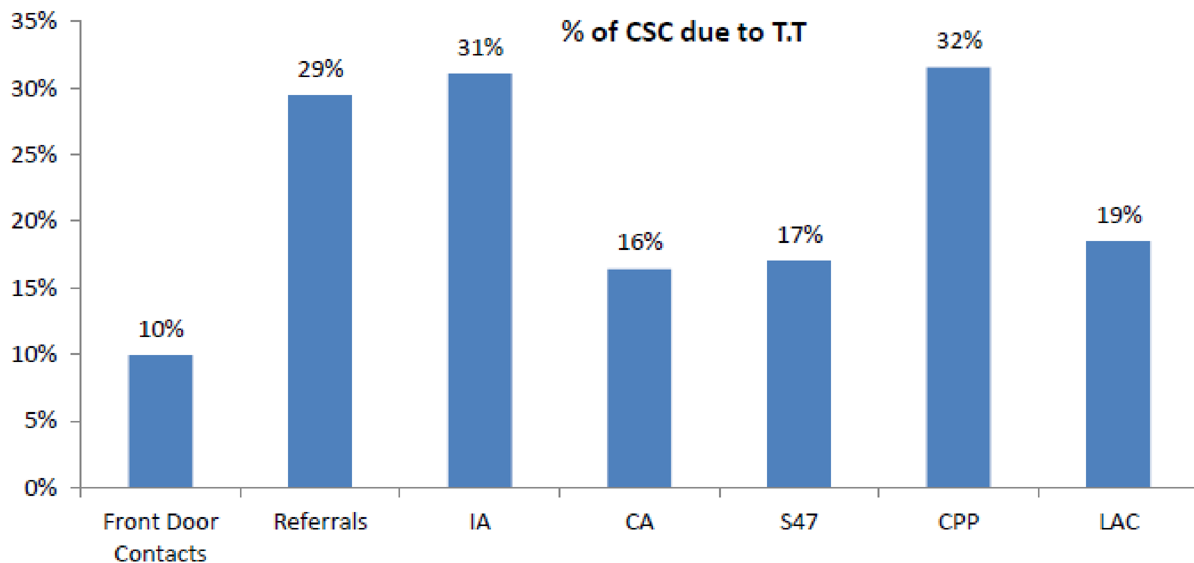
The data in the table and graphs below were categorised by children's services based on the primary issue the child was experiencing. Front door contacts are all contacts that are made with Children's services. Referrals are through MAST to level 4 services. It can be seen that within the toxic trio the majority of cases have DV as the primary category, although the other issues may also be present (and most likely will be from feedback from children's services teams). Children from previous years are included here where their care spanned 13/14 and 14/15. The final section of the table is all referrals to children's social care. Compared with all front door contacts, children who are experiencing the toxic trio are more likely to progress to all further stages. These data also demonstrate that better recording of other issues needs to be done to enable linkages to be made.

	Front Door Contacts	Referrals	IA	CA	S47	CPP	LAC
Child Sexual Exploitation							
2014/15	90	85	78	32	33	3	2
Total	90	85	78	32	32	3	2
%		94%	87%	36%	36%	3%	2%
Mental Health							
2014/15	69	64	65	7	9	8	3
Previous Years	1	0	0	1	1	1	1
MH	70	64	65	8	10	9	4
%	4%	91%	93%	11%	14%	13%	6%
Substance Misuse							
2014/15	236	214	206	40	25	20	8
Previous Years	10	5	5	9	8	5	5
SM	246	219	211	49	33	25	13
%	14%	1	1	0	0	0	0
Domestic Abuse							
2014/15	1,313	1,259	1,217	198	162	89	13
Previous Years	188	99	98	33	38	26	5
DV	1,501	1,358	1,315	231	200	115	18
%	83%	90%	97%	18%	87%	58%	16%
Toxic Trio 2014/15							
Grand Total	1,817	1,641	1,591	288	243	149	35
% of T.T.		90%	88%	16%	13%	8%	2%
CSC 2014/15							
Total	18,274	5,567	5,120	1,755	1,427	472	189
% of CSC	10%	29%	31%	16%	17%	32%	19%


Toxic Trio Flow 2014/15
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1,501
1,358
1,315
231
200
115
18
DV
SM
MH
Front Door Contacts
Referrals
IA
CA
S47
CPP
LAC


Toxic Trio Flow (%) 2014/15
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
83%
83%
83%
80%
82%
77%
51%
14%
13%
13%
17%
14%
17%
37%
4%
4%
4%
3%
4%
6%
11%
DV
SM
MH
Front Door Contacts
Referrals
IA
CA
S47
CPP
LAC


% of Toxic Trio Conversion Rate
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
90%
88%
16%
13%
8%
2%
Referrals
IA
CA
S47
CPP
LAC



Early help service demand
The tables below track the demand for Early Help services. In 14/15 there were a total of 2891 requests for Early Help Assessments and Plans. These came from a variety of sources including schools and health. 29% were for DV and 35% for abuse/neglect demonstrating that these issues are being identified at a lower level. The data were not broken down by referrer to see whether DV&A is recognised more by one agency than another. This would be an interesting comparison and could help to inform workforce plans.

Based on the identifiable needs code, the early help re-request rate (due to DV A&N) **within 12 months for 2014/15** is **19.1%;** (EH Request – **1018** (due to DV A&N), No of Children had a previous EH Request – **194** (due to DV Abuse & Neglect)). This means that nearly **1 in 5** children will come back to our services again with 12 months after being discharged..

Early Help Service Demand Flow 2014/15

1. Number of Requests for Early Help Assessments and Plans?

A: EH Assessment		B: Step down from Initial Assessment/Interal Case Transfers	
1,494	(52%)	1,397	(48%)
2,891 EH Requests			

2. Who is asking for help?

	a.Schools & Education	b.Police	c.Health Services	d.Individuals	e.LA Services - Other Internal	f.Anonymous	g.Children Centre	h.LA Services - External	i.Other Professional
	Request Sources								
A: EHA 1,494	470	283	287	186	78	42	80	40	28
	31%	19%	19%	12%	5%	3%	5%	3%	2%
B: Step down 1,397	427	396	208	85	134	35	60	32	20
	31%	28%	15%	6%	10%	3%	4%	2%	1%
Overall 2,891	897	679	495	271	212	77	140	72	48
	31%	23%	17%	9%	7%	3%	5%	2%	2%

Requests raised by agencies were based on the Dataset A 1,497 EH Assessments and Dataset B: 1,397 Step down from IA & internal case transfers.

3. For who and what are people asking help for?

Sub Needs Cat.	Domestic Violence	Physical/Emotional Abuse/Neglect	Sexual Abuse	Alcoholic Parents/Carers	Drug Taking Parents/Carers	Drug Taking Household Member	Anti Social Behaviour	Child Sexual Exploitation	Others	Blank
	Presenting Sub Needs Cat.									
Under 5 - 38 %	238	250	28	13	21	4	5	2	85	465
6-9 Years - 22 %	101	122	17	16	8	1	2	2	60	294
10-15 Years - 33	101	172	27	17	9	4	24	15	139	444
16 & over - 7 %	23	17	6	0	1	0	6	6	39	107
Total	463	561	78	46	39	9	37	25	323	1,310
%	29%	35%	5%	3%	2%	1%	2%	2%	20%	See 150 Spots
2,891 Requests										

Presenting Needs were based on the Dataset A: 1,494 EH Assessments and Dataset B: 1,397 Step down from IA & internal transfers (150 Spot-check to follow)

4. Who is taking on the Lead Professional role?

Children's Centre	School and Education	Inclusion Team	Healthcare	Other	EH Lead Professional Holding	April - Oct 2014
EH Team Data Nov14 - Apr15						Not Stated
1151	328	46	23	15	7	1,321
73%	21%	3%	1%	1%	0%	
1570 Early Help Assessments						

Case Allocations were classified based on the 1,570 EHAs list from the EH Team's Data Nov14- Apr15.

5. What is the impact at the end of a early help plan?

a.Step Down From EH To Single Agency	b.Closed to Csc,Now Universal	c.Parents or Child Disengaged	d.Stepped Down To:	e.Stepped Up To:	f.Moved Out of Area	g.Other Exceptional Reason	(Blank)	EHA Total	Others	NFA?
Outcomes										
119	212	30	67	36	2	29	1,012	1,507	?	?
24%	43%	6%	14%	7%	0%	6%	See 150 Spots			

Case Allocations were classified based on Dataset A: 1,507 EH Assessments (150 Spot-check to follow)

3.2.6 Walsall Housing Group

Data have been requested from Walsall Housing Group, data on numbers, services offered and outcomes would be particularly useful

3.2.7 Caldmore/Accord

Data have been requested from Caldmore/Accord. Data on emergency accommodation at Aven House are included below. Additional data on numbers, services offered and outcomes would be particularly useful

Demand/referrals to the refuge and floating support accommodation services:

- 2013

Number of referrals	Number accommodated
428	99

- 2014

Number of referrals	Number accommodated
375	106

- 2015

Number of referrals	Number accommodated
141	72

- Demand outstrips supply
- Over demand numbers are accommodated by Staff providing details of alternative accommodation for referrals to contact for bed space
- Average length of stay: The majority of families are with us between 0 – 6 months, we do have some families who tip into stays of 6-12 months
- Number of residents (family units)that have been permanently re-housed per annum/quarter

	2013	2014	2015
Re-housed	47	53	17
Returned home	24	18	8
Moved in with family / friends	12	17	7
Other (including abandoned, eviction, move to other refuge provision)	16	18	13

3.2.8 Hospital data

A&E Linxs Data

The Linx system is a piece of software which is located at A&E with the purpose of collecting violence related data and sharing with relevant partners. No data were available post 2013/14, so can't be included in this document.

Hospital data is available in the form of Secondary Uses Services (SUS) and includes both A&E and Inpatient, patient level records (see appendix 6a). Analysis of this data set is detailed below.

A&E Data - Analysis

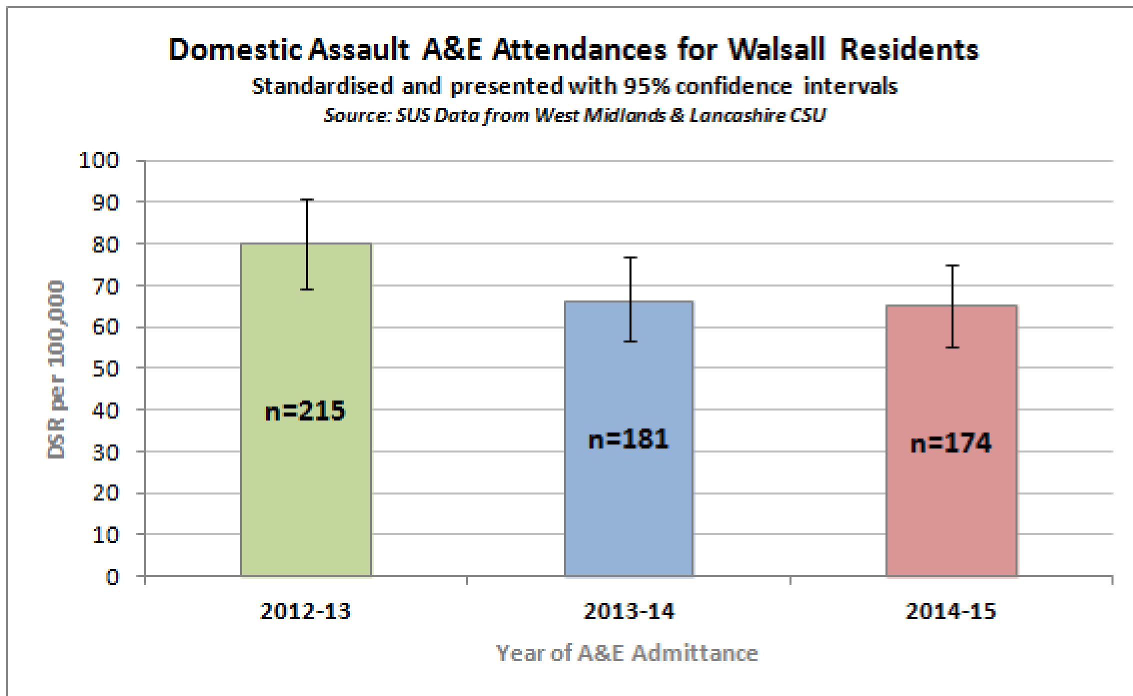
All the following results refer to Walsall residents who presented at A&E as a result of an assault at home between April 2012 and March 2015. If the attendance is one of a series, then only the first attendance is counted. Initially, some comparisons will be done between the 3 years to see if any trends are visible and the latter part of the analysis will combine the three years of data in order to look at geography by Ward.

Incidence of Domestic Assault

In the table below, it can be seen that the number of attendances have fallen from 215 in 2012/13 to 174 in 2014/15. The methodology of filtering this A&E data can be seen in 6b.

Year of Attendance	Number of attendances
2012/13	215
2013/14	181
2014/15	174
Total	570

These attendances have been converted into a rate per 100,000 population and can be seen in the chart below. The actual number of attendances are shown in the middle of each bar.



This chart shows that the rate of A&E attendances for Domestic Assault has reduced from 80 (per 100,000) in 2012/13 to 65 (per 100,000) in 2014/15. However, the overlapping 95% confidence interval shows that this reduction is not statistically significant. These data need further intelligence and should be interpreted with caution – is there a real change in attendance (are injured parties not attending), is this a data recording issue or is there a reporting issue where the threshold for capturing the injury as a result of domestic violence has increased due to staff becoming partly immune to it.

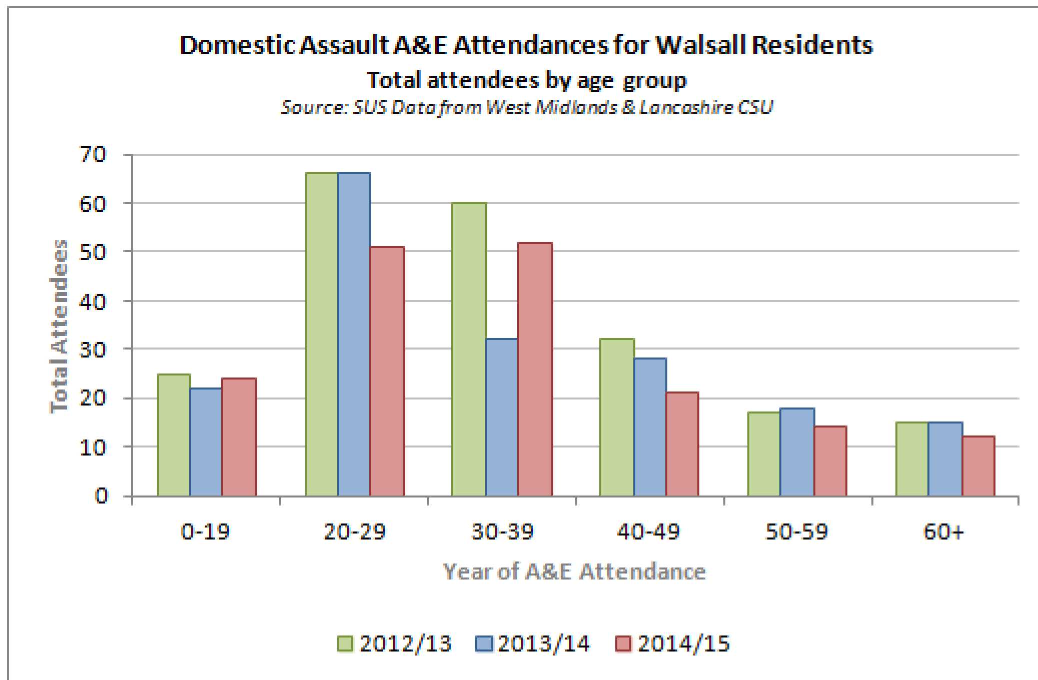
Gender

The table below shows the gender split for Domestic Abuse A&E attendance. In 2012/13, 58% of those attending were females, but by 2014/15 this had reduced to 46%. Over the three years, the 53% (n=301) of attendances were female. The gender field within the database was analysed for completeness and each record contained a valid entry i.e. each patient was coded with a gender.

Gender	2012-13		2013-14		2014-15		3 years combined	
	n	%	n	%	n	%	n	%
Female	124	58%	97	54%	80	46%	301	53%
Male	91	42%	84	46%	94	54%	269	47%
Total	**215**		**181**		**174**		**570**	

Analysis by Age

To maintain patient confidentiality, patient ages have been analysed by age group. The spread between the age groups over the three years is quite consistent. The age group most likely to present at A&E are those in their twenties, followed closely by those in their thirties.



Ethnicity

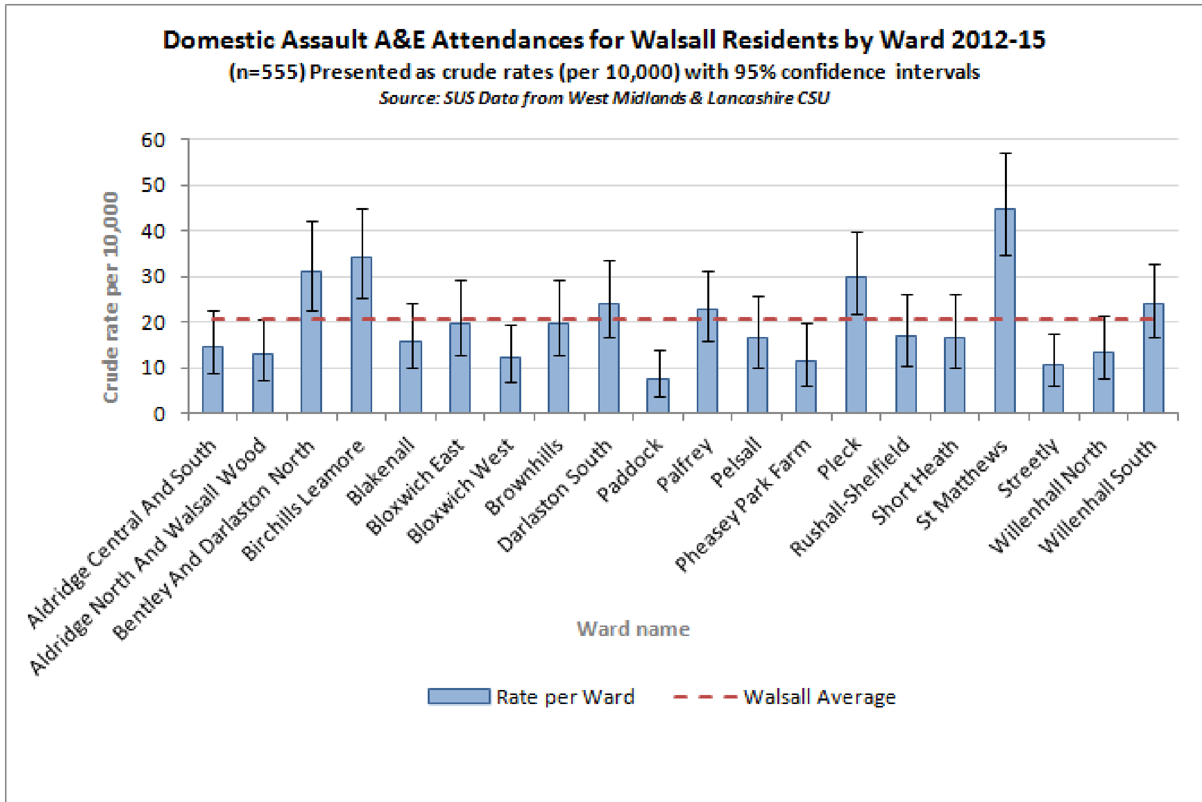
Ethnicity has been analysed for the 3 years but the data wasn't comprehensive enough to allow analysis. Most patients (67%) were classed as British, without further ethnicity breakdown, with the remaining patients either from another ethnic group or not known.

Geography

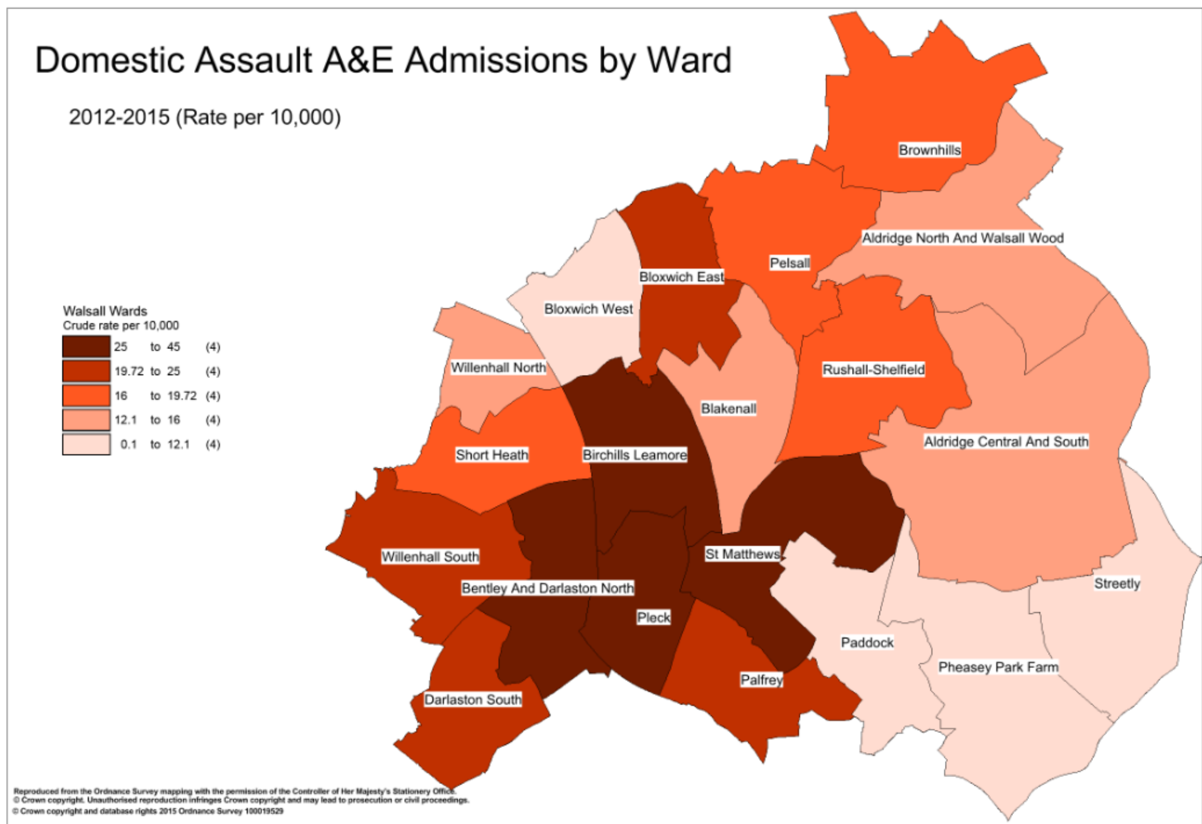
Due to patient confidentiality, it is not possible to see individual's full postcodes in the SUS data set. However each patient is given a Lower Layer Super Output Area code (LSOA) which is a Census bases geographic area based on residential address. As each LSOA is assigned to a Ward, it was possible to calculate the number of A&E attendances in each ward, by age group. To facilitate comparison between each ward, this data was standardised using a crude rate. It was not possible to standardise using a Direct Standardised Rate (DSR) due to the relatively low number of patients in each age group.

As crude rates have been used, it is not possible to accurately compare wards, however the results will provide a good indication to the residential wards of A&E attendances. From the chart below we can see that four wards are significantly higher than the Walsall average (20.5 per 10,000); these are Bentley and Darlaston North, Birchills Leamore, Pleck and St Matthews. Wards showing the least number are Paddock (7.6 per 10,000) and Streetly (10.7 per 10,000).

A&E Attendance for Domestic Assault by Ward
Crude Rate (per 10,000) with 95% Confidence Interval for the 3 year period (2012-15)



These rates for the three years have been mapped and can be seen below. Wards have been grouped into quintiles based on their rates. The highest rates can be seen in the central and western areas of the borough. Fifteen patients couldn't be mapped as the postcodes could not be validated.



