Ending domestic abuse

Domestic Abuse Act: Draft Statutory Guidance consultation

1. Are you responding as an individual or as an individual on behalf of, or as part of, an organisation?

- An individual
- An individual as part of an organisation
- An individual on behalf of an organisation

2. If you are responding on behalf of or as part of an organisation, what is the type of organisation?

- English local authorities
- Police forces
- Police and Crime Commissioners
- Crown Prosecution Service
- Courts and Tribunal Services
- Prison and Probation services
- Criminal Justice System service
- Children and Family Court Advisory and Support Service (Cafcass)
- Services for forms of violence against women and girls including any specialist domestic abuse services (this will include services serving men and boys)
- Local housing and homelessness teams, registered social landlords
- Early years, childcare, schools, colleges and higher education setting
- Children's social care providers
- Adult social care providers
- NHS England and NHS Improvement
- Clinical Commissioning Groups
- NHS Trusts and NHS Foundation Trusts
- Employers
- Jobcentre
- Financial services (banks, building societies etc)
- Community and faith groups
- Other

3. What is the name of the organisation?

SafeLives

4. From the list below, where are you or your organisation based?

- North East
- North West
- Yorkshire and The Humber
- East Midlands
- West Midlands
- East of England
- London

- South East
- South West
- Wales
- National

5. Do you have any comments on Chapter 1 ('Objectives') in terms of content or clarity?

N/A

6. Do you have any comments on Chapter 2 ('Understanding Domestic Abuse') in terms of content or clarity?

In the section on teenage relationship abuse, we are concerned at the use of the term 'perpetrator' for children under the age of 16. **Instead, we recommend language around "young people causing harm" or "young people who harm."** Wherever possible, young people causing harm should not be criminalised and should, instead, be offered specialist interventions tailored towards young people.

'Alienating behaviours' and 'parental alienation'

We are deeply concerned by the inclusion of 'alienating behaviours' in Paragraph 57 as an example of coercive control. We urge that this be removed from the guidance.

Coercive control legislation already recognises patterns of behaviour such as those described as 'alienating behaviours' in footnote 26: for example, the legislation includes 'isolating a person from their friends and family.' Coercive control involves unequal power relations where the perpetrator harms, punishes or frightens their victim and, to meet the threshold of coercive control, such behaviours must be intentional, repeated and part of a sustained pattern of behaviour.

As one of SafeLives' Pioneer survivors explained on the basis of her own experience of the family courts, parental alienation "will be weaponized by abusers to silence legitimate safeguarding concerns of [adult] victims and children." She told us that following her eldest child experiencing child sexual abuse (CSA) perpetrated by a friend of their father's during a contact visit, neither child was allowed contact with their father. However, on the basis of the eldest child's right to privacy and a requirement for legal anonymity, this Pioneer was unable to tell her youngest child the reasons behind the lack of contact. The Pioneer was so frightened of the concept of parental alienation (PA) being used against her that she asked her social worker to practice the conversation she planned to have with her youngest child, beforehand, and to be present for the conversation so there was a witness to the content of the conversation should the father allege PA.

In addition, the child sexual abuse (CSA) case was dropped before it reached court due to the case resting on the account of a child under the age of ten who was experiencing trauma. As such, the Pioneer was, and continues to be, afraid that she will be accused of PA due to the allegation of CSA not being legally found to be based in fact.

- **Poor evidence base**

  Ideas, concepts and theories around 'parental alienation' or 'alienating behaviours' have developed over several decades and are used to describe parents (usually mothers) who are judged to be blocking contact between their child and the other parent, or coaching a child to believe they have been abused by the other parent, without prioritising their best interests. However, the concept of parental alienation has been heavily criticised for its weak evidence base, harmful assumptions and negative impact.

  In contrast, coercive and controlling behaviour is much better understood, with a much

more developed evidence base.

- **No clear definition**
  A review of research and case law in England and Wales, commissioned by Cafcass Cymru, notes that there is no commonly accepted definition of PA and insufficient scientific evidence on its existence. It notes "the label parental alienation syndrome (PAS) has been likened to a 'nuclear weapon' that can be exploited within the adversarial legal system in the battle for child residence."[1]

- **Impact on safeguarding**
  Evidence gathered by the Ministry of Justice expert harm panel found that fears of false allegations of 'PA' are silencing abuse victims from disclosing the abuse they have suffered.[2] This echoes a growing evidence base from the UK, US, Canada and several other countries to show that a significant proportion of 'alienation' claims are made by perpetrators of domestic abuse to rebut allegations of domestic abuse. Statistically, where an abusive father alleges alienation, the mother is highly likely to lose residence of her children.[3] Findings from Women's Aid's Child First research, conducted in 2018 in partnership with Queen Mary University London, highlighted the experiences of women who had raised valid safety concerns about their children having contact with perpetrators of domestic abuse, and in return had been accused of parental alienation.[4] Over a third of the women taking part in the focus groups and interviews had had their child or children removed to the perpetrator as a result of parental alienation allegations. In the most extreme cases in the sample, women were prevented from seeing their children for almost a decade.[5]

- **Ignoring children's voices**
  Focusing on PA or 'alienating behaviours' detracts attention away from children's best interests. A number of the examples of what are described in the guidance as 'alienating behaviours' could have the impact of silencing legitimate concerns raised by children. Proponents of the term 'alienating behaviours' pre-suppose that children cannot be trusted to describe their own experiences, as any opposition to a parent is a product of 'alienation' rather than a valid response to abuse. This runs entirely contrary to the purpose of the family courts (where these terms are most frequently used), and to the Domestic Abuse Act which now recognises children as victims in their own right. It also runs contrary to one of the key pillars of the Ministry of Justice's private law

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[1] Doughty, J., Maxwell, N. and Slater, T. (2018) Review of research and case law on parental alienation, Cafcass Cymru, p. 5

[2] Hunter, R. Burton, M. and Trinder, L. (2020). Assessing risk of harm to children and parents in private law children cases: Final report. London: Ministry of Justice

[3] For example: Barnett, A. (2020a) 'A Geneology of Hostility: Parental alienation in England and Wales' in Journal of Social Welfare and Family Law 42 (1) pp. 18-29; Birchall, J. and Choudhry, S. (2021, forthcoming) '"I was punished for telling the truth": How allegations of parental alienation are used to silence, sideline and disempower survivors of domestic abuse in family law proceedings' in Journal of Gender Based Violence; Meier, J. (2020) 'US child custody outcomes in cases involving parental alienation and abuse allegations: What do the data show?' in Journal of Social Welfare and Family Law 42 (1) pp. 92-105; Neilson, L. (2018) Parental alienation empirical analysis: Child best interests or parental rights? Muriel McQueen Fergusson Centre for Family Violence Research and The FREDA Centre for Research on Violence Against Women and Children.