Source: Secondary Uses Services (SUS) A&E Data – April 2012 to March 2015

Inpatient Data – Analysis

Inpatient data is also available from 2012/13, and for consistency with the A&E analysis, the three years from 2012/13 to 2014/15 were analysed. See Appendix 6c for technical details of how the inpatient data were filtered.

Incidence

The number of admissions per year can be seen in the table below. Even though four categories of ICD codes were used during the data extract, most admissions were coded as assaults, therefore all categories were combined into one group for analysis. See Appendix 6d for total admissions in each ICD category.

Year of Admission	Total Admissions
2012/13	147
2013/14	166
2014/15	123
Total	436

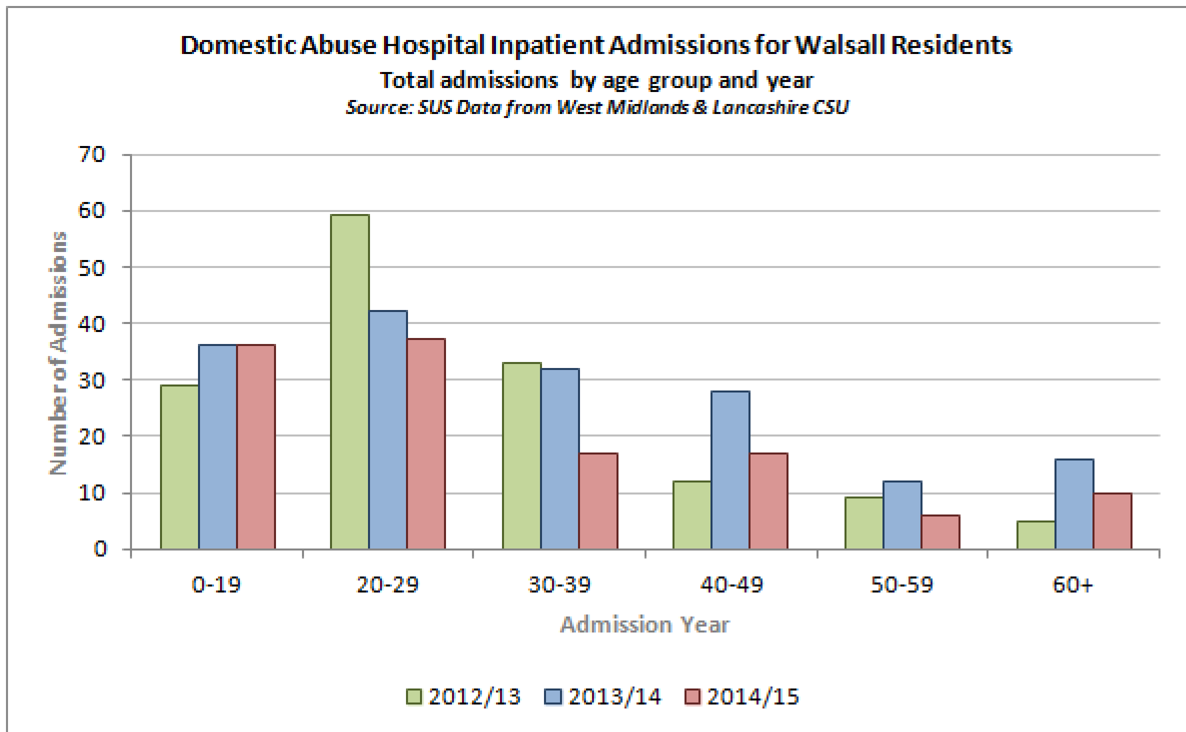
Gender

The table below shows the proportion of females and males over the three years. Over the whole three year period, almost three-quarters of admissions are males. The proportion of females however has increased from 22% in 2012-13 to 38% in 2014-15.

Gender	2012-13		2013-14		2014-15		3 years combined	
	n	%	n	%	n	%	n	%
Female	32	22%	44	27%	47	38%	123	28%
Male	115	78%	122	73%	76	62%	313	72%

Analysis by Age

The chart below shows the number of hospital admissions by age group over each of the three years. The younger age groups (<40 years old) are more likely to be admitted to hospital.



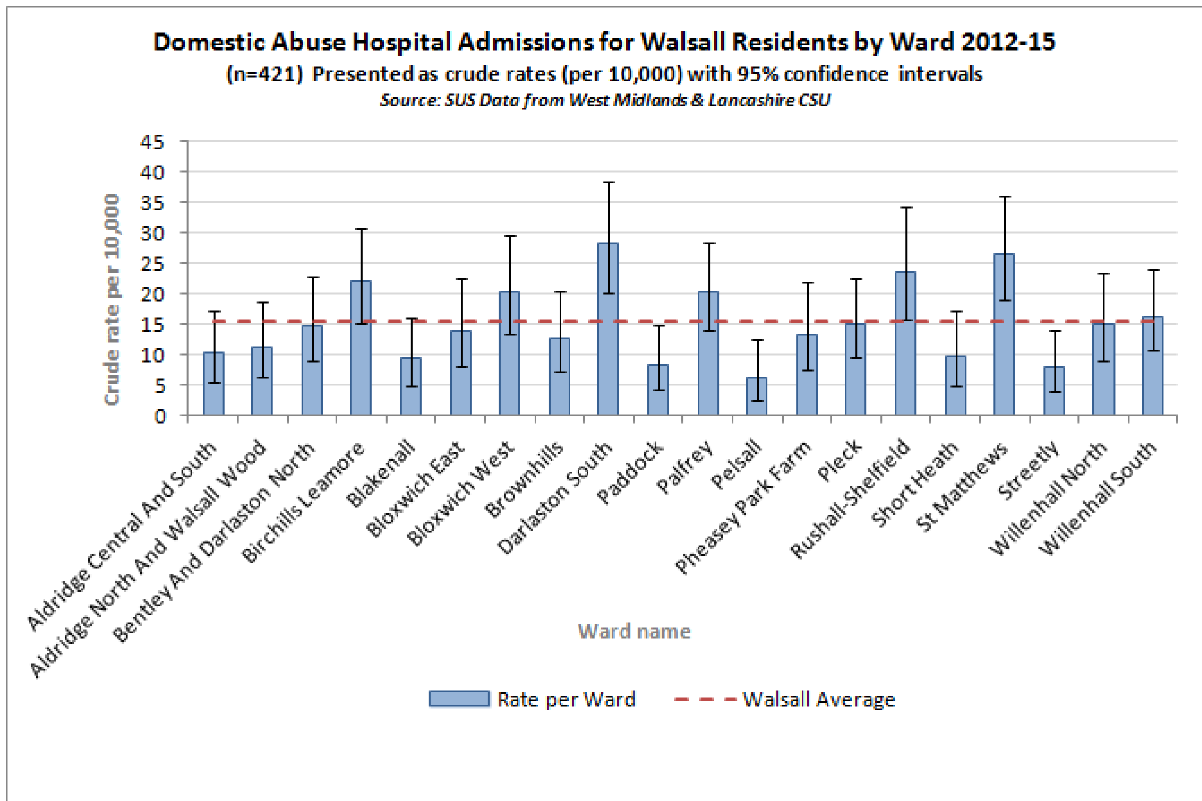
Ethnicity

Ethnicity has been analysed for the 3 years but the data wasn't comprehensive enough to allow analysis. Most patients (68%) were classed as British, without further ethnicity breakdown, with the remaining patients either from another ethnic group or not known.

Geography

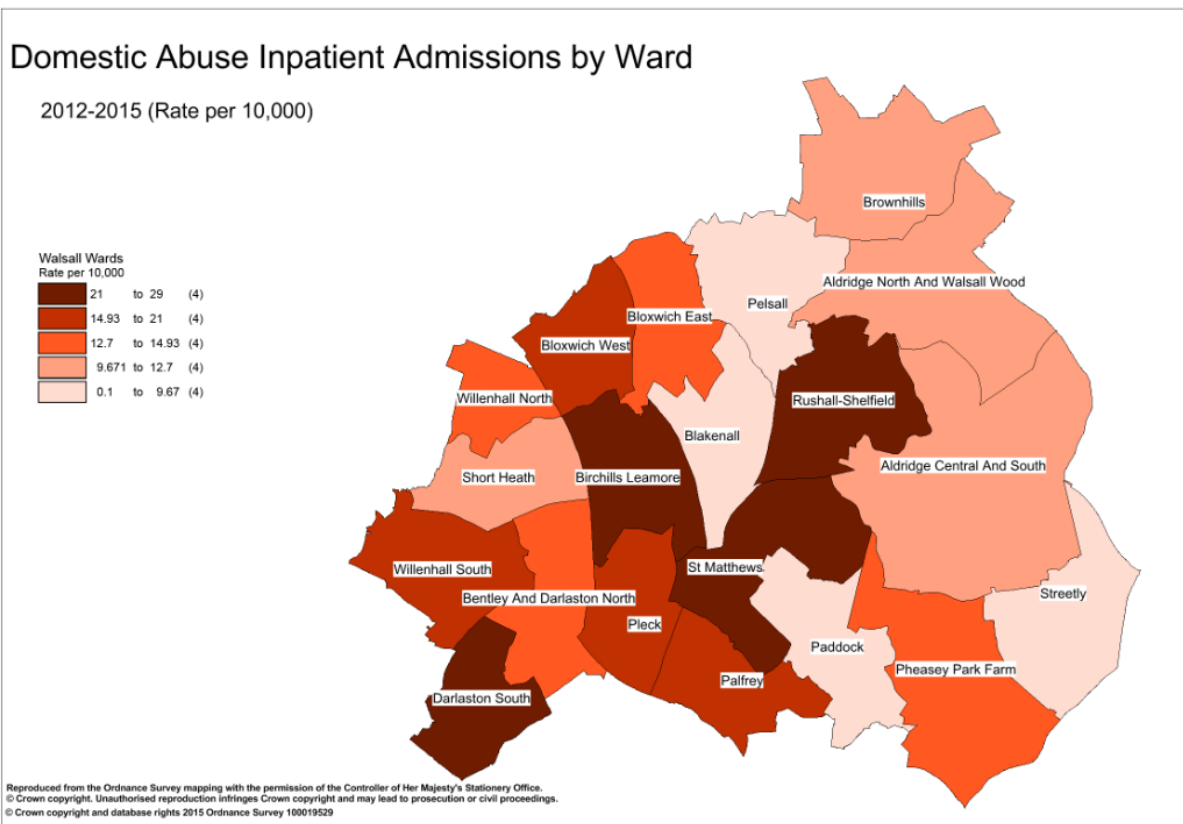
As with the A&E data, it was not possible to provide directly standardised (DSR) rates due to the relative low numbers in each age group. As a crude rate was calculated for each ward, care must therefore be taken when interpreting the results.

Hospital Admissions for Domestic Abuse by Ward



From the chart above it can be seen that Darlaston South, Rushall-Shelfield and St Matthews wards all have admission rates which are higher than the Walsall average. Pelsall has the lowest rate (6 per 10,000) followed by Streetly (7.8 per 10,000).

The above rates for the 3 years have been mapped by wards and can be seen in the figure below. As with the A&E data, the highest rates of inpatient admissions occur in central and western side of the borough. Fifteen patients could not be mapped as their postcodes could not be validated.



Source: Secondary Uses Services (SUS) Inpatient Data – April 2012 to March 2015

3.2.9 Probation service[1]

Staffordshire & West Midlands Probation Service
Walsall Community Rehabilitation Company (CRC) cohort

Although the data included here is not exclusively for DV&A, for the purpose of this needs assessment it may be useful to understand the context of offender behaviour within which DV&A occurs.

Background
Staffordshire and West Midlands Community Rehabilitation Company (CRC) manages offenders in the community – those subject to a court order and those released from prison on licence; providing services for low and medium risk offenders. The following analysis relates to this cohort. The National Probation Service (NPS) manages high-risk offenders, details of these offenders are not covered within this briefing.

The OASys assessment process is an integral offender management tool used to assess the risk of reoffending and the needs of an offender. By identifying and prioritising offenders' needs OASys helps tailor interventions based on evidence of needs linked to an individual's offending behaviour 'Criminogenic needs', including the risk of re-offending.

[1] Source: OASys Profile July 2014 to July 2015. Information courtesy of Jas Pejatta, Head of Probation: Walsall & Wolverhampton. Reproduced by Vanessa Holding (Walsall Intelligence Network) Walsall Council

The following OASys profile analysis is based on Walsall Community Rehabilitation Company (CRC) cohort only covering period; July 2014 to June 2015. There were 992 offenders managed by Walsall CRC whose Criminogenic needs were assessed (OASys Profile).

Risk of Harm[2]

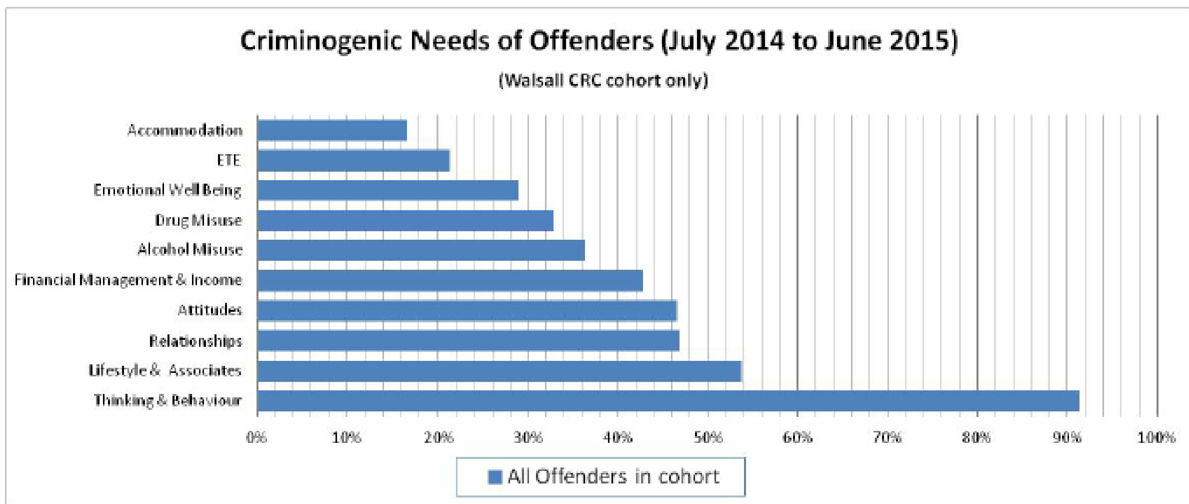
Walsall Community Rehabilitation Company (CRC) only

Walsall Community Rehabilitation Company (CRC) only Of the 992 CRC offenders managed, just under 70% of those with an OASys assessment were at medium risk of harm; 30% were at low risk of harm. There was 1 offender assessed as high risk of harm, with one fifth of the overall cohort not having a Risk of Harm level clearly recorded within the OASys tool. However, the CRC will have a Risk Of Harm Classification recorded on all cases within it's mainstream Case Management System

Criminogenic Needs

OASys assesses the needs i.e. vulnerabilities that offenders present with, known as Criminogenic needs. Assessment is against nine identified needs as detailed in Appendix 7, and shown below for the Walsall CRC cohort.

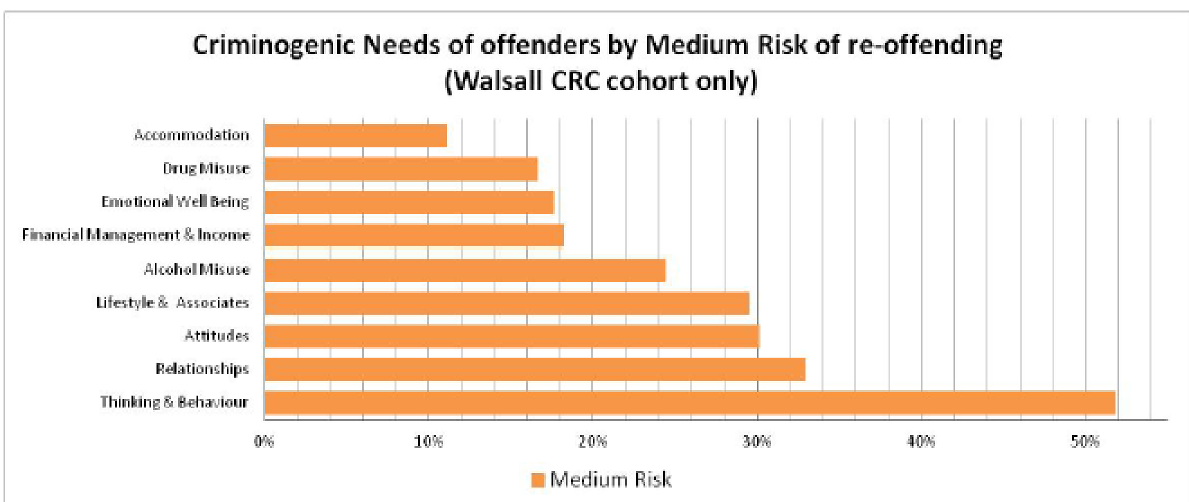
[2] Risk of serious harm addresses, risk to others, to children, to the individual, other risks i.e. abscond, control issues, breach of trust.

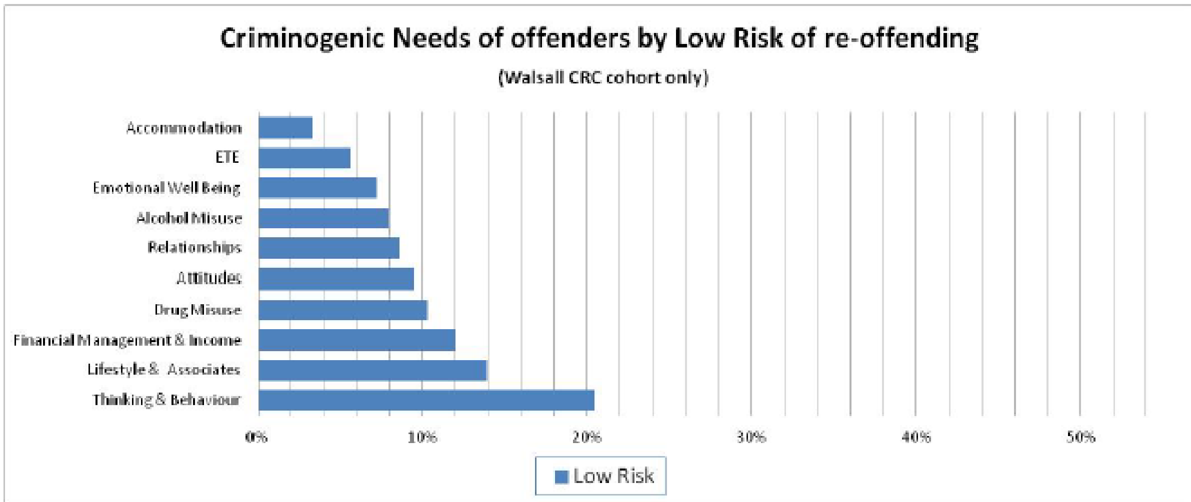


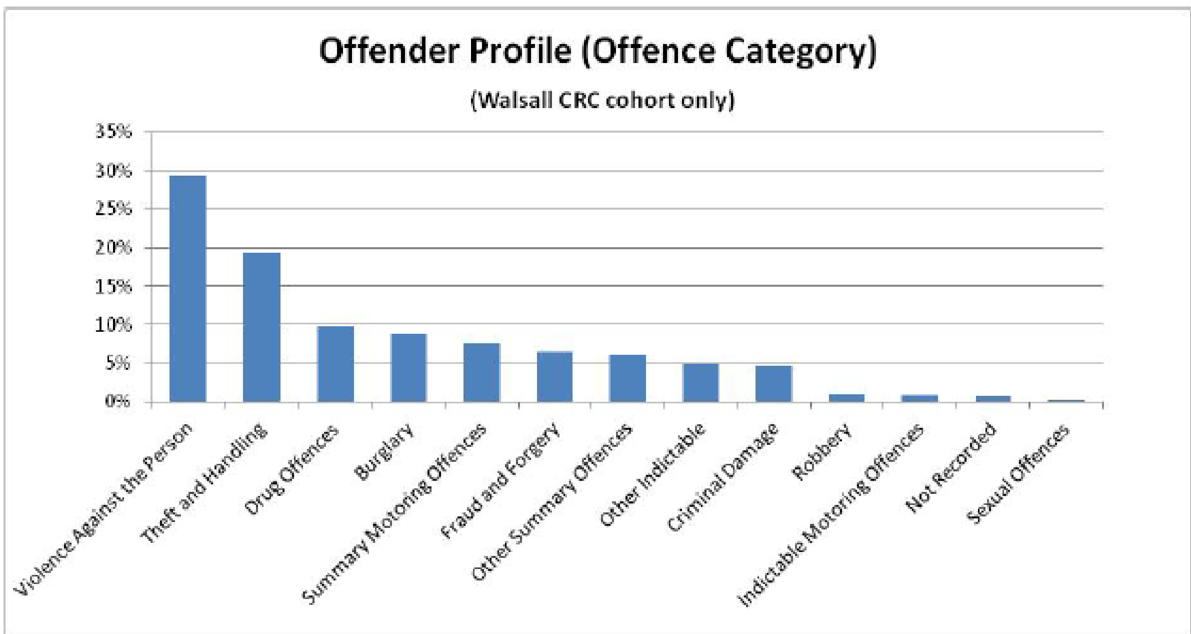
In Walsall, the above chart shows the pattern of need for the entire cohort of 992 CRC offenders.

It shows that overall, Thinking and Behaviour needs stand out as a common factor influencing most (91%) offenders. Followed by, Lifestyle and Associates, Relationships, Attitudes, Financial Management and Income and so on. Whilst Accommodation is an issue it features lowest on the list of needs.

However, as the following two charts show; the extent to which other factors influence offending differs slightly across low and medium risk cohorts. For example, relationship needs are second most key issue amongst medium risk offenders, whereas it is Lifestyle and Associate needs that secondly influence low risk offending.







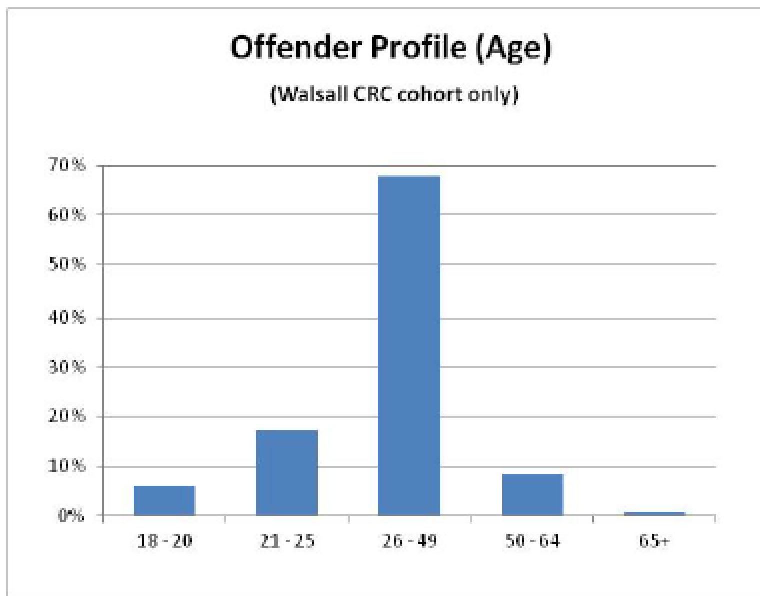
Just short of half of all offences involved to Violence against the person and Theft and Handling.