[4] Birchall, J. and Choudhry, S. (2018) What about my right not to be abused? Domestic abuse, human rights and the family courts. Bristol: Women's Aid.

[5] Birchall, J. and Choudhry, S. (2021, forthcoming). "I was punished for telling the truth": How allegations of parental alienation are used to silence, sideline and disempower survivors of domestic abuse in family law proceedings, Journal of Gender Based Violence

reform programme, namely: “Enhancing the voice of the child at all stages.”[6]

- **Harmful stereotypes**
  As well as silencing abuse adult victims and child victims, focusing on PA or ‘alienating behaviours’ also helps to prop up harmful stereotypes and attitudes around mothers, fathers and domestic abuse survivors. Mothers who are domestic abuse survivors are positioned as overprotective or vengeful, deliberately obstructing contact between father and child, and fathers are seen as ‘‘wronged”. Ideas that mothers who have experienced domestic abuse should “put this experience behind them,” and focus instead on the importance of their children having contact with both parents, entirely misunderstands the dynamics of domestic abuse and its harmful impact on children.[7] The Domestic Abuse Act and statutory guidance should be helping to break down harmful stereotypes and ideas, rather than strengthening them.

Adrienne Barnett’s recently published analysis of case law argues that ‘raising PA dominates cases to the exclusion of all else. The complex and complicated lives, emotions and circumstances of the mothers, fathers and children who come before the family courts are reduced to stark binaries of good and bad, deserving and undeserving, excluding many other ways of explaining parents’ and children’s views and behaviour.”[8]

The Pioneer survivor told us: “parental alienation campaigns suggest we should not trust our children's voices, it completely goes against what the Harm Report showed.”

It is clear that concepts around alienating behaviours and PA, no matter how they are packaged or theorised, cannot be accepted without recognition of the ways they are loaded with harmful gendered ideas about mothers, fathers, and domestic abuse survivors. Such theories should not be accepted without analysis of the impact they have on survivors of domestic abuse and their children.

By including this term, the government is legitimising a disputed term with no legal or medical basis, which carries significant risks for domestic abuse survivors. The inclusion of the term within a definition of coercive control, without any evidence base to support it, is highly problematic and risks undermining the aims of the Domestic Abuse Act itself. We strongly recommend it is removed.

Migrant survivors of domestic abuse

With regards to Paragraph 121, we echo the concerns of the Domestic Abuse Commissioner, Anti-Slavery Commissioner and Victims’ Commissioner with regards to representing the National Referral Mechanism as a route to support for migrant survivors of domestic abuse: “we fully appreciate the challenges in safeguarding vulnerable migrants with NRPF, however urge the Government not to use the already fragile NRM as a means to address this gap in

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[6] Private Law Advisory Group (December 2020), Final report, 5.

[7] Barnett, A. (2014) ‘Contact at all costs? Domestic violence and children’s welfare’ in Child and Family Law Quarterly 6 (4) p.439; Birchall, J. and Choudhry, S. (2018) What about my right not to be abused? Domestic abuse, human rights and the family courts. Bristol: Women’s Aid; Coy, M., Perks, K., Scott, E. and Tweedale, R. (2012) Picking up the pieces: domestic violence and child contact, London: Rights of Women and London Metropolitan University; Thiara, R. and Harrison, C. (2016) Better safe than sorry: Supporting the campaign for safer child contact, Bristol: Women’s Aid.

[8] Barnett, A. (2020) ‘A Geneology of Hostility: Parental alienation in England and Wales’ in Journal of Social Welfare and Family Law 42 (1) p. 26

provision."[9] We recognise that a number of migrant victims of domestic abuse will also be victims of modern slavery and human trafficking but, in such cases, frontline services will give careful consideration on a case-by-case basis to whether the NRM is an appropriate response to the survivor's needs. **We recommend that the reference to NRM be removed from this guidance.**

On Paragraph 124, we recommend that the Domestic Violence Rule and the DDVC be extended to all migrant survivors, regardless of their immigration history, so that no migrant survivor is prevented from accessing the support and services they need due to NRPF conditions.

Paragraph 125 should include a reference to the HMICFRS' report on the super-complaint brought by Southall Black Sisters and Liberty, which recommended that Police forces restrict the sharing of information about vulnerable victims of crime, including domestic abuse, with immigration enforcement agencies.[10] The independent investigation concluded that data-sharing with the Home Office does not safeguard victims of domestic abuse but, instead, causes further harm to individuals and to the public interest, as crimes go unreported and perpetrators unidentified and unchallenged. We note that we have also published guidance for Maracs around this issue, see our response in Q9.

7. Do you have any comments on Chapter 3 ('Impact on Victims') in terms of content or clarity?

SafeLives welcomes the inclusion of a chapter on the impact of domestic abuse on both adult and child victims of domestic abuse. **We urge the guidance, however, to consistently refer to victims as 'adult victims' and 'child victims', as seen in Paragraph 173, and avoid referring to '*the* victim' when discussing adult victims of domestic abuse (as seen in the title of the first section**). This would better represent the welcome change in legislation to recognise children as victims, and not solely witnesses.
Paragraph 173 would benefit from the inclusion of the wider health impacts of domestic abuse. As we highlighted in our 2019 report, *Psychological Violence*, many studies have shown that psychological violence is associated with poorer physical health.[11]

A nationwide German survey with 10,264 women showed that among those aged 16-65, psychological Intimate Partner Violence was strongly associated with allergies; problems maintaining weight; gastrointestinal syndromes (e.g. nausea, and eating disorders); psychosomatic symptoms (e.g., numbness and thrombosis, shaking and nervous twitching, cramps and paralysis, heart and circulation illness, dizziness, low blood pressure, breathlessness, and chronic throat problems); and pelvic problems (e.g., abdominal pain, pain or infections in intimate areas, menstrual cramps, and heavy, weak, or irregular menstruation). All are known symptoms of psychological stress. Women aged 65+ also experienced gastrointestinal syndromes and problems maintaining weight. Controlling behaviour,

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[9] Independent Anti-Slavery Commissioner, Victims Commissioner and Domestic Abuse Commissioner (2020). Letter to Victoria Atkins MP. Available at: https://www.antislaverycommissioner.co.uk/media/1432/iasc-letter-to-victoria-atkins-mp-june-2020.pdf

[10] HMCIFRS (2020), 'Safe to share? Report on Liberty and Southall Black Sisters' super-complaint on policing and immigration status.' Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/945314/safe-to-share-liberty-southall-black-sisters-super-complaint-policing-immigration-status.pdf

[11] SafeLives (2019), Psychological Violence. Available at: https://www.safelivesresearch.org.uk/Comms/Psychological%20Violence%20-%20Full%20Report.pdf

measured separately from psychological violence, was moreover associated with weight problems among women aged 16-65 and allergies among women aged 50-65.[12] In a Slovenian study of 470 men and women, psychological IPV victims were more likely to suffer muscle inflammations; and gynaecological disorders and inflammations.[13]

Studies conducted in the USA have similarly shown that psychological violence is associated with a range of physical health conditions, including: hypertension; chronic prostatitis and chronic pelvic pain syndrome; urinary frequency and urgency; type 2 diabetes; disability preventing work; arthritis; migraine and other frequent headaches; stammering; sexually transmitted infections; irritable bowel syndrome; and stomach ulcers.[14,15,16,17,18]

Moreover, *Domestic abuse and suicide* (2018) found that almost a quarter (24 per cent) of Refuge's clients had felt suicidal and 83 per cent of clients had felt despair or hopeless, which are key determinants for suicidality.[19]

Also in Paragraph 173, we recommend that 'present as' be changed to 'be perceived as' when discussing the impact of trauma on victims of domestic abuse.