CRC Cohort Demographic profile

Gender breakdown

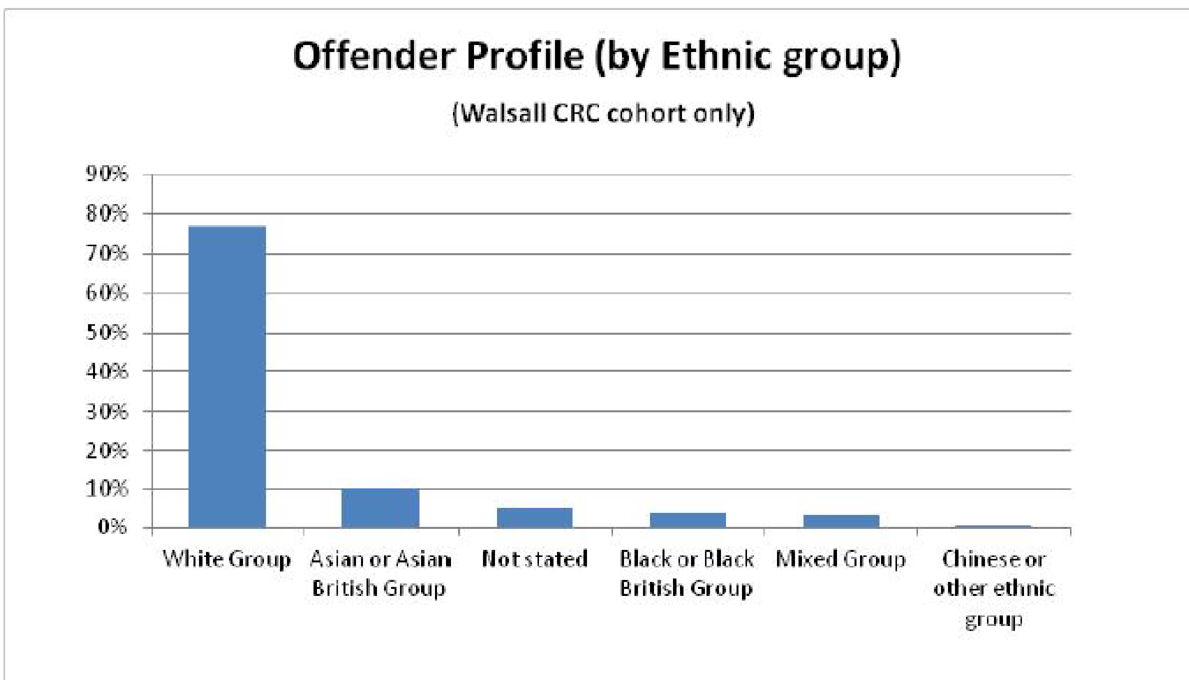
83% of offenders are male

Age breakdown



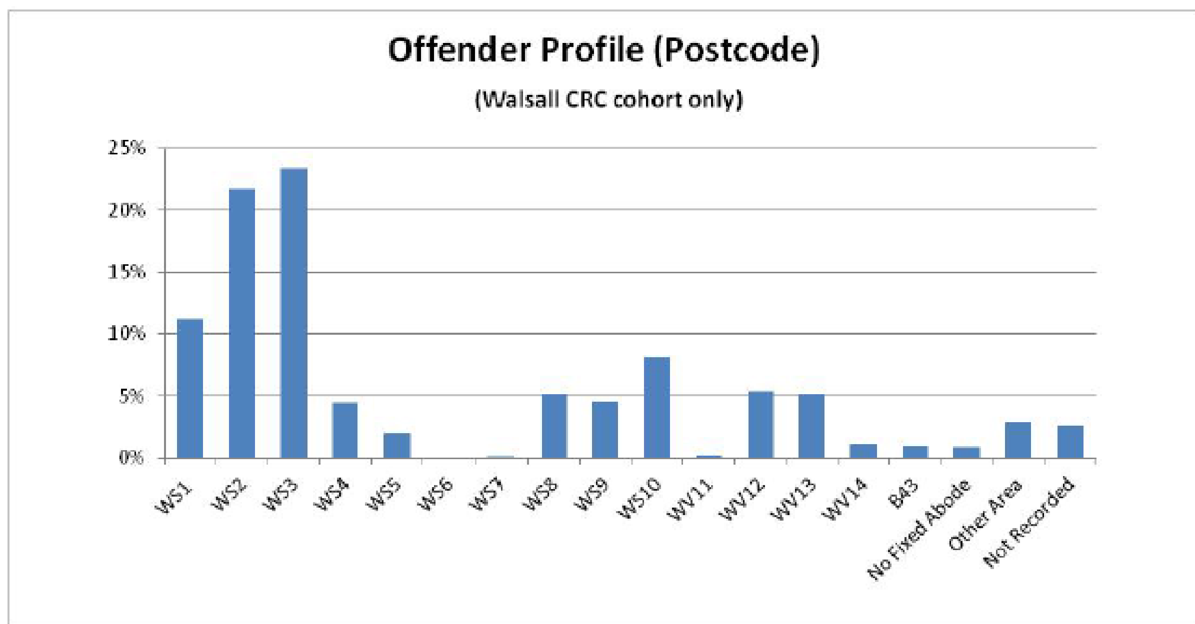
Most offenders fall into the 26-45 age group

Ethnicity; By Ethnic Group



Most offenders are of White ethnic origin; most offenders within this group are actually White British. Most of those with an Asian/Asian British background, are from Indian and Pakistani backgrounds. Most of those with a Black/Black British background are from a Caribbean background, including those from a mixed/white (Caribbean) background.

Residential Postcode

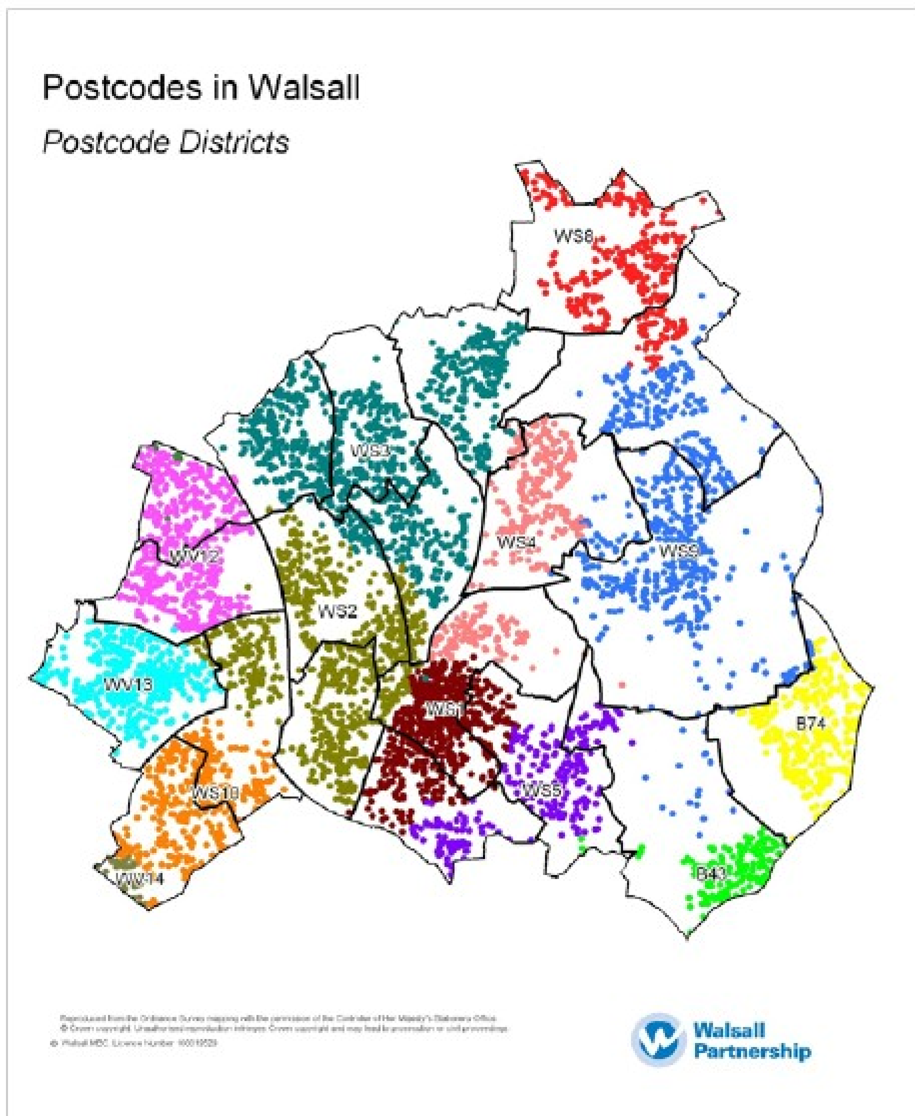


OASys only records postcode district for resident location of offenders and hence we are unable to pinpoint offenders resident locations from that information. However, postcode sector information broadly indicates that most offenders (80%) live in WS;

Walsall Postcode Districts. The vast majority of these live within WS1, 2 and 3 postcode districts; broadly speaking within Walsall North and Walsall South Areas; with pockets in Brownhills, Aldridge and Darlaston.

12% live in WV; Wolverhampton Postcode Districts i.e. within Willenhall Area, less than 1% live in B; Birmingham Postcode District, notably B43 which is the southern tip of Pheasey ward close to boundary with Birmingham. 6.5% of offenders live in other areas, where postcodes aren't recorded or are of no fixed abode.

To visually assist further understanding of the broad areas offenders reside; the following map shows the location of postcode districts within Walsall borough. Please note this map does not map the postcodes of offenders as these are not available, it merely shows where the districts are located within the borough.



4.0 Service mapping: current services

Services focus on provision after a domestic incident has taken place. A review of services was conducted for the Domestic Abuse Strategy 2014-16, a summary of this information is included here.

NICE (PH50 2014) recommends mapping services against the Home Office endorsed Co-ordinated Community Response Model (http://www.ccrm.org.uk/), see appendix 4. Local work in Walsall has identified a Domestic Abuse Prevention Pathway (Appendix 8). Work is in progress to map current services against this pathway in more detail (see Appendix 9 for latest version) and aims to demonstrate the integrated and co-ordinated provision of services for adults, parents and children against increasing levels of risk (in line with the CCRM).

4.1 Main Service Provision

A number of support services for victims and interventions with offenders of domestic abuse are provided. The following information has been taken from the Domestic Abuse Strategy (2014-16).

4.1.1 Aaina

A community based organisation that provides a specialist needs led support service for BME victims of domestic abuse. Aaina also provide domestic abuse awareness raising workshops and specialised training for frontline staff in Walsall and regionally.

4.1.2 Caldmore/Accord

Caldmore/Accord provides support to people experiencing or at risk of domestic abuse. This includes:

- Court IDVA
- Aven House 24h refuge provision for women and children
- Feeling safe programme for women who have been ar are likely to be affected by domestic abuse
- Floating support to women and children living in the community including: access to welfare provision, support with legal remedies, life skill training, basic emotional support, support to access education, employment and training, health and wellbeing support, support with tenancy sustainment
- Children and Young People's service
- Music therapy

4.1.3 Crisis Point

Independent sexual assaults advocate (ISVA).

4.1.4 Health services

Healthcare services have a valuable contribution to make in the interests of safeguarding children and adults where domestic abuse features in their lives and as preventative and protective measures. Walsall Clinical Commissioning Group and the large provider organisations (Walsall Healthcare Trust and Dudley and Walsall Mental Health Partnership Trust) support the multi-agency partnership arrangements to address local domestic abuse needs and as in the context of both strategic and operational concerns.
Health services that contribute to responding to domestic abuse include: A&E; Maternity Services, Health Visiting and School Nursing Services, Primary Care Services, Adult Mental Health and Addiction Services.

4.1.5 Walsall Domestic Violence Forum

- Contributor to DART (now replaced by MASH)
- Stepping Stones – 24 hour helpline
- SAYA – 24 hour multi-lingual helpline
- Two IDVA's; one ISVA (Independent Sexual Violence Advisor); one Young Persons IDVA
- Family Support Workers working with children and young people affected by domestic abuse and Outreach Officers
- Stopping Aggression in the Family Environment (SAFE) Programme – for male perpetrators

- Domestic Abuse Risk Assessment (DARA) involving intervention and assessment for families where domestic abuse has featured
- Spousal Abuse Risk Assessment (SARA) – for separated parents who wish to resume contact with their children
- Single and multi-agency training in domestic abuse

4.1.6 Walsall Housing Group (WHG)

WHG is the largest social housing provider in the Borough. It has two IDVA's to support tenants with regard to domestic abuse concerns and are members of DART (now replaced by MASH).

4.1.7 Walsall MBC provision

4.1.7.1 Adult Social Care

The multi-agency Walsall Safeguarding Adults Board co-ordinates the strategic development of safeguarding adults within Walsall. The Board has a strong commitment to promoting and supporting work to prevent and respond to adults with care and support needs subject to domestic abuse. Together with recognising the needs of the wider family, carers and the perpetrators. The Board monitors and reviews approaches to domestic abuse of adults with care and support needs across Walsall. From April 2015 it can require partners to share information and must assure itself that enquiries are made where there is suspected or known abuse of an adult. The Board is keen to promote prevention as a key approach to domestic abuse, but will also look to be assured that the following service provisions in response to domestic abuse are working in a co-ordinated way to provide an integrated and effective pathway for victims/survivors of domestic abuse . Together with the recognition of the need for the further development of perpetrator programmes.

4.1.7.2 Children's Social Care

The multi-agency Walsall Safeguarding Children Board co-ordinates the work of safeguarding children and young people from harm and abuse. Children living in households where domestic abuse is a feature as one cohort of all children for whom the Board, through its partnership arrangements has a responsibility.

Through its early help and specialist social care provision children and their families are protected to ensure that the risk of the impact of living with domestic is reduced and children are protected. There are a number of teams who may be involved with families affected by domestic abuse: MAST (multi-agency screening team), Early help team, Safeguarding teams, Corporate parenting teams, Edge of care team

4.1.8 Walsall Probation Service

The Probation Service has both strategic and operational levels of response to Domestic Abuse. It provides services to offenders and victims of domestic abuse. Reports are provided for the courts regarding domestic abuse offending alongside risk assessments of the perpetrators using nationally recognised risk assessment tools. The service aims to protect the public by supervising offenders in the community and also contributes to custodial assessments where necessary. Probation is the only statutory agency that is involved in the offender journey from entry into the criminal justice system,

through court preparations, the court hearing, in prison, in the community and afterwards to support voluntarily through care. Offender Managers are trained in the Integrated Domestic Abuse Programme (IDAP) which is a nationally recognised intervention. Victim liaison staff also have specific training for work with domestic abuse.

4.1.9 Walsall Specialist Domestic Violence Court (SDVC)

This brings together domestic abuse cases to improve criminal justice outcomes and reduce the rates of repeat victimisation. Trained IDVAs are available to support witnesses through the court process.

4.1.10 West Midlands Police Public Protection Unit

Domestic abuse forms a key element across all areas of Public Protection. The Public Protection Unit delivers investigations and safeguarding to victims and families of domestic abuse. Front-line uniformed officers initially attend domestic violence incidents, and where a criminal offence has been committed they will proactively seek to arrest the offender to bring them to justice. The Public Protection Unit provides a specialist domestic abuse team of officers to assist with investigations, deal with offenders within the custody environment and take responsibility for ongoing safeguarding strategies. The Public Protection Unit officers also provide specialist investigation, advice and safeguarding for victims of forced marriages or Honour Based Violence.

There are specialised domestic abuse workers within the Borough Public Protection Unit and all front-line officers receive mandatory domestic abuse training and regular refresher training.

4.2 Current service partnerships

4.2.1 MARAC

MARAC is funded by HM Government Home Office. The purpose of the MARAC is to make the strategic connection between the victim/survivor of domestic abuse and public protection mechanisms. The MARAC identifies “high risk” victims/survivors of domestic abuse and offers professional support and guidance, to reduce the threat of further harm and repeated domestic abuse to the victim/survivor and their immediate family members.

Safelives MARAC development programme 2015

Safelives reviewed the current MARAC and identified key strengths and areas for development (May 2015). Some of these recommendations are specific to the functioning of the MARAC but the following are relevant to this needs assessment:

- At present only 5% of cases referred to Marac come from non-Police agencies, which is significantly below the recommended 40% for an effective Marac and currently one of the lowest referral rates in the country. With such a high volume of cases coming from police there is a concern that early identification and risk assessment is inadequate
- It was not always clear at the meeting what referral criteria had been used, professional judgment, visible high risk or potential escalation.

- The data also shows that victims from diverse communities are under represented at the Walsall Marac. For example, just 9.8% referrals were for victims from BM&E communities; this does not reflect the local population of 23.1%. In addition, just 0.2% of referrals were for victims with disabilities and 0.4% were for victims identifying as LGBT.
- Not all risks were identified and action plans did not always reflect the risks, particularly in terms of finding ways to engage victims who had not previously engaged with support (including joint visits).
- It appeared that on occasion, when a perpetrator had been charged, the Idva referred the victim on to the court Idva for support; there is a risk that victims can disengage if too many support agencies are involved.
- We are not aware of any methods (such as data analysis, case audits or scrutiny panels) being used to demonstrate the effectiveness of the Walsall Marac.

4.2.2 Domestic Abuse Response Team (DART)

DART provides a single coordinated point for information sharing, contact, assessment and intervention for domestic abuse incidents reported to the police. Specific aims of DART are:

- to provide an enhanced integrated multi-agency response to adults, children and young people affected by domestic abuse who are identified via a police call out which is tailored to meet individual need.
- to reduce the number of repeat incidents of domestic abuse and to raise awareness that domestic abuse will be dealt with seriously.
- to improve the co-ordination of multi-agency responses to safeguard children and vulnerable adults.
- to offer the most appropriate services based on a multi-agency assessment.
- to promote that all service delivery is adult and child centred and outcome focussed.

DART is managed, administered and facilitated by Walsall Domestic Violence Forum.

An independent review of the DART was carried out in 2014. A number of recommendations were made in relation to the running and governance of the DART. In October 2015 the DART will be replaced by a MASH (multi-agency safeguarding hub).

In relation to the needs of adults as victims being considered as part of the DART process: DART had a core membership and there were agencies which were not able to attend on a regular basis (Mental Health, Adult Social care). However, Mental Health and Adult Social care checked the Police logs and information was fed by email into DART. Hence, the move to using the existing Adults and Children Safeguarding contact points. The professionals involved are expected to liaise, risk assess and refer to appropriate agencies as required (even if not sitting in a hub). Adult Social care are currently moving onto the MOSAIC IT System which has a category of Domestic Abuse (under the Care Act 2014). The MOSAIC system in the future will be able to analyse DA activity for Adults with care and support needs.

4.3 Current Commissioning Arrangements

The following table is a summary of domestic abuse commissioned services. It only includes specialised domestic abuse services, it does not include mainstream services which contribute to domestic abuse service provision such as children's services, health services etc.

Project Name or Provider	Commissioning Lead	Service Area	Type of Service			Funding	Description	Outcomes Output
			Universal	Targeted	Specialist	2015/16		
Community Safety Grant	Safer Walsall partnership Board	Communities and Partnerships				50K*	Domestic Abuse Commissioning Walsall DVF to match fund Home Office funding and funds the MODUS software licence	
Accord Housing Women's Refuge	Walsall Council (Older People Vulnerable Adults) (Public Health Transformation Fund)	Older People Vulnerable Adults	✓			£275k	Provision of a women's refuge to support women & their children who are escaping domestic abuse. The service provides 24 units of accommodation, 10 floating support units, children and young people's worker and court IDVA	**11/12:** Service utilisation £101.16% (86% target) Service Throughput 240.63% (100- 120% target) Planned moves 93.47% (Target 82%) Outcomes are articulated in the annual performance report.
Outreach Domestic Violence Support Service	Public Health – ()	Public Health		✓		£30k	Provision of IDVA to support families & local communities where families have been identified as victims of domestic abuse.	Reduced repeat presentations of domestic abuse.
Walsall Domestic Violence Forum	Children's services ()	Children's Preventative and Targeted & specialist Services		✓	✓	£120,000.00	Administration and support services to the DART Process and DARA, Training Delivery, Advice Line and Awareness Raising	Reduction of referrals to Social Care – 40% Children identified = 3004 DART Referrals - 2794 Families Worked with 1710

5.0 Engagement

Engagement with stakeholders, service users and key population groups who are at greater risk of domestic abuse is a crucial part of needs assessment. Due to the short timescales involved at this stage engagement has been initially carried out with key stakeholders. The next stage of this work has to include engagement with service users and key target groups as well as further stakeholder engagement.

Stakeholder engagement has been carried out through a questionnaire based on the NICE (PH50) recommendations. This was sent to key stakeholders, and completed either electronically, or through attendance at team meetings. The table below shows the stakeholders who were contacted, and where replies have come from to date:

Stakeholder group	Stakeholder	Reply received to date	Completed questionnaire / Face to face
Children's services	Intensive Family Support Team	Yes	Face to face (Team meeting)
	Early Help Family Support Teams	Yes	Questionnaires from individual team members
	MAST (Multi-Agency Support Team)	Yes	Face to face (Team meeting)
	Safeguarding and Family Support Teams	Yes	Face to face (Team meeting)
	Independent Reviewing Officers	No	
	Workforce Development Team	No	
	SEND team	No	
	Troubled Families	No	
	Edge of Care	No	
	Head of Service – Safeguarding and Quality Assurance	Yes	Questionnaire
	Commissioning Team, Children's Services	Yes	Questionnaire
Key providers	Walsall Housing Group	Yes	Questionnaire
	Walsall Domestic Violence Forum	Yes	Questionnaire
	Accord Group	Yes	Questionnaire
Voluntary sector	Victim Support	Yes	Questionnaire
	Aaina	No	
Adults' services	Team Manager, Adult Safeguarding Unit	Yes	Face to face
	Money, Home, Job (Walsall MBC)	No	
Key partners	Police	Yes	Questionnaire

	Probation	No	
	Schools	No	
Health services	Mental Health	Yes	
	Primary Care	Yes	Feedback from recent safeguarding training
	Family Nurse Partnership	No	
	Maternity Services	No	
	Health Visitors	No	
	Teenage Pregnancy	No	
DV co-ordinator	Walsall MBC	Yes	

The responses have been amalgamated and summarised, and are presented below against each of the NICE questions. Practitioners focused on the delivery elements of the questionnaire (ie not questions 1-3 which are much more strategic). The gaps identified are presented here. There were also some examples of current services mentioned but these are included in the review of services section.

	Gaps identified
1. Is the need for domestic violence and abuse services assessed as part of the joint strategic needs assessment?	• Yes, this was done in 2013 as part of the strategy development and is being refreshed here. • Still need better data/information collection to inform the JSNA – lack of understanding of numbers, trends and outcomes across agenices
2. Is there a local strategic partnership to prevent domestic violence and abuse? Does it include senior representatives from all relevant sectors and representatives of frontline practitioners and service users?	• Current structures not as effective as they could be. • Need better joining up between adults and children. • Need clear accountability for completing actions. • Query raised as to whether strategic group includes all relevant stakeholder groups, practitioners and service users • Effectiveness of provider group also queried due to lack of reporting structure • Providers group and strategic group not always co-ordinated, results in some silo working • Current structures lack the authority to hold people accountable
3. Does the commissioning strategy for domestic violence and abuse services address the needs of those who experience, and are affected by it, as identified in the joint strategic needs assessment? Is the behaviour of perpetrators and their health needs also addressed?	• Commissioning strategy needs to follow the JSNA • Only victims who have children are prioritised, unless assessed as high risk by police – gap for victims without access to support services. • Commissioning is currently being driven by children's services due to the impact of DV&A on long term outcomes • Needs of perpetrators is a gap

4. Are there integrated care pathways for identifying, referring and providing interventions to support people of all ages and backgrounds who experience, or are affected by, domestic violence and abuse. Are there pathways to manage those who perpetrate this violence and abuse?	• No, there is an awareness of what services are provided by various providers but integrated care pathways are not in place (this was a consistent message that was fed back). • Need to join up adult and children's services better. • Need to agree a support package that is co-ordinated across the family, a menu of options that can be used to meet the needs of those involved • Need to look at causes of DV, triggering factors, psychology of victim – some are repeat victims from multiple partners. Nothing done to address this. • Pockets of good practice exist but not universal. • High risk cases are referred to MARAC which provides an integrated response. The response to lower risk cases and early help may be single agency or less co-ordinated and is considered to be less effective. • DART is led by children's services, there is a gap for adult victims. Police screening prior to DART may exclude victims/perpetrators who are known to other services. Change of DART to MASH may be a risk for lower level category victims of DA. • Multiple points of entry, which determine what is available and offered to victims/families/perpetrators (eg DARA only if social worker involved) • Limited services to refer to and only in limited geographical areas. • High numbers of re-referrals to children's services for DV&A demonstrate lack of pathways and support • Need more lower level work to prevent escalation of the problem • Gap in services for male victims. Issues of childcare availability to enable attendance at groups. • Lack of longer term support for victims • Lack of information for staff and those affected on what services are available • Some frontline staff may be aware of DV&A incidents but unable to discuss them (family support teams) • Unclear whether mental health and substance misuse services link in with pathways. • Needs a more holistic approach to family (adults and children). • Perpetrators needs not addressed in the DART process. • Very limited services for perpetrators – may be referred for DARA but if only one parent engages then of limited value. DARA often completed in isolation to CPP. • May be encouraged to self refer to SAFE (have to

	pay for this), group sessions only (not suitable for all) if they don't engage then nothing else available. Nothing in place for female perpetrators. • Lack of shared information system means that some cases are replicated or not identified properly. • Risk of children not being identified at risk.
5. Are there clear protocols and methods for sharing information (both within and between agencies) about people at risk of, experiencing, or perpetrating domestic violence and abuse?	• Varying responses from different stakeholders – some felt this is fine, others did not. This suggests that current protocols and methods are not fully inclusive or understood. • Referrals to MARAC and DART generally have good information sharing • Big gap for those not considered at DART/MARAC where multi-agency information is vital. No mechanism for sharing lower level concerns. • Some query over how the information is used by some agencies eg children's centres, and whether there is any action specific to DV. • Gap in information sharing to support understanding of needs and outcomes
6. Do services provide a supportive environment for disclosing domestic violence and abuse?	• Generally positive feedback but some indication of variability dependent on individual staff and agency • BUT need to consider impact of closure of children's centres and reduced youth services on opportunities for disclosure • Need awareness raising locally to encourage disclosure. Needs a trusted relationship for disclosure. • Would expect more referrals from health professional, most come from police. This may show an issue with disclosure. • Need to consider wider workforce who may come into contact with victims, perpetrators or children and may be considered to be the "trusted" relationship
7. Are all those currently (or recently) affected by domestic violence and abuse provided with advocacy and advice services tailored to their level of risk and specific needs?	• Consistent message that there is some provision but it is not available for all – very variable (depending on route of entry) • Needs better joining up of services and meeting the needs of specific groups • Not as easily or consistently available for those cases not referred through DART. Gap for lower level cases • Needs support for adults after DV episode or after child is removed. • If choose not to engage, need to check back more than once at a later date to try to engage with services. • Need work on root cause for victim – especially high risk cases

8. Is a coordinated package of care and support provided for children and young people affected by domestic violence and abuse? Specifically, does it: Address the emotional, psychological and physical harms, and their safety? Match the child's developmental stage? Aim to strengthen the relationship between the child or young person and their non-abusive parent or carer?	• No – this message was consistent and clear. This is a big gap in current services. • There is some very limited limited provision but with gaps across the system, particularly below tier 4 • Gap also for those families who are not considered through the DART process • Specific gaps identified for those going through high levels of trauma and boys (age 11+) • Wishes and feelings training given to staff but not implemented • Long waiting times for CAMHS or House on the corner, which could support with some of the emotional and psychological issues • Needs a co-ordinated therapeutic approach across Walsall including schools. • Staff need tools to use to work with children on this
9. Is support tailored to address any barriers that may prevent people using domestic violence and abuse services?	Barriers identified: • Lack of services • Geographical barriers (limited venues, too far to travel) • Timeliness (8-12 week wait for DARA, long wait for CAMHS) • Language barriers / lack of interpreters • Childcare • Age – low reporting by teenagers (not recognised as DV&A) • Child on parent abuse • Same sex discolsures • Cultural beliefs result in barriers • Transient communities – often move on before work is completed • Victims do not always want to be identified with experiencing domestic violence so need an expansion of reporting options (consider third party reporting centre for Hate Crimes as a model) • Access to refuge accommodation out of hours, and barriers for specific groups • Client relationship with authority – especially when poor response • Need easily accessible non-threatening walk-in services • Group work
10. Are staff trained in how to identify and respond to disclosures of domestic violence and abuse? Does this include staff in services where children and young people affected by domestic violence and abuse may be identified?	Needs training in the following: • Awareness raising for all staff – including healthy relationships, impact on children • More awareness raising with health professional – should have higher referrals • Direct work with victims • Direct work with perpetrators • Lots of training on how to identify but not enough

	on tools to use • What services are available • Need better joined up approach to training

Young people's emotional wellbeing and mental health workshop:

Feedback from the recent young people's emotional wellbeing and mental health workshop (Sept 2015) highlighted the need to consider the issues faced by parents as part of the response to the emotional wellbeing and mental health of children and young people. A more family-focused approach is needed, with clear pathways for support for parents available to those who work with children (eg in schools). Domestic violence was specifically identified as having a significant impact on emotional health and wellbeing, but a lack of support for schools when it comes to supporting parents.

6.0 Key Findings and Recommendations

6. 1 Primary prevention

What are we already doing?

- Very little information was available on what is currently being delivered on primary prevention. The consultation focused on support and services for those affected by DV&A (based on NICE)
- The current DV&A strategy action plan includes mapping of existing work being undertaken with children regarding "healthy and safe relationships"

What gaps have been identified? (C = consultation, D/I = data/intelligence)

- No local data/intelligence were identified that were relevant to primary prevention.
- Consultation responses were not received from those most likely to be involved in primary prevention

What should we be doing? (the evidence)

- The PEACH review made a number of conclusions that should be considered when commissioning prevention programmes (see section 2.7.2 and appendix 2)
- There are a wide range of strategies that can be used to address risk factors for violence and promote protective factors across the life-course, both universal and targeted (see section 2.7.3)
- The Early Intervention Foundation report (2014) includes evidence of programmes that can improve knowledge, attitudinal and interpersonal outcomes for young people at risk (see section 2.7.6)
- NICE (PH50) did not include recommendations on primary prevention, however the evidence review does include primary prevention programmes. There is modest evidence for programmes that target young people at risk.

Recommendations

- Complete the mapping of existing work identified in the DV&A strategy action plan
- Develop a strategy for primary prevention. This should include:
  - Delivery of primary prevention programmes such as those outlined in "Protecting People Promoting Health: a public health approach to violence prevention for England 2012" see section 2.7.3, or "Safe dates" (see section 2.7.4). These include:
    - Interventions that develop parenting skills and strengthen relationships between parents, carers and children
    - Developing life skills in children and young people
    - Working with children and young people at high risk, and with youth and gangs
  - Programmes should be delivered: at a whole population level; for children and young people outside of mainstream schools (as this group is likely to be high risk) and for children who are at high risk of experiencing DV&A. The needs of diverse groups should be considered (eg LGBT, disabled , BME etc).
  - Improve the readiness of schools to deliver prevention programmes through training and information for the school's leadership, governors and parents
  - Any school based programmes should build close links with relevant support services that can respond to disclosures of DV&A. Professional supervision should also be available for teachers and other school staff.
  - The strategy should seek opportunities to embed primary prevention in universal services eg education, health visiting, school nursing
- This work will also need to link with the workforce development recommendations (below)

6. 2 Workforce development

What are we already doing?

- There are a number of workforce development programmes in place for frontline staff, including awareness raising, identification and intervention (where appropriate). This includes recent training for GPs.
- The current DV&A strategy action plan includes:
    - the development of workforce training for universal and specialist professionals
    - workforce development and training for universal and specialist professionals
    - organisational level awareness raising
    - mapping of safeguarding training to ensure links to DV&A are recognised
    - Updating of the Local Children's and Adult's Safeguarding Boards procedures
    - Integration of DV&A training into the Joint Council Directorate training on recognising areas of vulnerability
    - A "domestic abuse" clause and minimum standards in contracts and service specifications for providers and organisations

What gaps have been identified? (C = consultation, D/I = data/intelligence)

- Nearly all referrals to MARAC come from the police, there are very few referrals from other agencies suggesting workforce development issues and/or process issues (D/I).
- There are low levels of referrals to MARAC for BME, LGBT, victims with disabilities and male victims suggesting issues with disclosure (D/I)
- Gap in referrals from health professionals, suggests issues with recognition or disclosure and therefore workforce development, greater engagement with midwives would be welcomed (C)
- Lack of clarity on training for frontline staff – Wishes and Feelings training given but not implemented (C)
- Support for greater workforce development was consistent in the consultation (C)
- Need more training on tools to use (rather than just assessment) for frontline staff (C)
- Need a more joined up approach to training across partners (C)
- Impact of closure of children's centres and reduced youth services could have an impact on disclosures (loss of trusted relationships). This needs to be mitigated in workforce development (C)

What should we be doing? (the evidence)

- Ensure trained staff ask people about domestic violence and abuse (NICE PH50) and know how to refer
- Help people who find it difficult to access services (NICE PH50)
- Provide specific training for health and social care professionals in how to respond to DV&A, including GPs (NICE PH50)
- Responding to violence against women and children – the role of the NHS (DH 2010) includes a number of recommendations for NHS workforce development
- NICE PH50 includes evidence on identification of domestic abuse which should be considered in workforce development programmes

Recommendations

- Carry out a training needs assessment for domestic abuse that includes all frontline staff from all partners. There should be a specific focus on frontline healthcare staff, including GPs and midwives.
- The training needs assessment should also include training needs for interventions (not just recognition and assessment)
- Identify and mitigate the barriers to partner agencies identifying domestic abuse and referring to services. This needs to include those who find DV&A services inaccessible or

difficult to use.

- Indentify and mitigate the barriers for BME, LGBT, victims with disabilities and male victims to disclose DV&A and access services
- Develop a multi-agency multi-professional system-wide approach to training (rather than each agency/profession "doing their own thing")
- NICE sets out a framework for training:
    - Universal response
        - Level 1: staff trained to respond to disclosure of DV&A
        - Level 2: Staff trained to ask about DV&A in a way that makes disclosure easier (eg midwives)
    - Specialist response
        - Level 3: initial response that includes risk identification and assessment
        - Level 4: expert advice and support to people experiencing DV&A
    - Other training – to raise awareness of DV&A in commissioners and managers

6. 3 Support for victims

What are we already doing?

- Support services for victims are commissioned from Walsall Domestic Violence Forum and Accord Group
- Support is also provided to tenants of Walsall Housing Group
- There is some voluntary sector provision in Walsall, including Victim Support and Aaina
- Walsall MBC Adult's Services work with individuals affected by DV&A to ensure children are protected. There are a number of teams involved, depending on the level of risk.
- Walsall Council Adult Soc ial Care work with individuals with care and support needs affected by DV&A to ensure they are protected (Safeguarding Adults). Together with the recognition of the needs of carers, families and perpetrators are recognised and responded to. There are a number of teams involved, depending on the type of input required. When Domestic Abuse concerns arise for Adults with care and support needs there is an established Adult Social care contact centre which operates on a 24/7 basis and where Safeguarding Adults concerns are raised.
- The current DV&A strategy includes work on publicity and promotional materials

What gaps have been identified? (C = consultation, D/I = data/intelligence)

- High number of referrals to MARAC in Walsall compared to the West Midlands and National may demonstrate a gap in services and support earlier in the pathway to prevent the DV&A escalating to high risk (D/I)
- There is a recent reduction in referrals to DART and a downward trend since 2007 which means fewer victims are offered this support (D/I).
- High number of re-referrals to MARAC for Walsall compared with neighbouring authorities demonstrates a gap in support to reduce the risk in families who are already identified with the highest levels of risk (D/I)
- 70% of referrals (4000) referred to children's services are for DV or abuse/neglect (D/I)
- Only victims who have children are prioritised, unless they are assessed as high risk by the police or other DART partners (this may reflect current commissioning arrangements) (C)
- Some services are available, but limited capacity. No integrated care pathways below MARAC. This applies to support services and also to advocacy/advice services. (C)
- The majority of victims do not receive support when issues are first identified at a lower level – have to wait until they escalate to hit the thresholds of DART/MARAC due to being screened out of DART or deemed NFA (no further action) by children's services (D/I and C)

- Multiple points of entry, which determine what is available to victims (C)
- Re-referrals to children's services for DV&A demonstrate lack of support services for adults (C)
- Lack of services for male victims (C)
- Lack of longer term support for victims eg after a child is removed to prevent it happening again (C)
- Insufficient support for victims who refuse services first time – need to do more to engage them at a later date (C)
- Lack of information for frontline practitioners on what is available (C)
- Unclear how mental health and substance misuse services refer into DV&A pathways (C)
- Need to consider the triggering factors / root cause of DV&A and deal with that, not just treat the consequences (C)
- Needs a more holistic approach to family, join up adult's and children's support better (C)
- A number of barriers were identified to people accessing DV&A services, including childcare (see consultation for more detail). (C)
- Barriers in access to refuge accommodation – limited out of hours and for specific groups (C)
- Insufficient emergency accommodation available (D/I)

What should we be doing? (the evidence)

- Create an environment for disclosing DV&A (NICE PH50)
- Commission integrated care pathways for identifying, referring and providing interventions to support people who experience domestic abuse that are tailored to meet their needs (NICE PH50)
- Ensure people who misuse alcohol or drugs, or who have mental health problems and are affected by DV&A are also referred to relevant services to treat their condition (NICE PH50)
- Provide specialist advice, advocacy and support as part of a comprehensive referral pathway (PH50)
- NICE PH50 includes evidence on different types of programmes and support for victims, There is also some evidence that home visiting programmes that support abused women are effective in reducing partner violence.

Recommendations

- Commission evidence-based specialist advice, advocacy and support as part of a comprehensive referral pathway. This should be within the framework of a coordinated community response model to DV&A.
- Ensure that the support commissioned is available at different levels, not just for cases considered to be high risk or those that meet certain thresholds (eg DART). There should be a focus on providing support before DV&A escalates to high risk levels.
- Complete the actions in the domestic abuse strategy action plan 2014-16 on domestic abuse publicity and promotional materials
- The consultation identified a number of barriers to accessing services, these should be taken into account when developing the commissioning strategy
- Support needs to include support for individuals who do not meet the DART (MASH) or MARAC criteria, but who could be prevented from needing more intensive services at a later date.
- Comparison with other local areas of system, processes and practices for referrals and repeat referrals to MARAC. This could form part of the response to the Safe Lives review (MARAC steering group)
- Commission longer term support interventions for repeat MARAC cases
- Contracts for services should include measures of effectiveness, including patient-reported outcome measures (see 2.7.8 for details)
- Integrated care pathways should include assessment tools and referral pathways for

addiction and mental health services

6. 4 Support for children

What are we already doing? • Support services for children affected by DV&A are commissioned from Walsall Domestic Violence Forum • Support is also provided to tenants of Walsall Housing Group • Accord Housing has a specialist CYP worker • Walsall MBC Children's Services work with children and families affected by DV&A to ensure children are protected. There are a number of teams involved, depending on the level of risk.
What gaps have been identified? (C = consultation, D/I = data/intelligence) • High number of referrals to MARAC in Walsall demonstrate a gap in services and support earlier to prevent the DV&A escalating to high risk (D/I) • High number of re-referrals to MARAC for Walsall compared with neighbouring authorities demonstrates a gap in support to reduce the risk in families at the highest level of risk (D/I) • 1,676 (30%) of referrals to children's services are for domestic violence and 2290 (41%) for abuse/neglect (D/I) • A large number of cases that are referred to Children's services have no further outcome recorded, at all levels of the system (referral through to child protection plan). There are a lack of data to support what happened to these cases but they are likely to repeat due to a lack of lower level services for DV&A (D/I and C) • DV&A is a significant issue as part of the toxic trio locally, recorded as the primary issue for the majority of cases identified (D/I) • Significant numbers of referrals for Early Help were also for DV&A (D/I) • There is very limited provision of support for children affected by DV&A, at all levels of the system (C). • Gap for families who are not considered through the DART/MASH process (C) • Specific gaps identified for those going through high levels of trauma and boys (age 11+) (C) • Long waiting times for CAMHS (C) • Where children have emotional wellbeing issues and mental health issues the needs of their parents should be considered (usually this is the cause of the problems). A much more family-focused approach is needed with clear pathways for referral into services for adults and children. School requested better access and referral processes to specialist and support services for parents (C) • Need a co-ordinated therapeutic approach across Walsall including schools (C)
What should we be doing? (the evidence) • Identify and, where necessary, refer children and young people affected by DV&A to local services that can support children and young people affected by DV&A (NICE PH50) • Provide specialist DV&A services for children and young people (NICE PH50) • NICE PH50 provides commissioning guidance and evidence of programmes that have been shown to be effective.
Recommendations • Develop clear referral pathways to local services that can support children and young people affected by DV&A • Include support for children in the workforce development strategy (see section 6.2),

particularly for frontline staff who work with children (e.g. schools)
- Commission more local services to provide support for children. An integrated approach should be taken, using the co-ordinated community response model as a framework.
- Integrated care pathways should include assessment tools and referral pathways for mental health and emotional well-being services

6. 5 Work with perpetrators

What are we already doing?

- The Probation Service works with perpetrators who are in the criminal justice system, including delivering the Integrated Domestic Abuse Programme (IDAP)
- Walsall Domestic Violence Forum is commissioned to deliver the SAFE programme for male perpetrators
- The current DV&A strategy includes:
    - information for all agencies on the perpetrator programmes
    - Co-ordination of criminal justice activities

What gaps have been identified? (C = consultation, D/I = data/intelligence)

- High number of referrals to MARAC in Walsall demonstrate a gap in services and support earlier to prevent the DV&A escalating to high risk (D/I)
- High number of re-referrals to MARAC for Walsall compared with neighbouring authorities demonstrates a gap in support to reduce the risk in families at the highest level of risk (D/I)
- Very limited provision for perpetrators who are outside of the criminal justice system (C)
- Perpetrators needs not addressed in the DART process (C)
- Very limited services available for male perpetrators, at a cost to the perpetrator (SAFE) and only group sessions available. Nothing available for female perpetrators (C)
- DARA assessments often not timely or as part of wider package for the family (C)

What should we be doing? (the evidence)

- Commission and evaluate tailored interventions for people who perpetrate DV&A (NICE PH50)
- There are evidence-based programmes which are effective in changing the behaviour of individual perpetrators (Project Mirabal report on RESPECT programmes section 2.7.7) (NICE PH50 evidence base)

Recommendations

- Additional capacity in evidence-based programmes for perpetrators that challenge their behaviour should be commissioned, with as many barriers to access removed as possible (eg payment by the perpetrator). These should be within the framework of the co-ordinated community response model for DV&A.
- Use the Project Mirabal measures of change to monitor the effectiveness and outcomes of commissioned services.
- Work with perpetrators should include assessment tools and referral pathways for addiction and mental health services

6. 6. System-based approach

6.6.1 Strategic leadership

What are we already doing?

- The Safer Walsall Partnership has produced a DV&A Strategy and accompanying Action Plan 2014-16

What gaps have been identified? (C = consultation, D/I = data/intelligence) • Current structures are not as effective or inclusive as they could be (C) • Current structures lack the authority to hold people accountable (C) • Need clear accountability for completing actions (C)
What should we be doing? (the evidence) • NICE (PH50) sets out who should be involved in a local strategic multi-agency partnership to prevent DV&A • An Integrated Commissioning Strategy should meet the needs of those experience DV&A, meet the needs of children and young people who are affected, address the perpetrators behaviours and health needs, meet the needs of all local communities (NICE PH50)
Recommendations • Clear accountability for the partnership responsible for DV&A should be communicated and implemented • Development of the local partnership should include the enabling factors and barriers for partnership working (see NICE PH50 evidence) • Clear accountability for DV&A within Walsall MBC should be agreed

6.6.2 Co-ordination

What are we already doing?
• The current DV&A strategy includes:
  ○ co-ordinating joint commissioning budgets
  ○ involving all commissioning agencies in joint strategic planning, commissioning and delivery

What gaps have been identified? (C = consultation, D/I = data/intelligence) • Better joining-up is needed across the system for adults and children. We need to look at the needs of the whole family and develop a package around these needs (C)
What should we be doing? (the evidence) • The co-ordinated community response model provides a framework for a whole system approach (recommended by NICE PH50)
Recommendations • Take a holistic approach to meeting the needs of the family, commission the whole system in line with the co-ordinated community response model • Look at the models in other areas which are considered to be effective

6.6.3 Data, intelligence and information sharing

What are we already doing?
• There is some collection of information by the various services involved.
• An information sharing agreement is in place
• The current DV&A strategy includes
  ○ work on mapping and sharing data
  ○ information sharing protocol

What gaps have been identified? (C = consultation, D/I = data/intelligence) • The Linx system (A&E attendances for violence shared with the police) has not been updated for 12 months due to staff issues at A&E (D/I) • There are very few data available on services and outcomes. There is very little sharing of

data and intelligence across agencies. (D/I and C) • Data that are available are agency specific, each agency collects their own indicators and these cannot be matched across agencies. Therefore it is not possible to get a system-wide picture of need or provision. (D/I) • Hospital data are not as expected (lower levels and unexpected gender split) (D/I) • MODUS system capabilities are under-utilised • Information sharing is not as good as it could be (C) • Particular gap in sharing information about cases that are not referred to DART/MARAC. No mechanism in place for sharing information about lower level concerns (C)
What should we be doing? (the evidence) • Adopt clear protocols and methods for information sharing (NICE PH50) • Clear information sharing protocols across agencies AND sharing of information and evaluation of any prevention services, pilots and interventions (West Midlands DHR reviews section 2.7.9)
Recommendations • Review current information sharing protocols to ensure relevant and appropriate information about victims, their families and perpetrators is shared • Further engagement work needs to be done with service users and high risk groups in the planning and commissioning of services to meet need • Information sharing protocols need to include data and intelligence about needs, service use and outcomes to enable the whole system to operate more effectively • Measure effectiveness of commissioned services through outcomes and other performance measures that are consistent across the system wherever possible (see 2.7.8 for proposed approach) • MODUS or equivalent software licences to be utilised across key provider agencies to optimise system-wide tracking and outcome monitoring. • Use the local data and intelligence to understand how current demand for services is changing.