In addition, a case study at this point detailing trauma-informed working with an adult victim who is perceived as 'difficult to engage' would help to make the effects of trauma and long-term mental illness more tangible and accessible to those seeking to support survivors.

In Paragraph 179, we recommend greater detail on the impact of economic and financial abuse. For example, experiencing economic abuse may mean a survivor of domestic abuse cannot access legal aid, due to having assets in their name to which they have no access. Surviving Economic Abuse's 2018 report, '*Economic abuse is your past, present and future'*, highlighted one victim's experience: "one woman described how she was taken to court by the bank. She was assessed as above the Legal Aid threshold but had no money and so had to represent herself which was a stressful and frightening process."[20]

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[12] Stöckl, H., & Penhale, B. (2015). Intimate partner violence and its association with physical and mental health symptoms among older women in Germany. Journal of interpersonal violence, 30(17), 3089-3111.
[13] Selic, P., Svab, I., & Gucek, N. K. (2014). A cross-sectional study identifying the pattern of factors related to psychological intimate partner violence exposure in Slovenian family practice attendees: what hurt them the most. BMC public health, 14(1), 223.
[14] Mason, S., Wright, R., Hibert, E., D, S., Forman, J., & Rich-Edwards, J. (2012). Intimate partner violence and incidence of hypertension in women. Annals of Epidemiology, 22(8), 562–567. http://doi.org/10.1016/j.annepidem.2012.05.003
[15] Coker, A. L., Smith, P. H., Bethea, L., King, M. R., & McKeown, R. E. (2000). Physical health consequences of physical and psychological intimate partner violence. Archives of family medicine, 9(5), 451.
[16] Link, C. L., Lutfey, K. E., Steers, W. D., & McKinlay, J. B. (2007). Is Abuse Causally Related to Urologic Symptoms? Results from the Boston Area Community Heath (BACH) Survey. European Urology, 52(2), 397–406. http://doi.org/10.1016,j. eururo.2007.03.024
[17] Mason, S., Wright, R., Hibert, E., D, S., Forman, J., & Rich-Edwards, J. (2012). Intimate partner violence and incidence of hypertension in women. Annals of Epidemiology, 22(8), 562–567. http://doi.org/10.1016/j.annepidem.2012.05.003
[18] Coker, A. L., Smith, P. H., Bethea, L., King, M. R., & McKeown, R. E. (2000). Physical health consequences of physical and psychological intimate partner violence. Archives of family medicine, 9(5), 451.
[19] Aitken, R., Munro, V.E. (2018), *Domestic abuse and suicide.* Available at: https://www.refuge.org.uk/wp-content/uploads/2020/08/NEW-Suicide-Report-HIGH.pdf
[20] Surviving Economic Abuse (2018), 'Economic abuse is your past, present and future'. Available at: https://survivingeconomicabuse.org/wp-content/uploads/2020/11/SEA-Roundtable-Report-2018-1.pdf

Furthermore, the effects of experiencing domestic abuse can include an inability to access relevant welfare benefits and Universal Credit. This is noted in Paragraph 78 in defining economic abuse, but should be stated here as well, as a key example of the long-lasting effects of domestic abuse. The impact of the trauma of domestic abuse can prevent survivors from working, but the process of applying for welfare benefits is not trauma informed.

A victim of economic abuse may be unable to move home to increase their safety due to arrears stemming from the abuse, and they may be subject to use of the legal system and of official processes as methods of ongoing perpetration, for example through vexatious claims in court. A family which has experienced economic abuse may not meet official definitions of ‘poverty’ and yet may lack access to food and basic necessities due to the actions of the perpetrator.

On Paragraph 183, it is important to note that children who are not in the household at the point of an incidence of physical abuse – and therefore do not see or hear what has happened – will still be impacted. They may see resulting injuries on the non-abusive parent, see resulting property damage, live in an environment of fear and coercion, and/or lack essentials due to economic abuse.

Domestic abuse also affects the relationship between child and the non-abusive parent who may find their confidence in their ability to parent undermined by the perpetrator. Perpetrators can seek to turn the children against the non-abusive parent or involve them directly in the coercive and controlling activities, for example, getting them to monitor the non-abusive parent’s behaviour and movements, and report back. Adult victims will often attempt to protect children from the worst of the abuse. This may be through acting to stop physical violence perpetrated against the children by the abusive parent. It can also be through a continual process of attempting to create a violence-free, more stable, or more ‘normal’ environment for the children, by trying to placate the perpetrator and mitigate the escalation phase of the often cyclical pattern of abuse, for a period of time.

Boundaries between the non-abusive parent and their children may become blurred, where one parent criticises the other to the child, or leans on a child for emotional or practical support. This may be overwhelming for a child, leading to anxiety and depression. Alternatively, it may evoke feelings of resentment towards a non-abusive parent who expects the child to play a role in supporting them. This, too, may lead to child exhibiting aggressive behaviour. In addition, the child may feel an overwhelming need to act as a protector of the non-abusive parent, which can heighten their anxiety.

Therefore, it should be noted that all children living in a household with domestic abuse will be impacted by it, whether or not they are present or witnesses to incidences of physical assault.

In Paragraph 185, it should be made clear that, while important to take note of when creating a bespoke support plan for each individual child victim, the type and frequency of abuse experienced will affect each child differently, and should not be used to uphold, however unintentionally, a hierarchy of abuse. Across statutory agencies, the legal system, and wider societal attitudes, we often see physical violence placed at the top of the ladder, with all other forms of abuse beneath. This means non-physical forms of abuse remain less well understood, recognised and responded to. We urge that the guidance ensures that no such hierarchical understanding of abuse could be interpreted through the recommendation around taking into account the type and frequency of the abuse.

We welcome Paragraph 190, focussing on children with special educational needs and disabilities (SEND), but feel Chapter 3 would be strengthened with the addition of a paragraph concentrating on *adult* victims with SEND. As detailed above in response to

Question 6, the omission of detail around adult survivors with learning disabilities must be rectified to make sure this Statutory Guidance improves the experiences of all victims of domestic abuse.

When highlighting the impact of "growing up in a household of fear and intimidation" (Paragraph 191), it should be made clear that this is a parenting choice made by the perpetrator to create such an environment in which the children are raised. Parent survivors tell us frequently that, in dealing with statutory agencies, they were made to feel that they were responsible for not mitigating the impact of domestic abuse on their children despite the fact that only the perpetrator can choose to stop perpetrating domestic abuse and instead choose to safeguard the children in the household.

In Paragraph 194, we welcome the recognition that those under the age of 16 can experience domestic abuse or use harmful behaviours in their own intimate relationships but we strongly recommend that the use of "damaging" is changed to "impactful". "Damaging" is a pejorative term which can suggest that those who have experienced teenage relationship abuse are, themselves, 'damaged.' Furthermore, "damaging" does not reflect how many survivors understand and speak about their own experiences.

The section on the impact of abuse on child victims focusses on supporting these victims while they are children. We recommend additional content recognising that child victims of domestic abuse will take their experiences and the effects of them, including their symptoms of trauma, into adolescence and adulthood, once services such as specialist children's workers and school-based therapeutic support are no longer available to them. Adult survivors of domestic abuse experienced in childhood must not reach a cliff-edge of support at age 18 and this should be reflected in the guidance.

This links to a persistent problem in state responses, including at the Local Authority level and in national policy, where children and young people start to fall through gaps and access to services becomes very mixed and unsatisfactory once they reach the age of 16. At the moment, SafeLives Pioneers are campaigning for a review of semi-independent accommodation so as not to create such a cliff edge of care for children when they turn 16. Replacing 'care' with 'support' services for young people at this critical age can significantly increase vulnerability as highlighted by our Spotlight on young people experiencing domestic abuse.[21]

We recommend that the Home Office includes references to the particular experiences of and risks to step-children in the household – either when the perpetrator is not the biological or adopted parent, or the adult victim is not.

We welcome the recognition of the long-term effects of experiencing domestic abuse. **Alongside this, we recommend commissioners must consider funding for open-ended recovery services, beyond the six therapy sessions available on the NHS for most**. Frontline specialist domestic abuse services, especially those by-and-for marginalised groups, tell us frequently of taking on the work of statutory agencies to provide longer-term support for victims and survivors without the necessary funding to continue doing so.

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[21] SafeLives (2017). Safe Young Lives: Young People and Domestic Abuse. Available at: https://safelives.org.uk/sites/default/files/resources/Safe%20Young%20Lives%20web.pdf

8. Do you have any comments on Chapter 4 ('Agency Response to Domestic Abuse') in terms of content or clarity?

With regards to Paragraphs 206 and 207, we recommend that further guidance is added regarding professional judgement, which can be used to increase the level of risk identified but should not be used to downgrade risk.

Moreover, guidance on 'Clare's Law', the Domestic Violence Disclosure Scheme, should be added at this point. Any agency using the DASH with a survivor should be able to explain their 'right to ask' and help the survivor complete an application.

The guidance should also highlight that the agency should signpost victims of domestic abuse to appropriate support services, including national helplines and local specialist services, including those run by-and-for marginalised groups such as Deaf and disabled, Black, Asian and racially minoritised, and/or LGBT+ survivors. Though the guidance does reference the potential for there to be multiple, colluding perpetrators in one part of the guidance (specifically related to so-called 'Honour'-Based Violence), this would helpfully be mentioned in different places throughout the guidance in order to remind readers that in many different domestic abuse situations there is more than one active or colluding perpetrator of abuse.

Schools and colleges

We recommend that Paragraphs 213 and 214 be strengthened to ensure that staff in schools and colleges have the requisite training to effectively identify domestic abuse and respond appropriately to disclosures, either from those experiencing domestic abuse in their households or in their intimate relationships, or from those using harm in their own relationships.

Domestic abuse should be talked about in a way that children and young people understand. Alongside On Our Radar and Comic Relief, we undertook a project in which we aimed to better understand how young people aged 13 to 18 in the UK considered, discussed and responded to harmful behaviour within their romantic relationships. We also aimed to understand how young people might better engage with support, and who they were likely to disclose worries and issues to. We found that young people do not use the term 'domestic abuse' and instead prefer terms such as 'toxic relationship', 'controlling behaviour' and 'manipulative.'[22] **The guidance should highlight that any education around domestic abuse needs to be delivered in a way which feels accessible and relevant to the age groups being taught.**

Similarly, **young people using abuse should not be labelled a 'perpetrator' but a 'young person using harmful behaviour' or 'causing harm.'** We need to make sure not to vilify the person causing harm or it may be difficult for a young person to come forward and seek help, whether as someone experiencing abuse or causing harm.

The guidance should also note that education around domestic abuse should not relate solely to stereotypical ideas of what abuse 'looks like:' it needs to cover forms beyond physical violence and households beyond a mum and dad in a nuclear family home. For example, post-separation abuse, and abuse perpetrated by extended family members can present a risk. Considering that a young person may be experiencing or using domestic abuse in many forms, educators must talk about all of its manifestations, including: parental abuse;

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[22] SafeLives (2020), My Story Matters: #TalkAboutToxic, Survey results. Available at: https://safelives.org.uk/sites/default/files/resources/Talk%20about%20toxic%20survey%20results%20Report.pdf

intimate relationship abuse; and adolescent-to-parent abuse. There should be a specific focus on so-called 'honour'- based abuse, forced marriage and female genital mutilation (FGM), and a specific focus on abuse in LGBT+ relationships.

There needs to be a clear balance between teaching to recognise and respond to both the victims of abuse (to recognise if you're a victim) and the causing of harm (if you're a person who is causing harm). We know that young people can easily fall into both roles, or at least to identify themselves with both roles. For example, a victim of relationship abuse, and a perpetrator of adolescent to parent violence, or a victim of abuse in the home and then causing harm in their own relationships.

When talking about how a victim should respond to the abuse, there also shouldn't be an exclusive focus on ending that relationship. Keeping that young person engaged will take a nuanced approach, proportionate to risk and the sensitivities of ensuring they can trust the adult engaging with them. Again, we know that young people often don't see the 'perpetrator' as a perpetrator and instead want to offer help and support. They tell us that they don't simply want to be told what to do: they often liken this to being misunderstood and their voices ignored. By the same token, a young person who opens up sufficiently to say they are worried about their own behaviour and its possible negative impact should be supported to explore that conversation, on the basis that shame and humiliation are poor drivers for change.

As there may be disclosures of domestic abuse or child abuse, the educators who are teaching about relationships should be equipped with ways of recognising children's disclosures and know how to respond. Previous research has identified a need for these programmes to be linked to services for young people who disclose abuse in their own or their parents' relationships.[23] Children may not outright disclose the abuse, so the teachers should be trained to recognised signs and symptoms that may be less obvious. Alongside this, schools must have robust referral mechanisms which all staff understand so that disclosures of abuse are acted upon swiftly and children are offered the support they need. Encouraging children to reflect on their experiences of domestic abuse without ensuring educators have the appropriate training and that the school has the resources to cope with disclosures could increase risk to those children disclosing.