7.0 References

Domestic Violence Perpetrator Interventions: Commissioning guidance summary for local commissioners, Respect 2015 http://respect.uk.net/wp-content/uploads/2015/03/Respect-domestic-violence-perpetrator-programme-commissioning-guidance-updated-January-2015.pdf

Effectiveness of home visiting in reducing partner violence for families experiencing abuse : a systematic review. (Prosman et al 2015; Family Practice 2015; 32 (3): 247-256 June 2015)

Interventions for preventing or reducing domestic violence against pregnant women (review). (Jahanfar et al, 2014; The Cochrane Library 2014 Iss 11)

Interventions to reduce domestic abuse in pregnancy : a qualitative systematic review (Leneghan 2012; Evidence Based Midwifery, vol 10, no 4, Dec 2012, p 137-142)

Intimate partner violence and pregnancy: a systematic review of interventions (Van Parys et al, 2014; PLoS ONE 9(1): e85084

Preventing domestic abuse for children and young people (PEACH): a mixed knowledge scoping review (Stanley et al, Public Health Research 2015; Vol 3 No 7)

Protecting People Promoting Health : a public health approach to violence prevention for England (DH 2012) https://www.gov.uk/government/publications/a-public-health-approach-to-violence-prevention-in-england

Report from the domestic violence sub-group: responding to violence against women and children - the role of the NHS (DH 2010)
http://www.health.org.uk/sites/default/files/RespondingtoViolenceAgainstWomenAndChildrenTheRoleofTheNHS_guide.pdf

Social value of Refuge services for survivors of domestic violence May 2013 (nef consulting)
http://www.refuge.org.uk/files/Refuge-SROI-report-25-09-13-NCV2.pdf

The cost of domestic violence up-date 2009 Walby.
http://www.lancs.ac.uk/fass/sociology/profiles/34/

8.0 Appendices

Appendix 1: Summary of evidence from NICE (PH50):

		Quality of evidence	N = None S = some but inadequate P = provided to meet needs in Walsall
Prevention (does not include primary prevention)	Prevention programmes that target young people at risk for partner violence may improve knowledge, attitudinal and interpersonal outcomes	Modest	
	Impact of media campaigns	Inconsistent	
	Prevention interventions implemented in healthcare settings (emergency depts.)	Weak	
	Prevention programmes in community settings for high risk women	Weak	
Identification (focus on abuse of women by male partner)	Different screening tools result in different identification rates, but not possible to determine which are most effective	Moderate	
	Screening format impacts disclosure. Not possible to determine most effective specific format although self report may be effective	Moderate	
	Cueing (providing information about a patient prior to clinical encounter) improves discussion of, disclosure of and referral to DV services	Moderate	
	Provider education interventions for improving screening practices	Weak	

	Implementation of policy or organisational changes to screening	Weak	
	Universal screening for DV in pregnancy, when supported by staff training and organisational support improves screening practices and documentation	Moderate	
Responses - Victims	Advocacy interventions improve a range of outcomes	Moderate	
	Skill building with victims has positive effects on victims' coping, well-being, decision-making abilities, safety and reduction of coercive and violent behaviour	Moderate	
	Counselling / brief interventions promote a range of outcomes including reducing depression and increasing empowerment. Interventions based on brief educational, cognitive-behavioural and motivational interviewing approaches	Moderate	
	Therapeutic interventions promote improvement in mental health impacts of violence – range of outcomes	Moderate	
Responses - Perpetrators	Interventions appeared to have a greater effect on attitudinal outcomes than recidivism/violence outcomes (improved in some studies but not all)	Moderate	
	Short duration group approaches (16 weeks or less)	Inconsistent evidence for recidivism/abuse outcomes. Moderate evidence for attitudinal, psychological and interpersonal outcomes	
	Long duration group	Inconsistent	

	approaches (16 weeks+)		
Responses – Elder abuse	Few studies on elders or caregivers	Weak	
Responses - Couple	Behavioural couples therapy within substance misuse treatment associated with improved abuse outcomes	Not grounded in a theoretical framework, no acknowledgement of gendered nature of violence	
Interventions - Children	Single component therapeutic interventions aimed at both mother and child are effective in improving child behaviour, mother-child attachment and stress/trauma related symptoms.	Moderate-strong (only weak evidence for single component therapeutic interventions aimed at children)	
	Single component psycho-educational interventions aimed at children are effective in improving children's coping skills, behaviour, emotional regulation, conflict resolution skills and knowledge about violence	Moderate	
	Multi-component interventions with focus on advocacy reduce trauma symptoms and stress and improve child behaviours such as aggression	Moderate	
	Multi-component interventions including therapy and advocacy increase knowledge and awareness, self esteem, self competence and interpersonal relationships	Moderate – in diverse populations of women and children	
	Multi component interventions focused on therapy and parenting showed improvement in children's behaviour and emotions, knowledge about violence, and reduction in mothers' stress and ability to manage children.	Moderate – in diverse populations of women and children	

Partnerships	Partnerships to address DV effective at: increasing referrals, reducing further violence or supporting victims of DV	Moderate	
	Partnership approaches have been effective in improving relationships, practices and policies of partner agencies to address DV.	Moderate	
	Evidence for enabling factors and barriers to partnership working	Moderate	

Appendix 2: Preventing domestic abuse for children and young people (PEACH): a mixed knowledge scoping review (Stanley et al, 2015)

Conclusions from the study:

1. Many of the long-term costs of domestic abuse are borne by the health service; there is, therefore, a strong argument for health services contributing more funding to prevention initiatives for children and young people.
2. Evidence about the lack of transferability of programmes suggests that strategic planning and development should focus on developing and testing interventions that are already being widely delivered in the UK.
3. Improving the readiness of schools to deliver programmes should include training and information reporting on current evidence for the school's leadership, governors and parents.
4. The values and attitudes of the peer group emerged as a crucial mechanism for change and it is therefore appropriate to continue to deliver interventions to whole populations of children and young people. While schools provide a natural choice of setting for programme delivery, young people outside mainstream schools should not be omitted, as this group is likely to include young people at high risk who may require additional services.
5. Programme take-up and effectiveness appear to be influenced by those children and young people who are at high risk of experiencing domestic abuse in their own or their parents' relationships. Identifying this group of children so that they can receive further support could happen in the course of delivering interventions to a whole class or school.
6. School-based programmes should build close links with relevant support services that can respond to children's and young people's disclosures of domestic abuse and offer additional interventions to those at high risk.
7. Interventions need to acknowledge diversity among children and young people, and programmes need to be developed for LGBT and disabled young people as well as for those from minority ethnic groups.
8. Teachers require training and support from those with specialist knowledge and skills in domestic abuse. This training could be provided at the level of teachers' qualifying education as well as at post-qualification level.
9. A statutory basis for delivering these interventions would enable schools, programme designers and staff to take a longer-term view which could include building ongoing evaluation, including analysis of costs, into programme delivery.

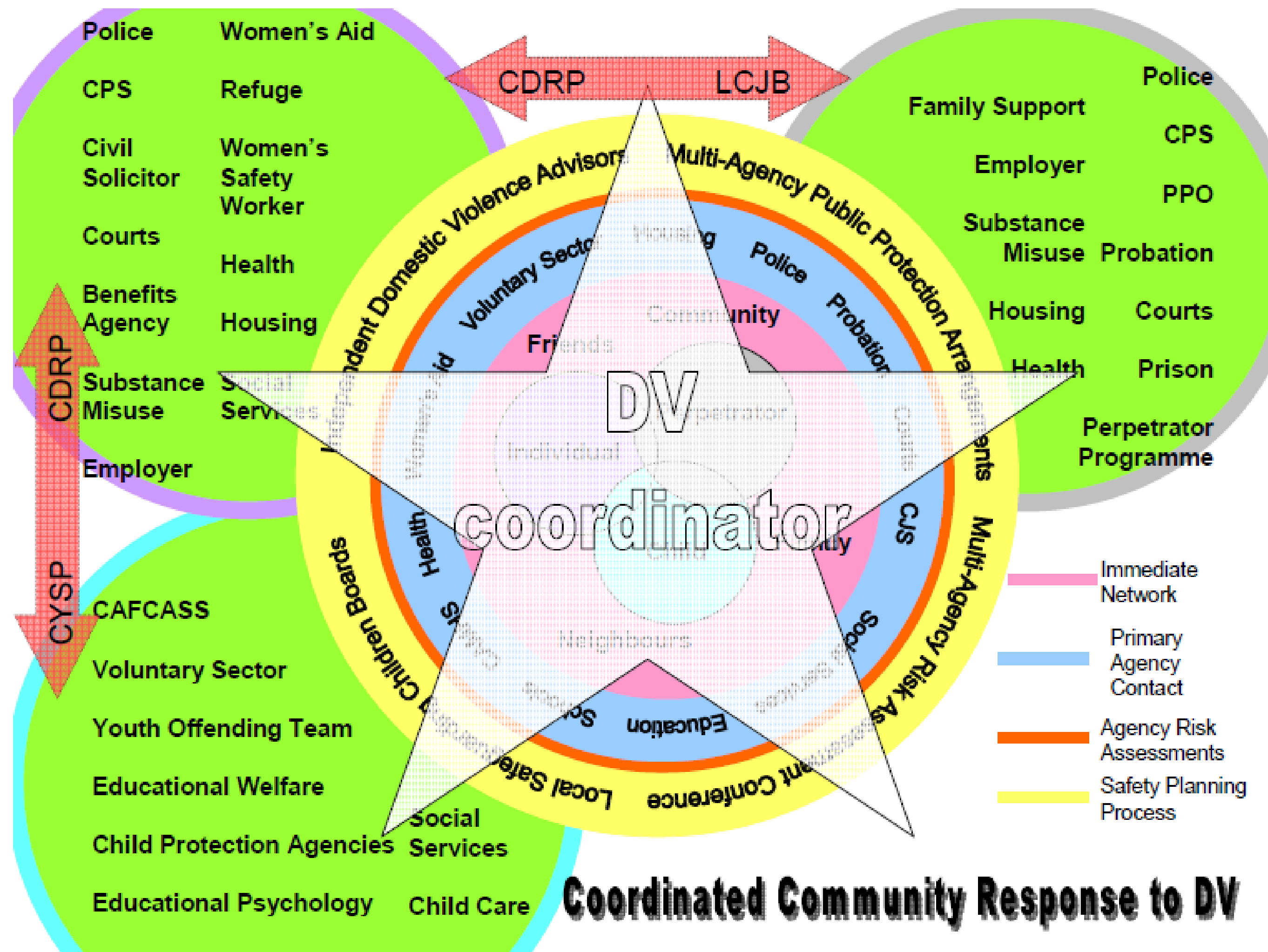
Appendix 3: Recommendations from the Report from the domestic violence sub-group: responding to violence against women and children - the role of the NHS (DH 2010)

- NHS staff should be made aware of the issues relating to violence and abuse against women and children, and of their role in addressing those issues.
- Primary Care Trusts (PCTs), their partners in Local Strategic Partnerships and NHS Trusts should ensure that women and children who are experiencing violence or abuse are provided with information that helps them to access services quickly and safely.
- All NHS staff should have – and apply – a clear understanding of the risk factors for violence and abuse, and the consequences for health and well-being of violence and abuse, when interacting with patients. This should include:
    - appropriate basic education and training of all staff to meet the needs of women and children who have experienced violence and abuse;
    - more advanced education and training of 'first contact' staff and those working in specialties with an increased likelihood of caring for women and children who have experienced violence or abuse; and
    - staff awareness of the associations and presentations of violence and abuse and how to broach the issue sensitively and confidently with patients.
    - Universities and other providers of education and training, employers, and regulatory and professional bodies should work together to make this happen.
- Midwives and health professionals should be trained to provide information to mothers from communities which practise female genital mutilation (FGM). Ideally this should take place during the antenatal assessment. The use of targeted questioning in those communities where FGM is practised should be employed as part of an integrated local pathway of care for FGM.
- PCTs and NHS Trusts should have clear policies on the use of interpretation services that ensure women and children are able to disclose violence and abuse confidently and confidentially.
- PCTs and NHS Trusts should work together with other agencies to ensure that appropriate services are available to all victims of violence and abuse.
- Every NHS organisation should have a single designated person to advise on appropriate services, care pathways and referrals for all victims of violence and abuse, providing urgent advice in cases of immediate and significant risk.
- NHS organisations should have health and well-being policies specifically for staff who are victims of domestic and sexual violence. A clear pathway should be implemented in every NHS-funded organisation so that staff and managers know where and how to access support.
- NHS organisations should ensure that information relating to violence and abuse against women and children is treated confidentially and shared appropriately. This means that:
    - there should be consistency and clarity about information sharing and confidentiality;
    - staff should be equipped, through training and local support from local leads on violence against women and children and Caldicott Guardians, to share information appropriately and with confidence. In the case of safeguarding children, advice should come from the named doctor and nurse for safeguarding;
    - women and children disclosing violence or abuse should feel assured that their information will be treated appropriately; and

    - the Government should clarify the grounds for public interest disclosure in relation to 'serious crime'.
- Clear, outcomes-focused commissioning guidance on services for violence against women and children should be issued by the Department of Health, with a particular emphasis on involving women and children in commissioning.
- Consistent and practical data standards should be agreed relating to the health aspects of violence and abuse against women and children to underpin the analysis of quality, activity, outcomes and performance management by commissioners and NHS and third sector providers.
- NHS commissioners should assess local needs and local services for victims of sexual violence and/or sexual abuse and ensure that appropriate commissioning arrangements are in place.
- Commissioners/PCTs with their partners in Local Strategic Partnerships should ensure that appropriately funded and staffed services are put in place along locally agreed care pathways.
- The Department of Health and the Home Office should make it clear to the immigration agencies and the NHS that direct treatment needs should be met for women and children experiencing violence and abuse, whatever their immigration status.
- NHS organisations should ensure that there is sustained and formalised co-ordination of the local response to violence against women and children through a local Violence Against Women and Children Board. NHS organisations should participate fully in multi-agency fora, such as Multi- Agency Risk Assessment Conferences (MARACs), set up to prevent or reduce harm to victims of violence. These arrangements should link appropriately to local structures in place for safeguarding children and vulnerable adults.
- PCTs and NHS Trusts should nominate local 'violence against women and children' leads, supported by the Violence Against Women and Children Board, to work with women and children and the NHS to drive change and improve outcomes.
- The Government, PCTs, Local Authorities and statutory bodies should ensure that partnerships with the third sector are outcome-focused, funded appropriately to meet service users' identified needs, involve women and children, and are supported, promoted and encouraged locally and nationally.
- Arrangements should be put in place to ensure leadership on this issue across the system – from Ministers and the Department of Health and system leaders, through to Strategic Health Authorities (SHAs), PCTs and NHS Trust boards. Boards should nominate a senior member to ensure that effective services for victims are put in place in line with this report.
- Regulators of health and social care services (in particular the Care Quality Commission (CQC)) should embed the issue of violence against women and children in their work programme, including registration. The CQC should consider undertaking a special review of how well the NHS deals with the issues highlighted in this report after implementation of the initial Government response.
- The Government should ensure that clear processes for clinical governance, supervision and regulation are put in place for Sexual Assault Referral Centres (SARCs), and these should be effectively communicated to those managing and working in SARCs and the National Support Team on the Response to Sexual Violence.
- The Department of Health should work with the relevant regulators and professional bodies to ensure that clinical staff undertaking forensic medical care are:
    - appropriately trained, skilled and experienced;
    - employed by the NHS;
    - integrated into NHS clinical governance;

    - working within a quality standards framework agreed by the Forensic Science Regulator and the Faculty of Forensic and Legal Medicine; and commissioned in sufficient numbers to meet the needs of women and children.
- A national steering group should be established to oversee implementation of this taskforce's recommendations.
- The Government should review the evidence base with a view to identifying and addressing significant gaps in the evidence base.

Appendix 4 Co-ordinated Community Response Model to DV



Appendix 5: Domestic Abuse Profile Sept 2015 West Midlands Police

Walsall Partnership

Domestic Abuse Profile
September 2015

WEST MIDLANDS POLICE

INTRODUCTION

Domestic Abuse is characterised as a pattern of abusive and controlling behaviour which creates compliance in victims through fear and entrapment. It involves repeated, random and habitual use of intimidation, threats and violence to control the victim. It can involve clear and unmistakeable forms of abuse, and the dynamics can also be subtle but equally as powerful. It affects the behaviour of victims, the choices they make and also their capacity to undertake important roles such as parenting children.[3]

The 2013/14 Crime Survey for England and Wales (CSEW) states that overall, 28.3% of women and 14.7% of men had experienced any domestic abuse since the age of 16, equivalent to an estimated 4.6 million female victims and 2.4 million male victims[4].

Domestic Abuse accounts for approximately 9.3 per cent of Total Recorded Crime (TRC) within the Walsall Local Policing Unit (LPU) committed during the period 1st July 2013 and 30th June 2015.

AIM

The aim of this document is to examine Domestic Abuse incidents, crimes and non-crimes on the Walsall LPU to assist with the Domestic Abuse Needs Assessment. It will examine locations, victims and offenders.

DATA SOURCES

The date range for this product is between 01 July 2013 and 30th June 2015. Other date ranges are used when appropriate and are specified within the document. Historical data, where used will be comparable to the date range used above.

This document utilises data from the West Midlands Police system Signals from Noise (SFN) and Discoverer 4i.

LIMITATIONS

- The analysis within this report is dependent upon the accuracy of the data held by force systems and the use of Special Interest Markers and Qualifiers.

[3] Domestic Abuse Strategy 2014-2016: Standing Together against Domestic Abuse (Walsall Council)
[4] Chapter 4: Violent Crime and Sexual Offences – Intimate Personal Violence and Serious Sexual Assault (12/02/2015).

- For over a year, assault data has not been received from the Manor Hospital in relation to individuals attending A&E. It has therefore not been used in this report.

DOMESTIC ABUSE DEFINITION

The Association of Chief Police Officers (ACPO) definition of Domestic Violence is:

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

- Psychological
- Physical
- Sexual
- Financial
- Emotional

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

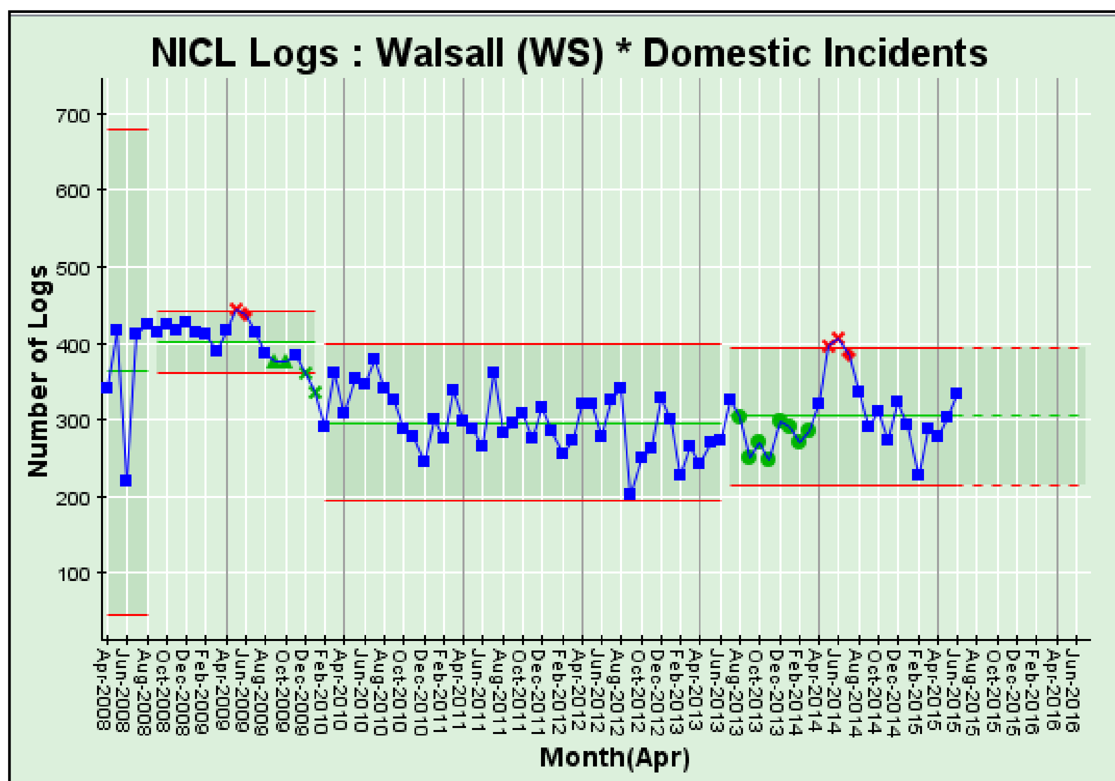
Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim." *

* This definition includes so called 'honour' based violence, Female Genital Mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.[5]

[5] http://intranet2/hq_departments/public_protection/public_protection_archive/domestic_abuse.aspx

LEVELS OF DOMESTIC ABUSE – DOMESTIC INCIDENTS

The below chart shows Domestic Incidents (where police are called but no crime is recorded, such as a verbal argument) from April 2008 are controlled with the exception of peaks above the upper control limits in May 2009 and June 2014.



The table below shows a continual decrease in Domestic Incidents year on year (July – June) from 5,033 offences in 2008/09 until 2012/13 with 3,289. In 2013/14 incidents rose to 3,667, an 11.5 per cent increase compared to the same time the previous year (2012/13). Between July 2014 and June 2015 however, incidents again decreased (3,643 incidents).

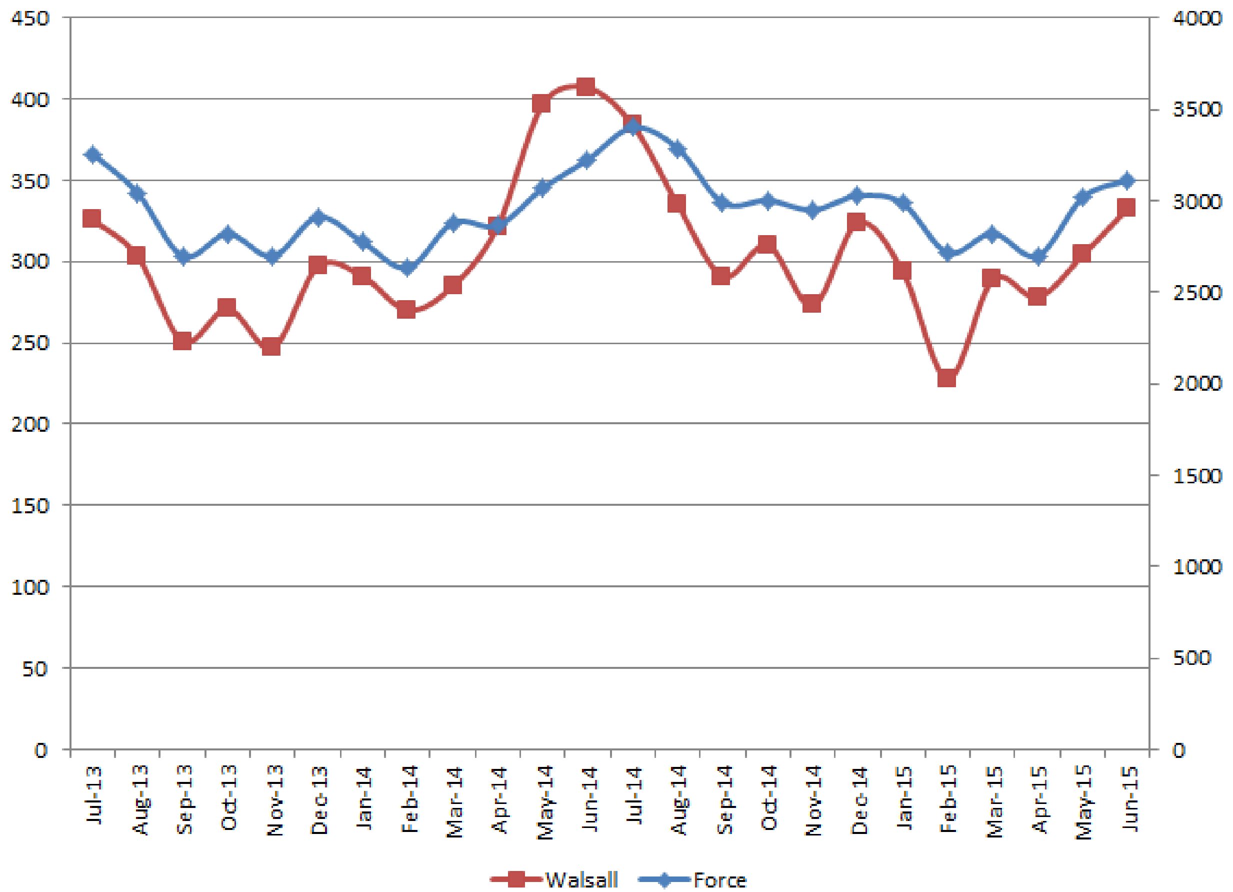
Jul-Jun 2008/09	Jul-Jun 2009/10	Jul-Jun 2010/11	Jul-Jun 2011/12	Jul-Jun 2012/13	Jul-Jun 2013/14	Jul-Jun 2014/15
5033	4290	3621	3575	3289	3667	3643

There were 7,310 Domestic Incidents throughout the Borough during the period 1st July 2013 and 30th June 2015, which is an average of 305 incidents per month. This equates to 5% of the Boroughs total demand for service.

Between July 2014 and June 2015, Domestic Incidents for the whole of the West Midlands Police force has increased by 3.3 per cent compared to the same period the previous year. Over the same period, Walsall had a 0.7 per cent decrease across the Borough.

The below chart shows that Walsall follows a similar trend in terms of monthly incidents as West Midlands Police Force with the exception of Walsall seeing a peak in June 2014 and the Forces peak occurring in the following month of July.