This section of the guidance would usefully make specific reference to educational settings which are outside the mainstream. The proportion of young people in Pupil Referral Units who have experience of domestic abuse, for example, merits specific attention and requires staff in those Units to work even more closely with local specialist DA organisations to address both previous experiences and the potential for the adoption of harmful and/or risk-taking behaviours. In all educational settings, it would be helpful to highlight even more strongly the need for professional curiosity which allows staff to look beyond presenting behaviours – acting out, aggression, sexually inappropriate behaviour, withdrawal – to the issues which lie behind them. This should be incentivised in order that schools are not unintentionally encouraged by national policies which prioritise educational attainment above all other markers of wellbeing, progress and achievement.

Children's Social Care

We welcome the recognition that children's social care must "view every family member as one part of a complex picture." This whole-family approach is vital to ensuring that all victims can get safe, and the perpetrator's behaviour is challenged; we

[23] Stanley, N. et al. (2015), Preventing domestic abuse for children and young people: A review of school-based interventions. Children and Youth Services Review, 59, 120–131.

have heard from Children's Social Care workers that they aren't confident working with perpetrators. This leaves the focus of their interventions on the non-abusive parent.[24] As Ofsted's Joint Targeted Area Inspection on domestic abuse in 2017 found, "there was a notable absence of attention given to the perpetrators of abuse, compared to the victim. Throughout the evidence, the complexity of coercive control and its role in the behaviour of abusers arose frequently."[25] Much of our recent work has demonstrated this lack of confidence amongst frontline practitioners in dealing with perpetrators of abuse. Our cultural change programme for children's social care workers, piloted in 2020 with funding from the Home Office, found that, before receiving training, 40 per cent of respondents felt confident in their knowledge of the tactics perpetrators of domestic abuse use to keep their adult victim(s) in a relationship and prevent them from leaving. Following the training, 92 per cent of respondents felt they had a very or extremely good understanding such tactics.

Therefore, in order to achieve Objective 2, this sub-section on children's social care should be expanded to fill this apparent knowledge gap.

Moreover**, investment in the further development and subsequent roll out of our cultural change training for children's social care could help to create a workforce which fills gaps in understanding as identified by Ofsted**: "Professionals did not always recognise that, though not always, separation could escalate risk. They did not sometimes realise that the abuse does not end when people stop living together."

We would welcome further reference to other local authority responsibilities for care providers, foster carers and adoptive parents who are known to LAs and with whom vulnerable children and young people are placed, and the need for greater understanding around domestic abuse.

Health professionals

We warmly welcome the recognition in the guidance that a whole-health response to domestic abuse is necessary, and requires more than training and standalone interventions, to include partnership working, cultural change, and "a strategic, funded commitment to implement the necessary structural changes to embed this work," (Paragraph 263).

We recommend that the guidance is strengthened further around the co-location of Idvas in health settings. As noted in A Cry for Health (2016), health-based Idvas have been shown to reach demographic groups which are likely to have unmet needs and be hidden from statutory services. The Draft Domestic Abuse Bill included, in 2019, NHS England's commitment to have health-based Idvas in every NHS Trust Domestic Violence and Abuse

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[24] SafeLives (2020), *Culture change programme for Children's Social Care professionals: pilot evaluation.* Available at: https://safelives.org.uk/sites/default/files/resources/Whole%20Picture%20Children's%20Social%20Care%20professionals%20cultural%20change%20evaluation.pdf

[25] HMIP, HMICFRS, Care Quality Commission, Ofsted (2017), *The multi-agency response to children living with domestic abuse.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/935983/JTAI_domestic_abuse_18_Sept_2017.pdf

Plan from April 2020, as part of the NHS Standard Contract.[26] Neither the 2020/21 or 2021/22 NHS Standard Contracts fulfilled this commitment, but we would welcome further support in this guidance for the vital work of health-based Idvas who frequently see a wider range of survivors, earlier on in the abuse, than community- based Idvas.

Our research has found that across the UK nearly a quarter of victims at high risk of harm and one in ten victims at medium risk went to A&E because of their injuries in the year before they got effective help. At the most extreme end of this, victims reported that they attended A&E 15 times during those 12 months.[27]

According to the Office for National Statistics: "around a third (33.1 per cent) of partner abuse victims who had experienced any physical injury or other effects received some sort of medical attention. Victims who had received medical attention were also asked where they received it; with the majority (83.1 per cent) doing so at a GP or doctor's surgery, 36.4 per cent at a specialist mental health or psychiatric service and 12.2 per cent had gone to a hospital's Accident and Emergency department."[28]

Hospital-based Idvas are a key method to ensure these survivors do not fall through the cracks and must be integrated as part of a whole-system, whole-health approach. They also act as a consistent apace for repeat disclosures: vital given many victims and survivors will present several times before feeling ready to engage fully with domestic abuse services. This is especially true for high-risk victims and those with protected characteristics and intersecting identities who may have concerns about encountering racism, ableism, homo-, bi- or transphobia or other prejudiced attitudes.

We welcome the inclusion of references to our Cry for Health research in the guidance. We recommend that further detail is included to ensure that the guidance effectively achieves Objective 2 and is a useful and comprehensive tool for commissioners.

Our evaluation of five co-located hospital Idva services in Cry for Health revealed:

- Hospital-based Idvas were more likely to engage victims who disclosed high levels of complex or multiple needs related to mental health, drugs and alcohol, compared with community-based domestic abuse services;
- Nearly twice as many victims in hospital had self-harmed, or planned or attempted suicide than victims in a community setting (43 per cent compared with 23 per cent);
- Victims in hospital had experienced abuse for an average of 30 months, compared to an average of 36 months for victims presenting at a community-based service, highlighting the opportunity health settings have to intervene earlier on.
- 29 per cent of victims accessing community-based Idvas had been to A&E in the six months before accessing the Idva service. The vast majority of their visits (86 per cent)

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[26] Draft Domestic Abuse Bill (2019). Paragraph 167. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/817556/CCS0619467038-001_Domestic_Abuse_Bill_Print_WEb_Accessible.pdf

[27] SafeLives (2015), *Getting it right first time.* Available at: https://safelives.org.uk/sites/default/files/resources/Getting%20it%20right%20first%20time%20-%20complete%20report.pdf

[28] Office for National Statistics (2018), *Domestic abuse: findings from the Crime Survey for England and Wales: year ending March 2018.* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2018#effects-of-partner-abuse-and-medical-support

were related to the abuse they were experiencing: nearly two thirds (64 per cent) of visits were due to injuries directly caused by the perpetrator.[29]

After the introduction of a hospital-based Idva service, referrals significantly increased. In one of the hospitals in the Cry for Health evaluation, there were 11 Marac referrals in the 11 months before the introduction of the Idva service; this increased to 70 in referrals in the following 11 months.

Idvas can help victims to understand, often for the first time, that what they are experiencing is domestic abuse. While victims may not accept support initially, they leave hospital with knowledge of the support they could receive, should they choose to engage later on.[30]

Commissioners may benefit from learning that hospital-based Idvas will often help with staff disclosures of domestic abuse, and staff are often an Idva's first referrals when a new service is established. This is why it is important for hospitals to have domestic abuse policies in place which meet the needs of both staff and patients.

There is also an opportunity to increase the number of specialist domestic abuse practitioners for those with protected characteristics co-located in healthcare settings. For example, Galop told us they recommend an additional Idva with specialist LGBT+ knowledge be co-located in healthcare settings which see high numbers of LGBT+ survivors presenting, such as HIV/AIDS services, Trans+ health services, and sexual health services.

Our Cry for Health analysis identified that there could be a net positive impact on health services' budgets once victims have accessed the hospital Idva service. Before accessing the Idva service, hospital victims cost on average £4,500 each year in their use of hospital, community and mental health services, whereas community Idva victims cost £1,066 per year for the same services. The net positive impact of Idva services was, on average, £2,050 per victim, per annum, consisting of:

- Reduction of hospital service use (i.e. inpatient, outpatient, A&E): £2,184 per patient, per annum;
- Reduction of ambulance use: £200 per patient, per annum;
- Increase in local surgery use (i.e. GP, practice nurse, nurse practitioner, health visitor): £64 per patient, per annum;
- Increase in mental health service use of £196 per patient, per annum;
- Increase in substance misuse service use of £74 per patient, per annum.

There is also an increase in social services use (social worker and child and family support worker), costing £282 per patient, per annum.
The higher use of mental health and substance misuse support services post-Idva may be because victims are in a better position to prioritise their own health, rather than needing to focus solely on survival in an abusive relationship. The rise in social services costs may be due to this agency often only getting involved with a family once a victim with children starts to receive Idva help.

In a separate pilot of the Idva service at Saint Mary's Hospital, Manchester, the evaluation team calculated that the 28 cases referred to Maracs as part of the pilot saved the public

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[29] SafeLives (2016), *A Cry for Health: Why we must invest in domestic abuse services in hospitals.* Available at: https://safelives.org.uk/sites/default/files/resources/SAFJ4993_Themis_report_WEBcorrect.pdf
[30] SafeLives (2016), *A Cry for Health: Why we must invest in domestic abuse services in hospitals.* Available at: https://safelives.org.uk/sites/default/files/resources/SAFJ4993_Themis_report_WEBcorrect.pdf

sector £170,800, compared with the costs of £50,591 to the health service of employing one full-time Idva.

It is important that the co-location of Idvas in hospitals is accompanied by training delivered by the Idva service and genuine integration into the hospital with honorary contracts, space made available and NHS email addresses. One member of our SafeLives' training team spoke of having only an hour with emergency department staff at one training session, during which time staff arrived late and left early as they were attending during a break time. Hospital-based Idvas can work on a longer-term basis to challenge processes and ingrained views which present barriers to survivors presenting. We recommend that training encompasses both clinical and non-clinical staff. We know that attitudes of reception staff can impact on a survivors' sense of whether they are safe and believed (see R's Case Study), while hospital cleaners and porters might oversee abusive behaviour by a perpetrator.

A key finding in Sandi Dheensa's 2020 report highlighted that the success of hospital-based Idva services depend on a range of structural factors. The findings "illustrated the importance of ongoing domestic violence and abuse training for staff, the Idva having private and dedicated space, and the service being embedded in hospital infrastructure (e.g. featuring it in hospital-wide policies and enabling Idvas access to medical records)."[31]

9. Do you have any comments on Chapter 5 ('Working Together to Tackle Domestic Abuse') in terms of content or clarity?

We warmly welcome the recognition of "intersecting forms of oppression and abuse that some victims face" and the barriers they might therefore face when accessing support, in **Paragraph 390. In addition, we are pleased to see inclusion of by-and-for services as a key component of an effective response to domestic abuse.**

In Paragraph 401, we recommend the role of survivor and victim voice is developed further here into service design and commissioning. As it stands, the guidance to "listen to the views and experiences of victims and their family members" seems to revolve around the risk-assessment process. This should be extended beyond this, to ensure that survivor voice is meaningfully incorporated into the whole process of service design and commissioning.

Wherever possible, **decision making around service provision should involve survivor participation**, for example, through survivor advisory groups. This would need to be conducted in a trauma-informed way which prioritises survivor safety and wellbeing (as noted in the final bullet point of Paragraph 401), as well as incorporating diversity of experience and intersectionality, but is key to ensuring decisions are made in the best interests of victims of domestic abuse.

We welcome the guidance that multi-agency working should seek to reduce the need for a survivor to have to share their story multiple times, which many survivors tell us is retraumatising and presents an added barrier to accessing services.

Furthermore, we are pleased to see the recognition that "the person responsible for the situation is the perpetrator."

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[31] Dheensa, S., Halliwell, G., Daw, J., Jones, S.K., Feder, G. (2020), *"From taboo to routine": a qualitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse*. BMC Health Serv Res 20, 129 (2020). https://doi.org/10.1186/s12913-020-4924-1

In Paragraph 416, Point F, we recommend that the guidance details how the Panel must recognise survivor voice and consider the impact of actions on risk to victims, especially in tandem with safeguarding considerations. Further development of this point, alongside potential measures available to the Panel to demonstrate adherence to this guidance point, would be helpful to ensure it can be practically implemented.

The whole-family, whole-picture approach

We welcome the guidance's signposting to the 'One Front Door' model in Paragraph 396 which we have further developed in partnership with a wide range of local areas as our Whole Picture public health approach.[32]

To end domestic abuse, we need to look at the whole picture. This means looking systematically through the lens of the whole family, identifying opportunities for improving the response to high-risk abuse as well as early intervention and prevention. This includes:

- seeing and responding to the whole person, understanding linked adverse experiences and individual characteristics and situation;
- wrapping around all family members involved, so the responses provided are coordinated and sustainable;
- ensuring appropriate roles are taken on by the community, and society as a whole;
- acting at each opportunity for change and intervention, from before harm happens to after the most imminently dangerous moments have passed and people are trying to rebuild.