Walsall / Force Domestic Incidents: July 2013 – June 2015



Offence Type

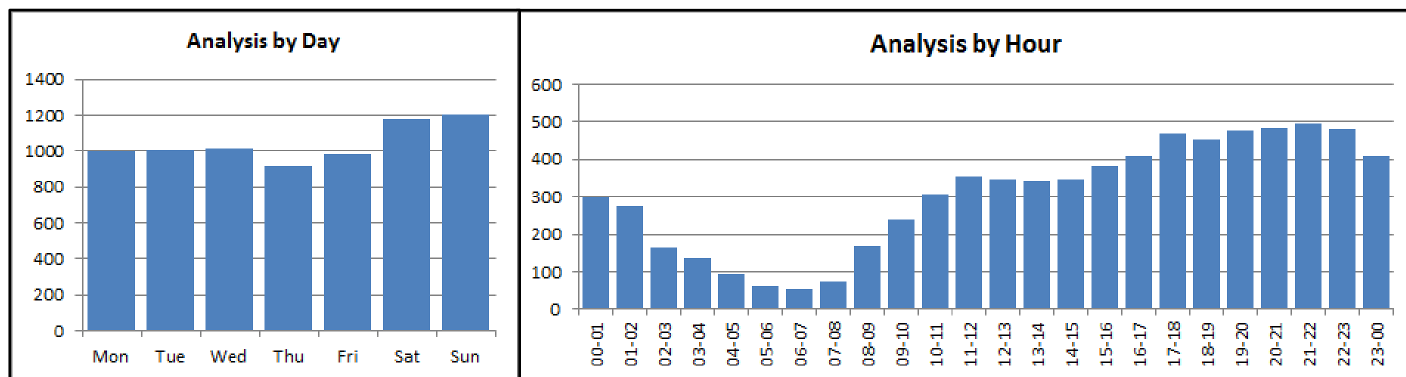
Within the Domestic Incidents data, a qualifier can be entered to provide more insight into the incident. The table below shows the majority of Domestic Incidents (between July 2013 and June 2015) having had 'Domestic Abuse' inputted (55%). This is followed by 'None' (36.6%), which refers to a qualifier not being entered. Excluding 'Domestic Abuse' and 'None', the majority of qualifiers refer to 'Alcohol' (2.2%) however there is also a 'Domestic Abuse/Alcohol' qualifier with 1.8%. 'Youth Related' also accounts for 1.8% of incidents over the 2 year period. Therefore due to data quality, no conclusions can be made and an improvement in quality is needed when logs are closed.

Qualifier	Total	%
Domestic Abuse	4018	55.0
None	2679	36.6
Alcohol	161	2.2
Youth Related	134	1.8
Domestic Abuse¿Alcohol	131	1.8
Vulnerable Child/Young Person	38	0.5
Mental Health	25	0.3
Domestic Abuse¿Mental Health	15	0.2
Drugs	11	0.2
Alcohol¿Domestic Abuse	10	0.1

Peak Days & Times

Overall peak days for incidents are Sundays (16.5%) followed by Saturdays (16.2%). Over the 2 year period, more incidents occurred over the weekend with around 200 more incidents on a Saturday and Sunday compared to a weekday. The peak times for incidents are 2100-2200hrs (6.8%) with 20% of all incidents occurring between 2000-2300hrs.

All calls for service during the same time period show the peak day as Friday (14.9%) followed by a Saturday (14.7%). Peak times for incidents are 1600-1700 hrs (6.3%) with 25% of all incidents occurring between 1500-1900 hrs.



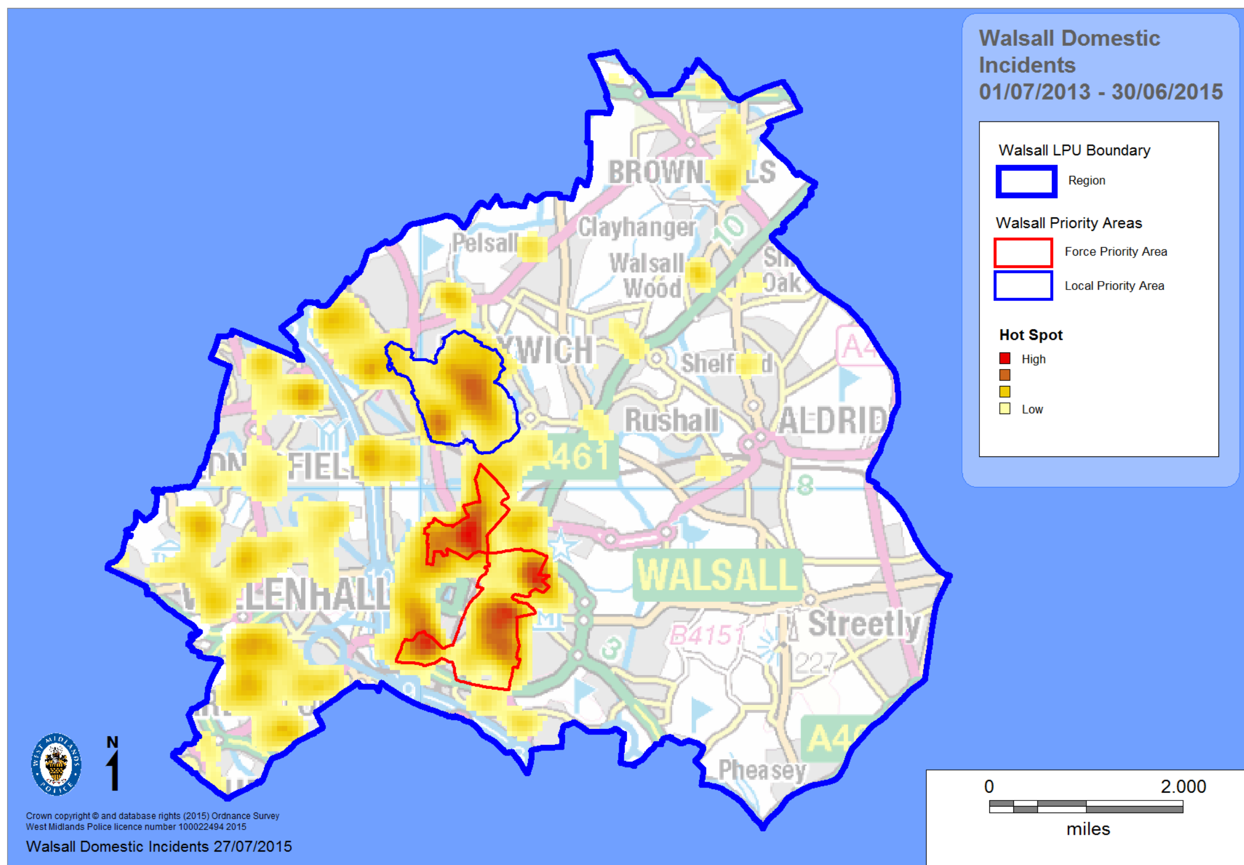
In relation to Domestic Abuse, Sundays alone have a peak time period of 1700-1800hrs. On a Saturday, incidents increase throughout the evening peaking between 2300-0000 hrs which corresponds with the Night Time Economy.

Totals by Day and Hour

	00-01	01-02	02-03	03-04	04-05	05-06	06-07	07-08	08-09	09-10	10-11	11-12	12-13	13-14	14-15	15-16	16-17	17-18	18-19	19-20	20-21	21-22	22-23	23-00	
Mon	45	34	15	13	6	7	6	9	28	34	49	42	44	57	57	63	57	72	57	66	70	66	61	42	Mon
Tue	30	21	19	9	8	3	6	10	19	33	48	59	49	48	54	52	73	60	55	68	66	69	85	60	Tue
Wed	45	33	18	8	12	5	5	12	23	31	44	48	47	46	41	53	52	75	80	79	66	75	66	50	Wed
Thu	31	30	22	13	8	2	4	11	27	37	43	44	46	56	34	57	48	49	50	57	56	76	61	57	Thu
Fri	36	20	13	16	11	6	11	11	28	32	31	50	36	39	50	53	58	66	81	67	77	61	67	64	Fri
Sat	50	65	37	38	14	15	10	13	26	38	53	64	59	36	52	51	57	65	63	66	73	81	67	89	Sat
Sun	60	72	39	41	33	23	14	6	18	36	38	45	65	59	58	51	64	82	65	74	77	68	72	47	Sun

Location

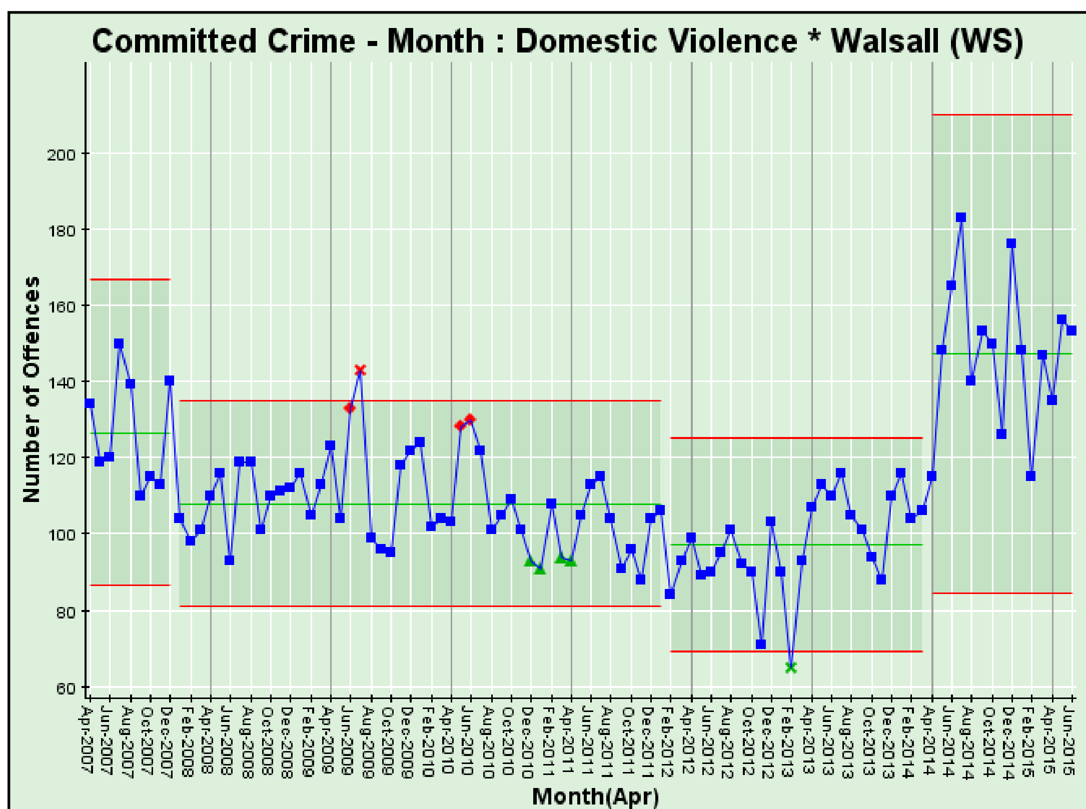
The map below shows the intensity of Domestic Incidents across the Borough. The highest intensity occurred within Birchills, Caldmore, The Chuckery and Pleck. There is also high intensity within the areas of Blakenall Heath and Leamore. All of which fall within the Walsall Priority Areas[6].



[6] The Priority Area (PA) Programme was initiated in response to disproportionate levels of crime and disorder in particular areas of the West Midlands. It was described as 'a huge opportunity to bring multiple agencies together, focussed on small geographical areas with multiple (and high cost) challenges, to implement coordinated and holistic interventions that could deliver substantial savings to all agencies involved.' – Safer Walsall Partnership Strategic Assessment, February 2014.

LEVELS OF DOMESTIC ABUSE – CRIMES

The below chart shows levels of Domestic Abuse continually reduced from April 2007 until April 2014. Committed crimes then increased and peaked in July 2014. Wolverhampton and Dudley also experienced similar increases in the summer of 2014. There are several reasons to suggest why this occurred; firstly the increase compared to previous months was anticipated due to seasonal trends, although not to the extent that was experienced. Work had also been taking place to improve data quality around Domestic Abuse offences and ensure they are accurately recorded, which may account for a proportion of the increase. There was also a general step change up in the monthly recording levels since Operation Sentinel[7] was launched[8].

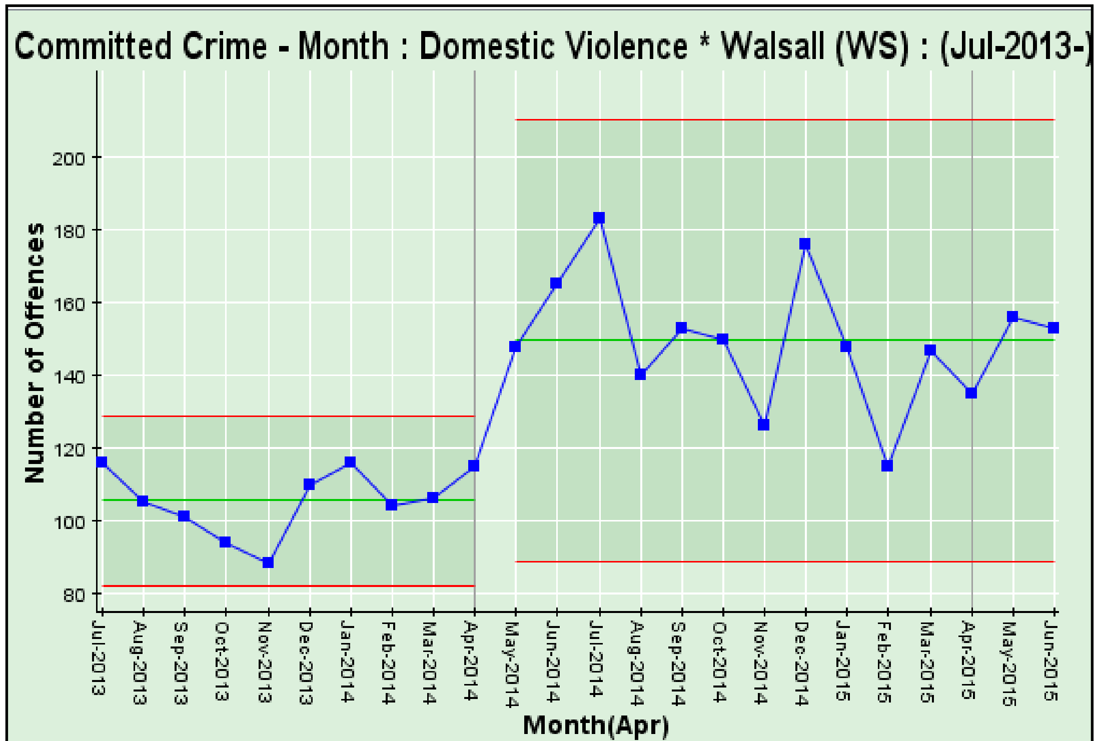


During the two year period (1st July 2013 and 30 June 2015), there were a total of 3,150 crimes committed.

The chart below shows an increase in the average number of offences per month from 105 during the period July 2013 and April 2014 to 149 between May 2014 and June 2015. Incidents peaked with 183 offences in July 2014.

[7] Operation Sentinel – Began in July 2013 and ended on 31st December. It was a long-running initiative aimed at enhancing the service provided by West Midlands Police and its partners to vulnerable victims across the force area. Particular focus applied to domestic abuse, child sexual exploitation, human trafficking, honour-based violence and female genital mutilation.

[8] Safer Walsall Partnership Strategic Assessment – February 2015.



Seasonality

Seasonality[9] shows Domestic Violence as a threat to Walsall Local Policing Unit (LPU) during the months of May to July as well as in December.

Seasonality 2015-16	
	High
	Medium
	Low

Spring			Summer			Autumn			Winter		
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
-6.3%	1.8%	7.9%	9.7%	16.3%	4.0%	-0.1%	-4.4%	-17.2%	5.9%	1.2%	-18.9%

Offence Type

The following table shows the top 15 individual offences which have been committed within the two year period across the Borough;

[9] OSD Seasonality – Based on committed crime data 01.04.11 – 28.02.15

OFFENCE	TOTAL	%
ASSAULT OCCASION ABH	**1255**	**39.8**
COMMON ASSAULT	**444**	**14.1**
HARASSMENT	214	6.8
CRIMINAL DAMAGE TO DWELLING	197	6.3
MALICIOUS WOUNDING	149	4.7
BREACH OF NON-MOLESTATION ORDER	127	4.0
BREACH OF RESTRAINING ORDER	83	2.6
CRIMINAL DAMAGE TO VEHICLE	67	2.1
THEFT DWELLING NOT MACHINE/METER	55	1.7
PUTTING PEOPLE IN FEAR OF VIOLENCE	52	1.7
OTHER CRIMINAL DAMAGE	49	1.6
RAPE OF FEMALE 16 OR OVER	45	1.4
INFLICTING GBH WITHOUT INTENT	42	1.3
BURGLARY DWELLING	40	1.3
THREATEN TO DAMAGE PROPERTY	32	1.0

It can be seen that Assault Occasion ABH and Common Assault (shown in bold) accounts for over 50 per cent (53.9%) of Domestic Violence crimes. Outside of those key offences there are very few offence types which have statistical significance on the overall number of offences. There were however two murders and four attempt murders within the Borough whereby the victim was 1 year old or over.

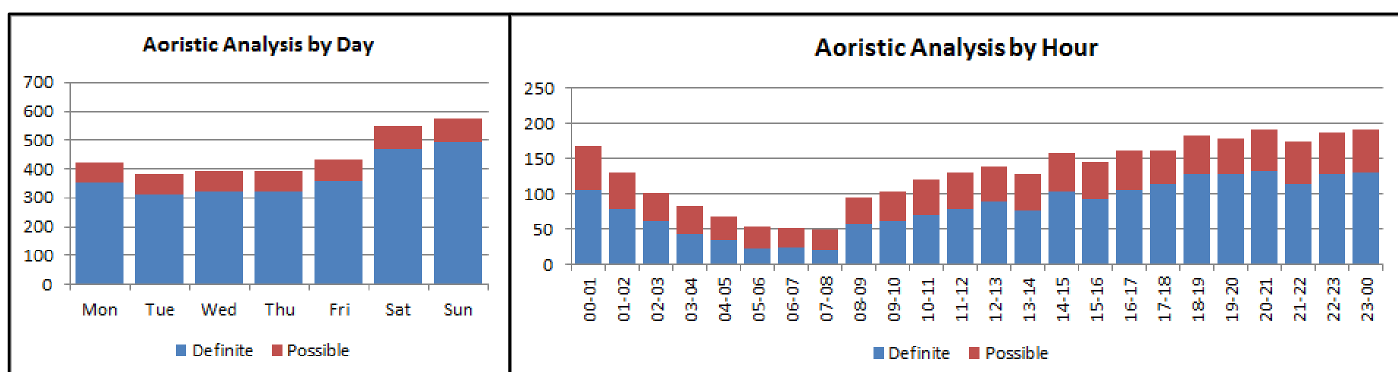
DASH Risk Assessment Tool

The DASH Risk Assessment is a tool that enables the Police to identify, assess and manage the level of risk at domestic abuse incidents. Of the 3,147 crimes I was able to obtain a DV risk for; the majority are classified as 'Medium' and 'Standard', both with 38%. 24% were assessed as 'High.'

DV Risk	Total
High	770
Medium	1190
Standard	1187

Peak Days & Times

Overall peak days for offences are Sundays (18.3%), Saturdays (17.5%) and Fridays (13.7%). The peak times for offences are 2000-2100 and 2300-0000hrs both with 6.1%. 40.3% of all incidents are occurring between 1800 hrs through until 0100 hrs.



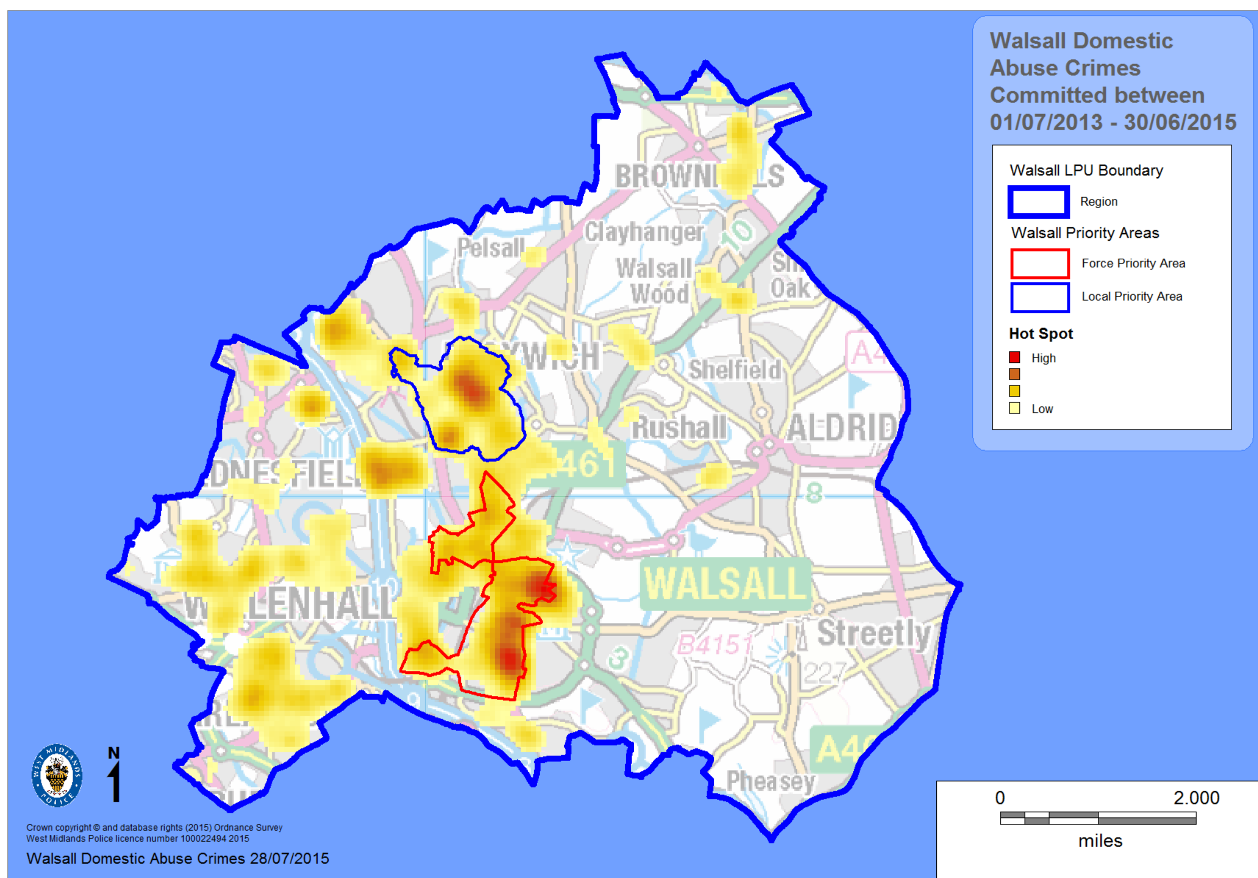
On Fridays and Saturdays, offences increase from 2200 hrs through until the early hours of Saturday and Sunday morning which corresponds with the Night Time Economy.