Our research, data, interventions and survivor feedback have shown how local systems fail to understand the whole picture of a family affected by domestic abuse. For example:

- Many individuals and families experiencing domestic abuse have multiple needs and many are 'hidden' from services;
- 87 per cent of survivors in our Whole Lives survey had told multiple people about their experience of abuse, yet only 31 per cent had managed to reach specialist support and this was most commonly through a self-referral route;
- 85 per cent of victims of domestic abuse seek help five times on average before they get effective support;
- 23 per cent of young people exposed to domestic abuse are also demonstrating harmful behaviour, 61 per cent against the mother;
- On average, older victims experience abuse for twice as long before accessing help as those aged under 61;
- Around 30 per cent of children in households supported by an Idva were not known to children's services;
- At the time they start school at least one child in every classroom will have been living with domestic abuse since they were born;
- Young victims are exposed to other risks – 29 per cent to child sexual exploitation and 15 per cent to gang violence;
- In 2016, we found that only 1 per cent of perpetrators of domestic abuse receive any specialist intervention to be challenged or change their behaviour.

We welcome the multiple references to whole-family models of safeguarding, but these are largely focussed on statutory agency responses which are led by children's social care. **We**

[32] SafeLives' Whole Picture public health approach to ending domestic abuse | Safelives

recommend the guidance references other models of response which are increasingly 'wrapping round' a whole family to provide an integrated response to domestic abuse. This would include the work of Talk, Listen, Change (beyond their behaviour change interventions referenced in Paragraph 436), the WISH Centre in Blackburn and Darwen, and the Drive model in South Wales, South London, and several other sites around the country. These models identify, sooner, a larger number of victims of the same perpetrator of domestic abuse; increase the likelihood of scrutiny on the individual causing harm, rather than acting in isolation for victims after the harm has occurred; reduce the onward costs incurred by families being made safe on a temporary basis and/or the perpetrator simply being moved on and allowed to start another relationship and demonstrate the same harmful behaviour with (a) new victim(s).

Marac

We welcome much of the section on Marac and have some comments and additions with regards to strengthening Paragraphs 410-413. Please also see our response to Question 12 regarding the inclusion of the daily Marac meeting in the Hounslow case study.

In Paragraph 411, we recommend that the emphasis on action-planning is increased. Often, there is too great an emphasis on the information-sharing aspects of a Marac process, to the exclusion of effective action planning to increase victims' safety. As such, "to discuss the shared information and expertise, and suggest actions" should be changed to "to share information and expertise, and develop a bespoke, creative and intelligent action plan."

In Paragraph 412, we recommend an addition to the role of the Idva in a Marac meeting: while they should work in partnership to implement the plan, they should lead in the action-planning process.

In the same paragraph, we recommend the removal of "Whilst they are not a statutory requirement" as we feel this undermines the vital role of the Idva in the Marac process. Instead, this section should read: "The Idva is a highly trained, skilled specialist who, crucially, represents the victim at the Marac, making sure their voice is heard."

In Paragraph 413, any agency needs to consult with partner agencies before the decision is made to disclose personal information in the event that the victim objects to the disclosure. **We recommend the insertion of a sentence highlighting the need for communication between agencies should such a path be considered.**

We welcome the inclusion of guidance on the application of the Caldicott Guardian Principles. **We recommend the addition of the below pieces of guidance:**

- 10 Principles of an Effective Marac;
- Guidance for Maracs on sharing information in relation to victims who may have insecure immigration status;
- Marac Information Sharing Protocol Checklist;
- Sharing Information and Marac: GDPR and DPA 2018.

10. Do you have any comments on Chapter 6 ('Commissioning Response to Domestic Abuse') in terms of content or clarity?

On Paragraphs 424 to 426, we recommend that Tier One authorities must be directed <u>explicitly</u> to include representatives from community-based services on the Local Domestic Abuse Partnership Boards (LDAPB). While Part 4 relates solely to the provision of accommodation-based services, we are concerned that we are already beginning to see the establishment of a two-tier system with regard to the community-based specialist services which provide vital support to adult, teen and child victims and survivors of domestic abuse – and to those who use abuse. Many frontline practitioners are telling us that they have not been invited to their area's LDAPB and are finding lines of

communication harder to establish since the Domestic Abuse Act received Royal Assent and Local Authorities have started preparing for the accommodation-based Statutory Duty to come on-stream.

We warmly welcome the inclusion of survivor voice on the LDAPB but the guidance should highlight that Local Authorities must ensure the process is accessible to survivors of domestic abuse and that a trauma-informed approach is taken to survivor engagement. People who speak about their experiences should be believed, validated and their experience valued as expertise and a method of creating societal change. Too often, survivors are asked to 'rate not create'. Even where there have been excellent examples of government agencies and local commissioners inviting survivors to participate in policymaking or service design, survivors are often unremunerated, or they find that the space to engage fails to acknowledge their histories of trauma. This can lead to survivors feeling used, dismissed or, in the worst-case scenarios, re-traumatised.

The LDAPBs should be conducted in recognition of the additional barriers survivors might face, through providing creative ways of engaging and speaking out without being identified or recognising other access issues such as having mental health concerns, not speaking English as a primary language, or being disabled or Deaf. A trauma-informed approach would include recognition of elements such as:

- using lived experience to advocate for change can be emotionally draining and challenging, and that in open discussion contributions and questions from other people might be triggering for survivors, so a dedicated support person must be present;
- control and choice are important. For example, creating space for survivor participation in the early stage of a schedule both creates a boundary and allows freedom for comments and contributions at different points later in the discussion - without any need to explain why this is relevant each time;
- there may be risks involved in survivors' participation, not only regarding the impact on mental health, but also to a person's physical safety;
- appropriate safeguards must be in place to ensure that participation does not impact negatively on a person's emotional and physical wellbeing;
- there is inclusive representation to ensure that no one person or organisation is speaking on behalf of others, whose experience they may not know or understand. Survivors whose experiences are layered with additional marginalisation, discrimination and disadvantage should be central to debates, to ensure these are more representative of the full range of communities across the local area;
- individual needs around recording and storing information must be considered when organisers plan to film, record or transcribe events. This is not only to comply with legal standards under the General Data Protection Regulations 2018 (GDPR), but also to be sensitive to sharing of what is highly personal information – regarded as 'personal data' under GDPR – especially as wider dissemination of material means survivors lose a sense of who their audience is, and their control over their own story is reduced.

In Paragraph 430, we are pleased to see the guidance state that intersecting identities and experiences of abuse are crucial components of meaningful needs assessment, but this needs much more detail. There is no mention of the calculations readers of the guidance should make regarding: accepted prevalence rates; the proportionate weighting of prevalence to different groups of individuals of victims of domestic abuse and of perpetrators; accepted guidance about safe caseload levels for frontline practitioners; and, finally, how these calculations can create a sense of safe and effective levels of local provision. **We recommend this section is developed further to ensure commissioners have the necessary information to calculate appropriate service provision.**

In addition, when calculating provision**, the guidance should make clear that services should be proportionate to the evidence around the characteristics of those most frequently affected by domestic abuse.** We are very concerned about the sentence in Paragraph 422, stating "this means that, in some instances, in order to have regard to these factors, a local authority might (or might not) need to commission single-sex services and specialist 'by-and-for' services, depending on their needs." Gender-informed provision does not mean the exclusion of male victims of domestic abuse or victims in same-gender relationships. Furthermore, it does not pre-suppose how services can make provision inclusive of transgender and non-binary survivors. Instead, gender-informed provision means an acknowledgement of how the dynamics of gender, and sex, are inherent to domestic abuse, and therefore provides evidence around what services are required**. This paragraph needs**

further development to explain to commissioners the requirement to respond to the ample data around who is most likely to experience domestic abuse with appropriate provision.