Aoristic Totals by Day and Hour

	00-01	01-02	02-03	03-04	04-05	05-06	06-07	07-08	08-09	09-10	10-11	11-12	12-13	13-14	14-15	15-16	16-17	17-18	18-19	19-20	20-21	21-22	22-23	23-00	
Mon	18.0	18.9	10.5	7.6	5.8	3.4	5.3	8.3	11.0	11.3	18.8	17.6	22.3	23.8	23.9	23.8	28.0	21.2	29.7	29.3	28.9	18.8	17.1	17.5	Mon
Tue	14.9	11.0	8.3	8.6	4.1	6.7	8.1	6.3	12.4	12.2	16.7	17.2	16.0	13.8	25.9	19.3	23.3	16.2	26.2	21.4	20.5	26.6	24.9	22.3	Tue
Wed	18.7	17.9	13.5	8.0	4.3	5.0	3.8	7.9	13.7	16.5	18.5	17.0	19.8	16.2	19.7	14.4	18.2	22.0	23.4	26.0	25.9	23.5	23.9	16.6	Wed
Thu	20.3	9.5	6.3	8.5	7.5	5.1	3.2	6.4	13.9	14.0	15.7	15.7	15.5	11.1	25.5	17.3	17.0	25.6	25.6	24.7	22.2	28.9	25.9	26.4	Thu
Fri	14.4	14.8	8.7	9.2	11.5	6.8	11.8	8.1	12.4	11.2	11.8	14.2	17.2	24.2	17.6	25.0	22.0	28.0	19.9	25.5	28.8	18.4	31.2	38.7	Fri
Sat	39.6	26.9	23.1	18.9	17.1	15.0	9.9	7.9	14.8	14.4	22.5	25.6	21.8	17.1	16.2	17.7	17.9	25.2	34.1	26.9	27.8	28.2	37.7	46.0	Sat
Sun	41.3	30.8	31.8	22.3	18.2	11.6	9.5	4.8	15.9	24.5	15.2	23.6	26.3	22.0	29.0	28.0	35.3	23.6	22.7	25.6	36.7	29.2	24.9	23.4	Sun

Location

The map below shows the intensity of Domestic Abuse offences across the Borough. The highest intensity occurred within Caldmore and The Chuckery. There is also high intensity within the areas of Blakenall Heath. The majority of crimes therefore fall within the Priority Areas.



The top six locations for offences can be seen in the table below. These six make up 88% of all locations, 78% of those relate to dwellings. Other than dwellings, 'Road' is the next highest location with 6%. The remaining locations not shown in the table did not have statistical significance on the

overall number of offences. Public House – Licensed Premises only accounted for 1% (24 crimes) over the 2 year period.

Location	Total	%
TERRACE - DWELLING	872	28
SEMI DETACHED - DWELLING	814	26
FLAT - DWELLING	645	20
ROAD	190	6
OUTSIDE ADDRESS	140	4
DETACHED - DWELLING	126	4

Victims

Over the two year period, 4.3% of crimes were classed as Regina[10]. The remaining crimes show that overall; there are predominantly more female victims than males (84:15%), with White Skinned European being the highest victim ethnic group (80%); followed by Asian (11%) and African-Caribbean (5%). The majority of victims were aged 23, with the peak age range of victims between 21-30 accounting for 38%. Where an occupation was entered, the majority of victims were shown as unemployed (57%) followed by 9% who were students.

Offenders

The majority of offenders in Walsall (where details are available), are male (91%) with White Skinned European being the highest offender ethnic group (79%), followed by Asian (10%) and African-Caribbean (7%). The majority of victims were aged 24, with the peak age range of victims between 20-29 accounting for 41%. Where an occupation was entered, the majority of victims were unemployed (66%) followed by 8% who were students.

Out of 66 Prolific Priority Offenders (PPOs), 22 have previous for some sort of Domestic Abuse.

Arrests

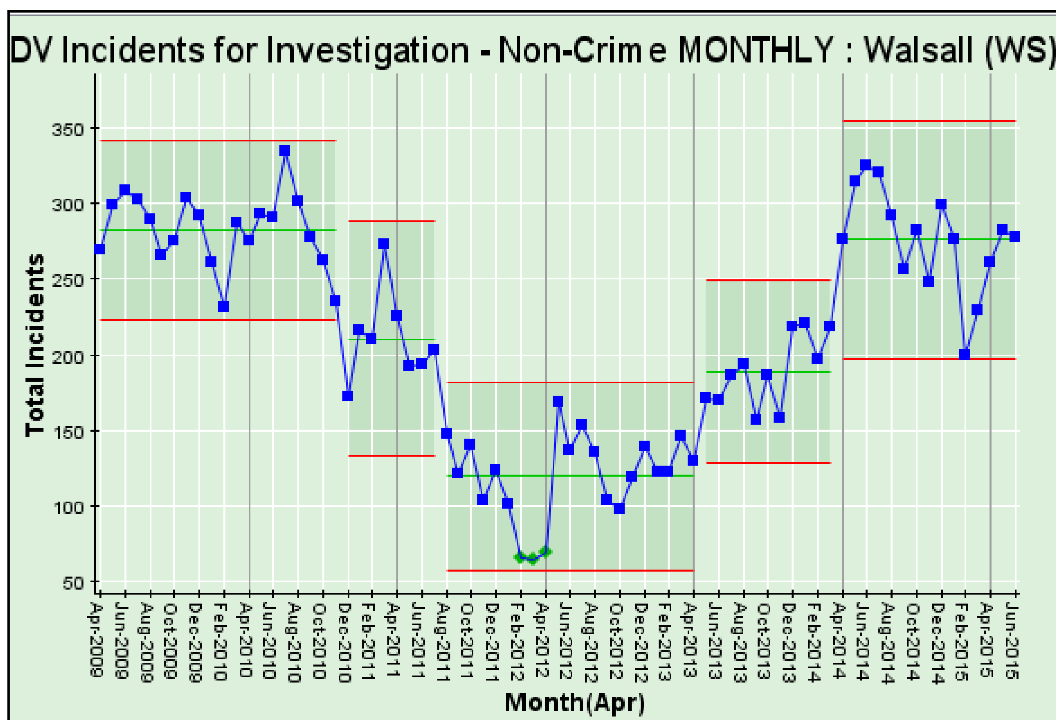
Between July 2013 and June 2015, there were 2,329 arrests for Domestic Abuse whereby the offender was taken to Walsall custody station. The majority of arrests resulted in 'No Further Action' (60 per cent) followed by 32 per cent who were 'Charged'. There were also 7 per cent 'Cautioned'. A small number were also given 'Police Bail' and a 'Postal Charge / Requisition'.

[10] Regina is a term used for offences where there is no victim but an offence is still being committed. The offence is against the crown e.g. public order

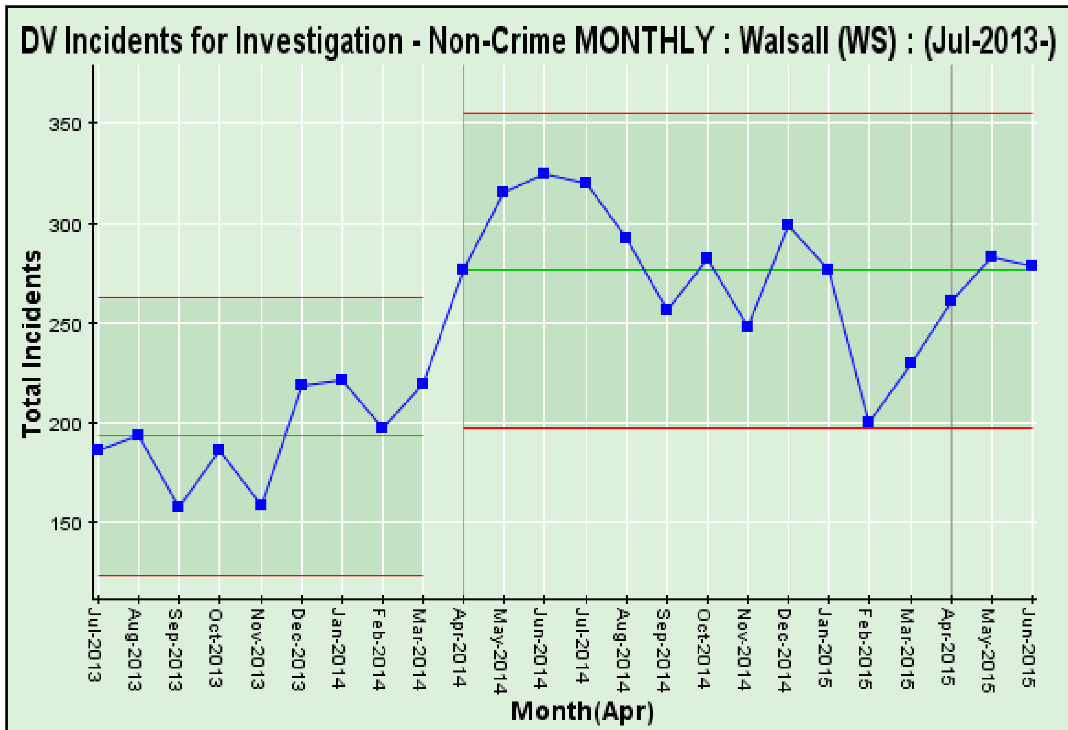
Disposal Code	Total	%
No Further Action	1391	60
Charged	745	32
Cautioned	169	7
Police Bail	23	1
Postal Charge/Requisition	1	0
Grand Total	**2329**	**100.0**

LEVELS OF DOMESTIC ABUSE – NON CRIME

The below chart shows levels of Domestic Abuse Non-Crimes have continually reduced from April 2009 until April 2013. They then continue to increase to similar levels seen in 2009 with a peak of offences occurring in June 2014.

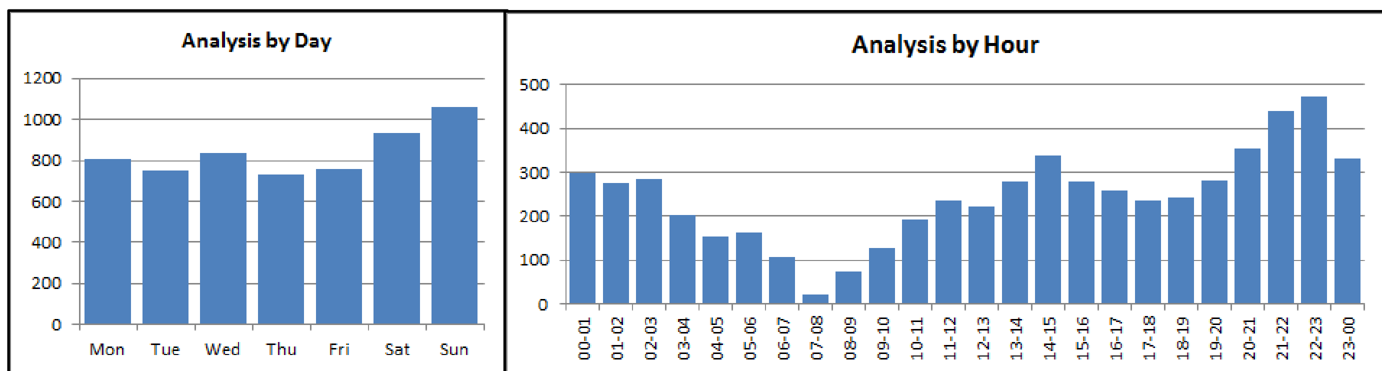


During the two year period (1st July 2013 and 30 June 2015), there were a total of 5,875 non-crimes recorded. The chart below shows an increase in the average number of non-crimes per month from 193 during the period July 2013 and March 2014 to 276 between April 2014 and June 2015. Incidents peaked with 325 offences in June 2014.



Peak Days & Times

Overall peak days for the recording of non-crimes are Sundays (18%) followed by Saturdays (15.9%) and Wednesdays (14.2%). Peak times are 2200-2300 (8%) followed by 2100-2200 (7.5%). There is also an increase in non-crimes recorded between 1400 to 1500 hrs (5.75%), however 41.8% of all non-crimes were recorded between the hours of 2000 and 0300.



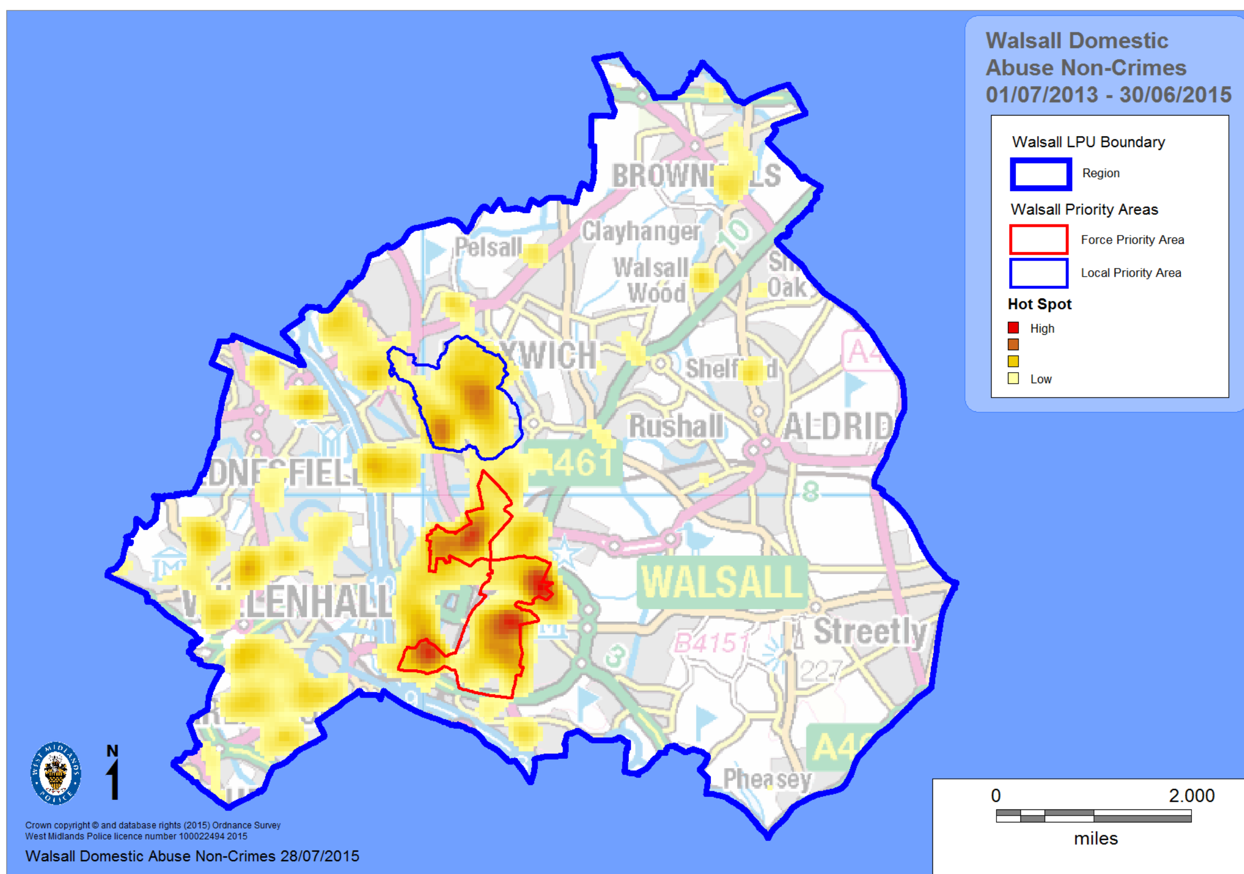
In relation to Sunday alone, peak times are between 2100 and 2200 hrs followed by 0100 and 0200 hrs. Monday to Thursday, the majority of non-crimes were recorded between 2200-2300 hours, however on a Friday and Saturday night recorded non-crimes are at their highest between 2300-0000 hours and remain at a higher level into the early hours of the next day. This corresponds with the Night Time Economy.

Totals by Day and Hour

	00-01	01-02	02-03	03-04	04-05	05-06	06-07	07-08	08-09	09-10	10-11	11-12	12-13	13-14	14-15	15-16	16-17	17-18	18-19	19-20	20-21	21-22	22-23	23-00	
Mon	39	29	39	27	19	18	13	5	9	16	26	26	36	41	51	36	31	36	41	34	43	66	87	41	Mon
Tue	32	35	26	20	23	19	8	2	8	17	26	40	30	44	44	39	21	38	29	35	47	62	64	41	Tue
Wed	39	36	33	31	20	20	10	4	13	18	28	33	27	40	53	35	25	42	33	37	53	76	83	47	Wed
Thu	33	34	36	25	15	11	8	1	16	14	28	26	30	48	57	38	23	23	24	37	38	53	75	38	Thu
Fri	41	26	28	22	15	15	12	3	10	18	27	35	28	32	46	28	57	24	30	47	51	53	47	62	Fri
Sat	61	45	60	33	28	40	20	3	9	21	26	36	30	43	42	40	61	33	37	37	57	52	51	68	Sat
Sun	54	71	64	45	35	42	35	5	10	22	31	41	42	29	45	62	41	40	48	55	65	78	64	35	Sun

Location

The map below shows the intensity of Domestic Abuse Non-Crimes across the Borough. The highest intensity occurred within Birchills, Caldmore, The Chuckery and Pleck. There is also high intensity within the areas of Blakenall Heath and Leamore. The majority of Non Crimes therefore fall within the Priority Areas.



The top six locations for offences can be seen in the table below. These six make up 94% of all locations, 89% of which relate to dwellings. Other than dwellings, 'Road' and 'Outside Address' are the next highest locations both with 2%. The remaining locations not shown in the table did not have statistical significance on the overall number of offences. Public House – Licensed Premises only accounted for 0.24% (14 non-crimes) over the 2 year period.

Location	Total	%
TERRACE - DWELLING	1846	31
SEMI DETACHED - DWELLING	1683	29
FLAT - DWELLING	1445	25
DETACHED - DWELLING	249	4
ROAD	138	2
OUTSIDE ADDRESS	138	2

Victims

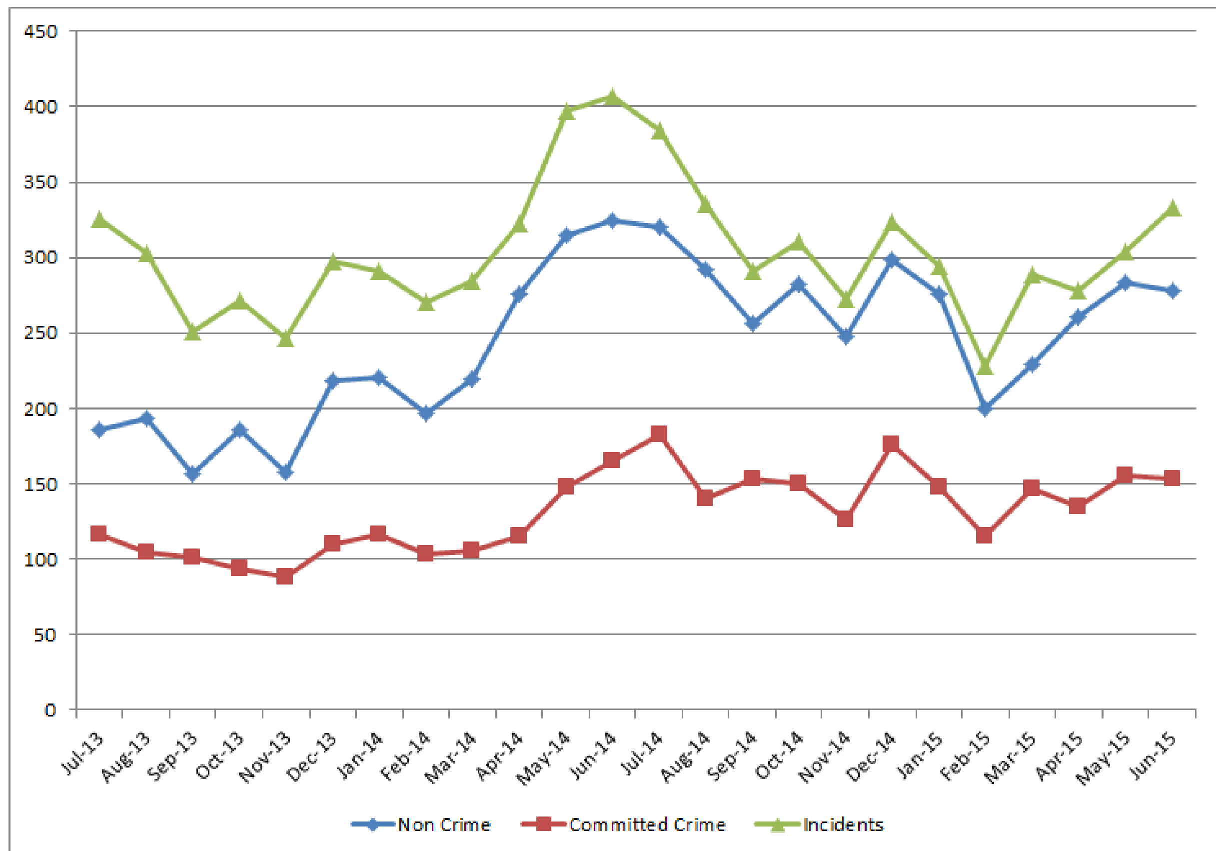
Over the two year period, 0.8% of non-crimes were classed as Regina[11]. The remaining non crimes show that overall; there are predominantly more female victims than males (82:17%), with White Skinned European being the highest victim ethnic group (77%); followed by Asian (13%) and African-Caribbean (5%). The majority of victims were aged 25, with the peak age range of victims between

[11] Regina is a term used for offences where there is no victim but an offence is still being committed. The offence is against the crown e.g. public order

25-34 accounting for 33%. Where an occupation was entered, the majority of victims were unemployed (63%) followed by 7% who were students.

DOMESTIC ABUSE NON-CRIMES, CRIMES AND INCIDENTS

The below chart shows a correlation between Non-Crimes, Committed Crime and Incidents across the 2 year period with a peak in the summer months of 2014 and a further peak in December 2014.



There are a higher number of incidents recorded over the two year period in comparison to non-crimes and committed crimes.

Committed Crime	Non Crime	Incidents
3150	5875	7310

REFERRALS

DART

Unfortunately we were unable to gain insight into the post referral DART returns.

Troubled Families

There have been 62 families who have had Domestic Abuse (DA) data provided through key worker notes ie searching on a system before the screening meetings and providing background information on the Links families system. During Phase 1 of the programme DA was not utilised as a qualifying criteria for eligibility and was noted as a local discretion factor. Moving into the expanded programme DA is a much more prominent factor in the identification of eligible families and regular data provision has been agreed. West Midlands Police will provide a monthly capture of all DA incidents on their system and provide it to the Troubled Families teams of each council to use in the identification of families.

Appendix 6a - Hospital SUS Data - Introduction

Secondary Uses Service (SUS) is a dataset maintained by the Health & Social Care Information Centre (HSCIC) and is a data warehouse containing patient-level information. NHS providers and commissioners use this data for 'secondary uses'; i.e. for purposes other than primary clinical care. SUS provides a range of services and functionality which can be used to analyse, report and present this data. (http://www.hscic.gov.uk/sus)

For the purposes of this analysis, anonymised SUS data is used to provide hospital A&E and inpatient data. Walsall Council Public Health Intelligence receive this SUS data on a quarterly basis from the NHS Midlands and Lancashire Commissioning Support Unit (CSU).

Much of the methodology used to extract SUS data is based on that used in the West Midlands violence analysis done in 2014, which was a collaboration between Public Health England (PHE) and West Midlands Police. *(Violence affecting local residents across the West Midlands Force area)*

Caveats to SUS data
Data is collected quarterly by public health and previous quarterly data are adjusted on occasions. Therefore these data should be considered provisional. When interpreting SUS data, care must be exercised as it possible the data can be refreshed in the most recent financial quarters.

The SUS data held by Walsall Public Health for 2014/15 has only recently been received (August 2015) and will be refreshed in the next quarter as the submitted data will be refreshed.

Appendix 6b - Hospital A&E Data - Data extract methodology

Three complete years of SUS A&E data are available, from 2012-13 to 2014-15 inclusive. Each attendance by a patient to A&E generates an individual record in the database. It is possible for a person to attend A&E several times in a year and in these cases, patients will be counted more than once.

When patients present at A&E, they are categorised into pre-defined groups, one of which is assault (coded as Patient Group = 20). Data is also collected to indicate whether this is the first attendance in a series or a follow up episode. For the purpose of this report, only the first attendance episode is used (coded as [AttendanceCategoryCode] = 1). Data is also collected which records the location of the patient prior to attending A&E (field = [LocationTypeCode and LocationTypeDescription]). One of the categories in this field is “Home”, which is useful to potentially identify those domestic violence cases. Only patient who are resident in Walsall are analysed in this report (using the [PatientResidentPCTOrganisationCode] field)

A summary of the number of SUS A&E data extracted can be seen in the table below.