Where the local geography and population does not facilitate all specialist responses (for example, rural areas where some groups with protected characteristics may be present in smaller numbers**), we recommend work should be undertaken by commissioners to join up on a regional basis to ensure those members of the local community are not disadvantaged by their location and can still access appropriate support**. Where regional support is being offered by highly specialist 'by-and-for' organisations, this should be appropriately costed into local commissioning plans and coordinated across usual geographical boundaries to ensure no victim of domestic abuse falls through the gaps. No local area should assume that their area does not contain groups with specific requirements: this erases individuals and groups on the basis that they happen to be smaller in number or less immediately 'visible' in routine needs assessment.

We recommend that Paragraph 433 is moved to before the section on perpetrator programmes. The standards named in the paragraph do not specifically refer to quality assurance of perpetrator work, and instead cover service delivery across the Violence Against Women and Girls sector.

We also recommend the addition of SafeLives' Leading Lights quality standard. The Leading Lights accreditation supports services to provide the most effective response to keep survivors safe and enables staff to gain knowledge and confidence in their roles. Moreover, it enables services to develop a better relationship with local commissioners and evidences the quality of their work during the process of bidding for funding and commissioning. **We recommend the removal of "(non-obligatory)" as we are concerned that this will mean that commissioners and other readers may skip the paragraph altogether**. It is clear enough without the explicit reference that the sector standards are not mandatory. The language, instead, should highlight the value of the various accreditations and commissioners should see them as helpful guidance around best practice.

On Paragraph 438, it is important to note that MATAC is not a behaviour change intervention but is focussed on disruption and is led by the Police, placing it within a criminal justice response. There is currently no codified MATAC model as highlighted by the recent HMICFRS report which leaves unclear the actual practice referred to, when referring to MATAC.

Guidance on commissioning should also include appropriate outcome measurement beyond relying on blunt data points such as referral and engagement rates. Though these are important, they should be measured and understood within the wider context. Specialist services should be supported in a process of meaningful and streamlined data collection and analysis which is subject to peer review by survivors, commissioners, and service managers. Moreover, this must be used for iterative learning and reflection, as well as improving collaboration on future improvements and changes to commissioning and services.

Local contracts and commissioning must include the opportunities for data capture and analysis, workforce development, and clinical supervision and wellbeing support. These are not 'nice to have' additions to be funded or not depending on the priorities of each Local Authority, but are absolutely essential to the running of an effective domestic abuse service and appropriate levels of accountability. During the last 18 months, we have seen high levels of staff burnout, unsustainably high caseloads, and low morale in frontline services, but the Covid-19 pandemic has only worsened an already poor state of affairs in which the value of these vital services is not recognised in long-term funding. Without building into contracts the opportunity for development, clinical supervision and

wellbeing support, we will see a high turn-over in the sector and the loss of highly qualified specialists and their years of experience.

As highlighted above in relation to Paragraph 401, **we recommend an addition to the guidance around the crucial role of survivor voice in the development and improvement of both commissioning processes and local service provision.** Engagement and input of a diverse range of survivors should be sought throughout decision-making processes, and the survivors must be remunerated for their time and expertise.

11. Are there any overarching ways you think the guidance could be improved? Please provide comments.

N/A

12. Do you think the case studies are helpful? If there are any case studies which you did not find helpful, please provide additional comments ensuring you refer to the case study to which your comment relates.

On the Hounslow case study, page 118, we recommend the removal of the daily Marac. SafeLives does not routinely recommend the implementation of daily Marac meetings.

In an information-gathering exercise in 2019, we found that areas which had implemented or planned to implement daily Marac meetings frequently did so to manage high volumes of referrals and to reduce repeat cases. However, we found that although the approach was implemented to reduce volume, the model of a daily Marac meeting actually increased the volume of referrals. In some instances, this increase was significant and swiftly became unmanageable. Similarly, we saw a significant increase in repeat cases discussed at the Marac where daily meetings have been introduced.

It is essential that victims of domestic abuse are at the heart of the Marac process; only by hearing the survivor voice can agencies create the most effective, impactful and supportive action plans to keep families safe. One disadvantage of the daily Marac approach is that it severely reduces the opportunity for the Idva to effectively engage with the survivor(s). We recommend that the Idva attempts contact within the first 48 hours of receiving the referral but, in reality, they may not be able to make contact for a number of days. In addition, the approach puts pressure on agencies to conduct their research in a much shorter timescale. We observed that, in some areas, the impact of this was a lack of survivor engagement and voice within the Marac, alongside a lack of research. This culminated in a lower quality of action planning. As such, lack of survivor voice, research, and effective action planning are significant and worrying deviations from the Marac model.

Furthermore, there is no consistent definition, or indeed practice, of a daily Marac model. The only consistent factor across the areas we looked at was that a daily meeting was held.

In some areas, cases were heard within 24 hours of referral, which often meant the morning was spent conducting research and the afternoon spent attending the Marac meeting.

Some areas implemented a delay between the referral and the Marac meeting at which the case would be discussed, meaning each daily Marac meeting heard cases from between two and five days previously. In implementing such a delay, the Idva service had a greater opportunity to engage with survivors: a fundamental element of an effective Marac process.

In other areas, the daily strategy meetings did not resemble the Marac process at all.

Moreover, the model of daily Marac meetings has yet to be comprehensively researched and evaluated, unlike the fortnightly or monthly Marac meeting. **We recommend that the guidance does not spotlight a model which is not rooted in the same amount of research and robust evaluation.**

We are concerned at the inclusion of any single Marac as a case study in the guidance. This statutory guidance is a long-term document, aiming to achieve its objectives over a significant timespan. The success of a Marac, on the other time, often relies on a few passionate individuals in the attending agencies. The success of a Marac can differ hugely in a matter of months if, for example, the Chair changes and an Idva leaves the local area or their service loses their funding. No matter how successful the Hounslow daily Marac is at responding to the needs of survivors in the area and effectively action planning, its inclusion in the case study undermines the longevity of this guidance due to the short-term nature of the formulation of a single Marac.

Therefore, we recommend the removal of the daily Marac from the case study. Its inclusion reads as a recommendation to other areas to implement a daily Marac meeting in response to high referrals volumes but we are concerned the model does not effectively respond to such challenges, and that it is likely to deviate significantly from the researched model of monthly meetings.

13. Is there anything missing in the guidance that you would like to see included?

N/A

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