Year	Total A&E records	Total number of assaults (PatientGroup = 20 i.e. Assault)	Total assaults where Location of Assault was home (LocationTypeCode = 10 i.e. Home)
2012/13	94,188	1181	215
2013/14	111,053	1132	181
2014/15	105,117	986	174

A separate dataset was extracted for each of the 3 years 2012/13, 2013/14 and 2014/15. It was then possible to analyse the following parameters for each of the 3 years:

- Age groups
- Gender
- Ethnicity
- Geography

Because patient data was available at ward level it was possible calculate a rate for each ward, as well as the borough as a whole.

Data accuracy for A&E data
Some notes regarding the accuracy of main fields used during data extract.

Patient Group Code
As one of the main filters to identify assault patients is the Patient Group code [AEPatientGroupCode], this field was analysed to summarise all values for Walsall residents for the 3 individual years. In this analysis, only the first attendance episode in a series is considered ([AttendanceCategoryCode] = 1).

Although only around 1% of attendances are categorised as assaults, over 60% of all attendances in all 3 years have been categorised as "Other than above". More than a quarter of all attendances are coded as "Other accident" which is rather ambiguous. It is possible that these codes may be used as a catch-all, so it is not possible to discover how many of these attendances may have been assaults. It may be possible that the victim gives false information to disguise the true reason for presentation at A&E.

Due to possible inconsistencies in the coding of assaults, this must be a consideration when drawing conclusions from this analysis.

The table below doesn't filter those 'domestic only' cases.

AEPatientGroupCode	AEPatientGroupDescription	2012-13	2013-14	2014-15
	Not coded	1.2%	0.1%	0.0%
10	Road traffic accident	2.4%	2.5%	1.7%
20	Assault	1.4%	1.2%	1.1%
30	Deliberate self-harm	1.4%	1.1%	1.0%
40	Sports injury	1.6%	1.2%	1.6%
50	Firework injury	0.1%	0.0%	0.0%
60	Other accident	30.9%	29.0%	26.8%
70	Brought in dead	0.0%	0.0%	0.0%
80	Other than above	61.1%	65.0%	67.7%

Multiple Presentations

Even though the analysis only considers the first attendance in the series, it is also possible for a patient to present at A&E more than once in a year. The pseudonomised patient identifier [LocalPatientIdentifier] could also be used to check re-presentations (as each patient is given a uniqueidentifier).

Time of attendance at A&E

As part of this analysis it would have been useful to extract the arrival times at A&E, to see if there is a trend over a 24 hour period. This data was available for the 2012/13 dataset but wasn't included in later data. It was decided not to analyse one year of data in isolation as this is not enough data to draw conclusions.

Appendix 6c - Hospital Inpatient Data - Data extract methodology

Data Extract Method

When a patient is admitted to hospital, they are placed under the care of one consultant and diagnosis is given, represented by ICD-10 codes). These ICD codes are used to extract those patients who have been admitted with a domestic abuse related diagnosis. It is possible to code up to 14 diagnosis items, so all 14 are checked when searching for ICD-10 codes.

There are 4 groups of ICD-10 codes which are relevant to domestic abuse and are summarised in this table below, with the column on the right showing the number of admissions in each group over the 3 years between April 2012 and March 2015. The "Neglect and abandonment" and "Other maltreatment" categories have been combined to show a total of 24 admissions (as one of these categories had less than 5 patients)

<table>
<tr><th>Diagnosis Group</th><th>ICD-10 codes</th><th>Total Admissions</th></tr>
<tr><td>Maltreatment syndromes</td><td>T74*</td><td>21</td></tr>
<tr><td>Assault</td><td>Range between X85 and Y09 inclusive</td><td>391</td></tr>
<tr><td>Neglect and abandonment</td><td>Y06*</td><td rowspan="2">24</td></tr>
<tr><td>Other maltreatment</td><td>Y07*</td></tr>
</table>

Total		436

Each individual ICD-10 code belonging to the above groups can be seen in Appendix #
Inpatient episodes were extracted for each of these diagnosis categories, for each of the three years. An indicator was placed on each record to enable summarising by diagnosis group. Once extracted, all data for each year is combined and then only those records for Walsall residents are filtered (PatientResidentPCTOrganisationName = "*Walsall*"). In addition, only the first episode of each hospital spell is counted. A filter is also applied, so only patients who have been admitted from their home are included. The field is called [AdmissionSourceDescription] with the following filters included:

- Local Authority residential accommodation i.e. where care is provided
- Temporary place of residence when usually resident elsewhere
- Usual place of residence unless listed below for example a private dwelling

In summary, with all these filters set, the remaining data includes inpatient admissions where:

- Walsall residents
- First episode in a hospital spell
- Diagnosed with assault
-

Data accuracy
The same principles apply as with the A&E data, in that SUS data should be treated as experimental statistics as they may be updated throughout the year.

It is possible that an individual can be admitted to hospital one or more times during one year. It is possible to use a local pseudonomised identifier to analyse frequency of those being readmitted, but has not been done in this analysis.

Time of admission
It would have been useful to analyse the time of admission, but the admission date and time fields were not populated in the SUS database post 2013/14.

Appendix 6d – Hospital inpatient admissions ICD-10 codes

Inpatient ICD-10 codes for domestic abuse. These codes were used to filter inpatient records related to domestic abuse.

Maltreatment syndromes

ICD-10 Code	Description
T740	Neglect or abandonment
T741	Physical abuse
T742	Sexual abuse
T743	Psychological abuse
T748	Other maltreatment syndromes
T749	Maltreatment syndrome, unspecified

Assault

ICD-10 Code	Description
X85	Assault by drugs, medicaments and biological substances
X86	Assault by corrosive substance
X87	Assault by pesticides
X88	Assault by gases and vapours
X89	Assault by other specified chemicals and noxious substances
X90	Assault by unspecified chemical or noxious substance
X91	Assault by hanging, strangulation and suffocation
X92	Assault by drowning and submersion
X93	Assault by handgun discharge
X94	Assault by rifle, shotgun and larger firearm discharge
X95	Assault by other and unspecified firearm discharge
X96	Assault by explosive material
X97	Assault by smoke, fire and flames
X98	Assault by steam, hot vapours and hot objects
X99	Assault by sharp object
Y00	Assault by blunt object
Y01	Assault by pushing from high place
Y02	Assault by pushing or placing victim before moving object
Y03	Assault by crashing of motor vehicle
Y04	Assault by bodily force
Y05	Sexual assault by bodily force
Y08	Assault by other specified means
Y09	Assault by unspecified means

Neglect and abandonment

ICD-10 Code	Description
Y060	By spouse or partner
Y061	By parent
Y062	By acquaintance or friend
Y068	By other specified persons
Y069	By unspecified person

Other maltreatment

ICD-10 Code	Description
Y070	By spouse or partner
Y071	By parent
Y072	By acquaintance or friend
Y073	By official authorities
Y078	By other specified persons
Y079	By unspecified person

Appendix 7 (for Probation)

Criminogenic Needs[12]

Accommodation: Research has shown a clear link between accommodation and reoffending, with those in unsuitable accommodation more at risk of
reoffending. Regular or sudden changes in accommodation have also been linked to reoffending
Education, Training and Employment (ETE): Both unemployment and employment history have been closely linked to offending, with analysis
showing that offenders are more likely to have a poor or irregular history of employment.
Drug misuse: The link between drug misuse and reoffending has been well documented, and therefore forms a key focus of the OASys assessment; not
only is current drug use explored, but also the frequency of use, and its apparent impact on the offender's life.
Alcohol misuse: The relationship between alcohol misuse and offending has been well established, with research citing a correlation between heavy and
regular alcohol use and reoffending.
Relationships: For male offenders, in particular, there is strong evidence that good relationships reduce reoffending. Supportiveness of families and
histories of offending can also have an impact, both on younger offenders but also adults in later life.
Lifestyle and associates: Research has demonstrated that offenders who spend more time with other offenders and less time with non-offenders are
most likely to offend.
Thinking and behaviour: There is some evidence to suggest that many offenders cope poorly with life because they exhibit various 'cognitive deficits'.
These include a lack of impulse control, poor problem solving, an inability to see other people's views and rigid and inflexible thinking. Behavioural
programmes that look to address these deficits have also been shown to decrease reoffending.
Attitudes: There is a growing body of research evidence suggesting that procriminal
attitudes are predictive of reoffending.

Staffordshire & West Midlands (SWM) Probation Service
Community Rehabilitation Company (CRC) cohort
Domestic Violence Risk Marker

[12] Source Results from the Offender Management Community Cohort Study (OMCCS) Assessment and sentence planning; MOJ 2013

Offender managed cases with a risk marker for Domestic Violence as at 12/08/2015 Source: SWM Case Management System				
Local Delivery Unit	**Community**	**Custody**	**Total**	**% of SWM total**
Birmingham LDU	383	60	443	20.5%
Stoke LDU	330	57	387	17.9%
Staffordshire LDU	274	21	295	13.6%
Sandwell LDU	189	26	215	9.9%
Coventry LDU	180	25	205	9.5%
Wolverhampton LDU	171	18	189	8.7%
Walsall LDU	**142**	**17**	**159**	**7.3%**
Walsall		**1**	**1**	**0.05%**
Dudley LDU	130	20	150	6.9%
Solihull LDU	61	9	70	3.2%
Unpaid Work - West of County	28		28	1.3%
Unpaid Work - Bham & Coventry	10		10	0.5%
Unpaid Work - Staffs & Stoke	13		13	0.6%
Total	**1,911**	**254**	**2,165**	**100%**

As at 12/08/2015, the SWM probation service case management system had a risk marker against 160 CRC offenders in Walsall, representing just under 7.5% of all those with markers across the SWM probation service LDUs. This is below LDU average of 10.8%.

Appendix 8 – Local Domestic Abuse Prevention Pathway

Prevention
• Direct participation activities in the Community that creates awareness of Domestic Abuse and related issues. • Domestic Abuse to be addressed in Nursery, Primary and Secondary school curriculums. • Media campaigns promoting awareness of domestic abuse and providing information about local resources and how to respond to Domestic Abuse situations/settings. • Interventions that develop conflict resolution skills. • Healthy relationships with an emphasis on teenage relationships and dating violence. • Responsive parenting programmes delivered in a wide range of settings. • Domestic Abuse training to be provided to staff working with children, families and young people. • Access to universal service provision /organisations for at risk groups. • Support services for family members identified as being at risk of perpetrating or becoming victims of domestic abuse. • Use of Peer Educators to provide advice and guidance to at risk groups.
Immediate Risk
• Targeted early help and counselling for victims and children. • Crisis support and advocacy via specialist Domestic Abuse and related services. • Community based interventions. • Access and guidance through the legal and welfare systems. • Perpetrator programmes. • Keeping Safe programmes deliver via, health, education and social care initiatives. • Practical support through the police.
Continued Risk
• Specialist Service provision including: Community based Home visits, crisis support, individual counselling and group work. • Community safety via police. • Emotional resilience services for victims and their children to enable them to break from the cycle of abuse. • Involvement of Adult/Children's social care to address safeguarding concerns
High Risk
• Emergency Accommodation • Intensive police, court, juvenile justice and community collaborations to address situations of chronic and dangerous domestic abuse. • Social housing and welfare support. • Therapeutic support to address the underlying trauma for victims and for those children who display emotional and behavioural problems

Appendix 9: Mapping of local services for domestic violence

This work has been carried out by the Children's Commissioning Team at Walsall MBC. It is a work in progress.

Domestic Violence	**Level 1** Prevention **(Universal Services)**	**Level 2** Immediate Risk **(Early Help ~ through a single agency response to identified additional needs)**	**Level 3** Continued Risk **(Early Help Additional Support ~ a co-ordinated multi-agency response to identified additional needs)**	**Level 4** High Risk **(Statutory Intervention of Children's Social Care)**
Adults (without children)	Probation Caldmore HSG TP Aaina National Helplines SAYA / Stepping Stones WHG IAG Supported Housing Access Team Victim Support Police A&E Outreach Worker	**As level 1** Adult Services SAFE Perps PH IDVA	IDVA - WHG x2 IDVA - WDVForum x4 FSW- Victim Support x3 SAFE* Aaina Specialist Services? Safeguarding (Adults) MARAC DARA Statutory Homeless A&E Crisis Point DVPP	Court IDVA - Caldmore x1 IDVA - WHG x2 IDVA - Forum x4 *FSW - Victim Support x3* Aaina Crisis Point DVPP

Domestic Violence

Parents Services

Level 1

Prevention

(Universal Services)

- Probation
- Caldmore HSG
- IYS
- TP
- Aaina
- National Helplines
- SAYA / Stepping Stones
- WHG
- IAG
- Supported Housing
- Access Team
- Childline
- Victim Support
- Early Help
- Children's Services
- Police
- A&E Outreach Worker

Level 2

Immediate Risk

(Early Help ~ through a single agency response to identified additional needs)

- **As level 1**
- Adult Services
- SAFE Perps
- PH IDVA
- CC Family Support Workers

Level 3

Continued Risk

(Early Help Additional Support ~ a co-ordinated multi-agency response to identified additional needs)

- IDVA - WHG x2
IDVA - WDVForum x4
FSW- Victim Support x3
- SAFE*
- Aaina
- Specialist Services?
- Safeguarding (CSC)
- MARAC
- Caldmore
- DARA
- Statutory Homeless
- EOC - DA PP Practitioner
- A&E
- Crisis Point
- DVPP
- CC Family Support Workers

Level 4

High Risk

(Statutory Intervention of Children's Social Care)

- Court IDVA - Caldmore x1
IDVA - WHG x2
IDVA - WDVF x2
FSW- Victim Support x3
- SAFE
- Aaina
- PH
- Safeguarding (CSC)
- IYS?
- Crisis Point
- DVPP
- CC Family Support Workers

Domestic Violence

Child Services

Level 1

Prevention

(Universal Services)

- Probation
- Caldmore HSG
- IYS
- TP
- National Helplines
- IAG
- Supported Housing
- Access Team
- Childline
- Early Help
- Children's Services
- Police
- A&E Outreach Worker

Level 2

Immediate Risk

(Early Help ~ through a single agency response to identified additional needs)

- **As level 1**
- CC Family Support Workers

Level 3

Continued Risk

(Early Help Additional Support ~ a co-ordinated multi-agency response to identified additional needs)

- IDVA - WDVForum x2
FSW- Victim Supportx3
- Specialist Services?
- Safeguarding (CSC)
- MARAC
- Statutory Homeless
- EOC - DA PP Practitioner
- A&E
- CC Family Support Workers
- Crisis Point

Level 4

High Risk

(Statutory Intervention of Children's Social Care)

- IDVA- WDVF/ WHG
FSW- Victim Supportx3
- Caldmore
- Safeguarding (CSC)
- IYS?
- CC Family Support Workers
- Crisis Point

Domestic Abuse				Adults (without children)	Parents	Children	Young people	Professionals
Name	**Address**	**Tel no.**	**Service provided**					
Aaina	Bath Rd, Walsall, West Midlands WS1 3BS	01922 644006	A community based organisation that provides a specialist needs led support service for BME victims of domestic abuse	L1 L2 L3 L4	L1 L2 L3 L4			
A&E Outreach Worker				L1 L2 L3	L1 L2 L3	L1 L2 L3		
Access Team				L1 L2	L1 L2	L1 L2		
Adult Services			This funds the provision of women's accommodation and floating support (for women only). This service provides 24 units of supervised 24hour accommodation and supports 20 women on a floating support basis. Floating Support to provide early intervention and support for victims at risk of domestic abuse. Provision of sessional play work to support children who have witnessed domestic abuse. Funding of a full-time IDVA post to support victims taking court action against perpetrators.	L2	L2			

Adult Social Care (to raise an Adult Safeguarding Concern)		0300 555 2922	Walsall Safeguarding Adults Board (provides support) Adult Social Care Teams who respond to Safeguarding Adults concerns.	L3				
Aven House		01922 721859	A safe refuge for women and children under threat of abuse/violence.					
Caldmore Housing		01922 614505 0300 111 7000	Court IDVA x 1 Provides support to people experiencing or at risk of domestic abuse including a floating support service and the direct access refuge. Floating Support services respond to the immediate needs of women fleeing abuse by providing safe accommodation and support and a 24 hour hep line for support and signposting services. They also help to secure and manage new and existing tenancies for women who are setting up a home free of abuse.	L1 L2 L3 L4	L1 L2 L3 L4	L1 L2 L4		
Crisis Point	Uplands House, 5 Lichfield Road, Walsall, WS4 2HT	01922 722777	Offers psychotherapy, counselling and support to victims and survivors of sexual crime. Independent sexual assaults advocate (ISVA).	L3 L4	L3 L4	L3 L4		
Children’s Services		IRS 01922 658170	<u>Area Family Support Team -</u> Comprises a Specialist Social Worker and Family Support Assistants. Respond to the particular needs	L4	L1 L2	L1 L2		

			of children who have or are experiencing domestic abuse with their families; direct work with individuals to allow them to come to terms with what they have seen and heard. Child Protection referrals are made asap. (Funding: Children's Services)					
DARA	WDVF Sneyd Hall Lane Bloxwich		Domestic Abuse Risk Assessment (DARA) involving intervention and assessment for families where domestic abuse has featured	L3	L3			
DVPP			Domestic Violence Perpetrator Programme. Approved by CAFCASS to deliver service for Birmingham, the Black Country and Solihull. Clients considered for DVPP are usually seeking a Court Order to establish or reinstate contact with their children. Funding: DfE		L3 L4			
Early Help	Children's Social Care, multi agency				L1 L2	L1 L2		
Edge of Care Team	EDC Pelsall Lane Rushall	01922 686200	DA, PP Practitioner One year pilot team 2015/16	L3	L3	L3		
IYS	IYS Blakenhall Village Centre Thames Road WS3 1LZ	01922 714966	Support for young people		L1 L2 L3 L4	L1 L2 L3 L4		
MARAC	Multi Agency Referral		This is a multi-agency forum with a wide membership from across the agencies in Walsall. MARAC assesses high risk notifications of domestic abuse and plans a	L3	L3	L3		

			relevant response to ensure safety for victims of domestic abuse.					
NSPCC Child Protection Helpline	Weston House, 42 Curtain Road, London, EC2A 3NH	0808 800 5000	Information, advice and counselling for anyone concerned about a child at risk of abuse.					
Police			The Public Protection Unit provides a specialist domestic abuse team of officers to assist with investigations, support victims and their families from initial point of contact with the police and providing statements through to the conclusion of court proceedings, offer support to victims in obtaining civil remedies, deal with offenders within the custody environment and take responsibility for ongoing safeguarding strategies. The Public Protection Unit officers also provide specialist investigation, advice and safeguarding for victims of forced marriages or Honour Based Violence.	L1 L2	L1 L2	L1 L2		
Probation	Walsall Probation Complex Midland Road Walsall WS1 3QE	01922 741321	It provides services to offenders and victims of domestic abuse. In addition, the Probation Service delivers the Structured Intervention to Address Domestic Abuse (SIADA) which addresses the behaviour of perpetrators of domestic abuse where an offender is not suitable for IDAP Specialist programmes staff are trained to deliver Building Better Relationships (BBR)	L1 L2	L1 L2	L1 L2		

			to male perpetrators. BBR is a group work programme which is nationally accredited.					
Public Health	IDVA		Funding for an Outreach Worker to support victims of domestic abuse with additional complex needs i.e. mental health, substance misuse or frailty issues. This role also includes liaison with the Hospital A&E to identify victims of domestic abuse and offer early help to avoid escalation or repeat victimisation.	L2 L4	L2 L4			
Rape and Abuse Helpline	P.O.Box 10, Dingwall, IV15 9HA	0808 800 0123			□	□	□	□
Rape and Sexual Violence Project	P.O.Box 9558, Birmigham, B4 7QE	0121 233 3818	Advice for women and men suffering sexual abuse.		□	□	□	□
Rape Crisis (England and Wales)	Rape Crisis (England and Wales), BCM Box 4444, London, WC1N 3XX	0808 802 9999	Counselling, help, support and advice.		□	□	□	□
SAFE (Perp)	Sneyd Hall Road, Dudley Fields, Bloxwich, Walsall, WS3 2NP	01922 406767	Stopping Aggression in the Family Environment. 32 weeks programme for men wanting to stop abusing their partners. Separate support is available for the female partners of attendees. (Funding: Children's Services, Charity Reserves)	L2 L3	L2 L3 L4			
Saya	Sneyd Hall Road, Dudley Fields, Bloxwich, Walsall, WS3 2NP	0800 389 6990	Support, information and advice to women who are experiencing or have experienced domestic violence. 24 hour volunteer helpline for BME communities, Asian language and cultural	L1 L2	L1 L2	□	□	□

			issue support. Funding: Charity Reserves					
Stepping Stones	Helpline	0800 389 5790	24 hour helpline staffed by trained and experienced volunteers providing support and information to people experiencing domestic abuse. Secures refuge accommodation for those needing a place of safety. Funding; Charity Reserves	L1 L2	L1 L2			
Supported Housing (Statutory Homelessness)	Public contact details: Civic Centre Darwall Street Walsall	01922 653405	This funds the Council's in house provision of 88 units of supported accommodation 56 units of external provision the external provision for homeless Walsall Council Housing Dept. and the registered providers in the borough have responsibility to support any person suffering from or being threatened with domestic abuse. The Council aims to enable people experiencing domestic abuse to remain in their home, give them accurate advice and guidance and help them make informed decisions of what they can do next.	L1 L2 L3	L1 L2 L3	L1 L2 L3		
Teenage Pregnancy	Blakenhall Village Centre Thames Road Blakenhall	01922 443940		L1 L2	L1 L2	L1 L2		
The Hideout	www.thehideout.org.uk		A website for children and young people experiencing domestic violence.		?	?	?	?

Think U Know	Child Exploitation and Online Protection Centre, 33 Vauxhall Bridge Road, London, SW1V 2WG	0870 000 3344	Offering internet safety advice for children and young people.		?	?	?	
Victim Support	The Hub Lichfield Road Walsall	01922 644000	3 Volunteer ‘IDVAs’/ support workers	L1 L2	L1 L2			
Walsall Domestic Violence Forum	Walsall Domestic Violence Forum, Sneyd Hall Road, Bloxwich, Walsall, WS3 2NP	01922 406767	Provide a menu of services to address and reduce domestic violence in Walsall. ? Two IDVA’s; one ISVA (Independent Sexual Violence Advisor); one Young Persons IDVA ? Family Support Workers working with children and young people affected by domestic abuse and Outreach Officers	L1 L2 L3 L4	L1 L2 L3 L4	L3	?	?
Walsall Multi Agency Screening Team (Mast)	The Quest, 2nd Floor, 139 - 143 Lichfield Street, Walsall, WS1 1SE	01922 658170	If you are concerned about a child or young person's safety, MAST can offer advice and take referrals.		?	?	?	?
Walsall Safeguarding Children Board	The Hollies, 10 Lichfield Road, Walsall, WS4 2DH	01922 659520	Bringing together organisations who work with children, young people and their families to safeguarding children and young people in Walsall.		L3 L4	L3 L4	?	
Walsall Street Teams	Bradford Street Centre, 51 Bradford Street, Walsall, WS1 3QD	01922 621208	Advice and support for women working in prostitution and 'at risk' young people under the age of 18 years.		?	?	?	?
Walsall Housing Group	2 x IDVA’S		WHG is the largest social housing provider in the Borough. It has an IDVA and an ISVA to support tenants with regard to domestic abuse concerns. In addition security devices with monitored CCTV are available to support victims of domestic abuse to remain in their homes.	L1 L2 L3 L4	L1 L2 L3 L4	L4		

			Fund 2 IDVAs which is part of their core business for WHG tenants						
Women's Aid Helpline		0808 200 0247	Working to end violence against women and children.		⍰				

Glossary of Terms

CSU Commissioning Support Unit
DSR Direct Standardised Rate
ICD-10 International Classification of Disease revision 10. This is the standard diagnostic tool for epidemiology, health management and clinical purposes. Hospital records use ICD codes to diagnose patient conditions. Each condition is allocated an ICD code. These codes were used during inpatient analysis in this document.
LSOA Lower Layer Super Output Area