Ending domestic abuse

SafeLives' response to the Victims' Bill Consultation: February 2022

Contents

Chapter 1 – Improving oversight and driving better performance

Survivor voice

People who speak about their experiences should be believed, validated and their experience valued as expertise and a method of creating societal change.

Hearing survivors' 'authentic voice' means giving them the power to co-create service design and delivery, represent their lived experience and that of other survivors in their own right, rather than being mediated through national or local partners. Too often, survivors are asked to rate, not create, and their experiences are side-lined in policy-making when they should be central to it. Even where there have been excellent examples of government agencies and local commissioners inviting survivors to participate in policy-making 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.

Hearing directly from people with lived experience helps to break the silence about domestic abuse and remove the stigma associated with it; this builds powerful communities of survivors and their families - who may also reach out to services for help - and helps to turn the public and statutory response away from victim-blaming and 'why doesn't she leave?'.[1] There is growing awareness across sectors and statutory teams that leadership, participation and co-production from people with lived experience cannot just be a 'nice to have' but is absolutely critical if high-quality, effective responses are to be developed.

Government, Parliament and national agencies can lead the way in providing welcoming spaces for engagement with survivors, ensuring there is no sense of 'them and us' and recognising that the majority of women will have experienced some form of abuse or discrimination in their lifetimes. This includes senior women in Parliament, Government departments, and frontline agencies.

We propose that this sense of 'no them and us' and commitment to hearing survivors' authentic voice is developed in a charter in which consultation processes are conducted through a trauma-informed lens. Evidence sessions should be conducted in recognition of the additional barriers survivors might have, through providing creative ways of engaging and speaking out without being identified, or recognising other access issues such as having mental health concerns, not having English as a primary language, or being disabled or deaf.

A trauma-informed approach would include recognition of elements such as:

- possible risks involved in survivors' participation, not only regarding the impact on mental health, but also to a person's physical safety – survivors' safety is paramount;
- 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;
- 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 UK;
- 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

[1] This applies whatever the gender of the victim or the perpetrator(s), and whatever the nature of their relationship.

dissemination of material means survivors lose a sense of who their audience is, and their control over their own story is reduced.

Question 9: Local-level partnership working is vital to ensuring the delivery of a quality service to victims. How can agencies better collaborate locally to deliver and monitor compliance with the Code? How could agencies be encouraged to consistently share data at local and national levels to support monitoring of Code compliance and drive improvements?

We recommend the Government acts on recommendations in the 2021 HMICFRS report, *Police response to violence against women and girls*, which proposed the introduction of a statutory duty requiring the police and relevant partner agencies to work together to collectively take action to prevent the harm caused by VAWG.[2] In doing so, the Government should consider whether this could be incorporated in any existing duties; how duties for safeguarding children will interact with and complement the changes; and how this duty will be incorporated into the new statutory framework for VAWG.

The report also noted the value of the approach used through separate legislation in Wales to encourage multi-agency collaboration on VAWG, including through the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 which, among other actions, requires local authorities and health boards to prepare a plan for tackling VAWG. We urge the Government to consider taking forward a similar cross-Departmental approach. **VAWG touches almost every area of Government and we want to see a pan-Government response.**

We also recognise the importance of effective data-sharing – too often vital information which could save lives and reduce harm is held but not recognised or shared. In 2018, we worked with the Office of the Information Commissioner to produce guidance on information sharing in light of the introduction of GDPR and the Data Protection Act 2018.[3] This makes it clear that agencies must ensure safeguarding takes precedence when it comes to data protection and that they are required to share information when a victim of domestic abuse's life is in danger. We note that this aspect of data protection is often not fully understood and concerns about privacy used as a reason or excuse not to share information. **Agencies must act in line with data-sharing principles and share when it is a matter of safeguarding.**

Question 11: Do you think the current inspectorate frameworks and programmes adequately focus on and prioritise victims' issues and experiences and collaborate effectively across the criminal justice system to do so?

We agree that the Inspectorates focus on and prioritise victims' experiences and collaborate effectively.

However, we note that there is no cohesive, overarching plan to inspections. Every year, Inspectorates look at preventing crime and promoting the wellbeing and welfare of victims in some form, but the process for this can be ad-hoc: there is no 'bigger picture' to look at victims' services as a whole.

Furthermore, at the point that an Inspectorate is able to investigate victims' experiences, we are effectively 'too late' to stop harm happening. We recommend a greater focus on preventative action to ensure that we are not only acting to improve victims' experiences after harm has occurred but acting to prevent harm occurring in the first place, looking at primary and secondary prevention and robust and creative use of enforcement powers.

A difficulty faced by Inspectorates is the lack of levers available to them to ensure the recommendations from each inspection are applied, no matter how many times they may repeat the same findings and recommendations.

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[2] HMICFRS (2021), *Police response to violence against women and girls: Final inspection report.* Available at: https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/police-response-to-violence-against-women-and-girls-final-inspection-report.pdf

[3] SafeLives (2018), *Information sharing: GDPR and Data Protection Act 2018*. Available at: https://safelives.org.uk/sites/default/files/resources/Legal%20Grounds%20for%20Sharing%20Information%20Guidance.pdf

We would like to see further measures to hold those responsible for acting on the recommendations to account. For example, we note the positive benefits of the former National Oversight Group, whose quarterly meetings were chaired by the Home Secretary. This was an example of effective collaboration in which representatives from the Police, Inspectorates, Commissioners and third-sector victims' services were brought together to hold the police to account to deliver the recommendations of HMIC's reports. The meetings sent a vital signal that the Inspectorate's recommendations and the Police's application of them were a priority for Government. The last time this group met, it was chaired by a mid-ranking official. **We recommend the reinstating of this Group or a similar pan-Government task force, chaired at Secretary of State level, to raise the profile of the recommendations from Inspectorates' reports and oversee their implementation.**

Question 13: What are the most critical functions to enable an effective Victims' Commissioner?

We agree with the recommendations of the Victims' Commissioner in relation to the functions the Office must hold.[4]

The Victims' Commissioner's 2020 report, *Constitutional Powers of the Victims' Commissioner for England and Wales*, examined the functions and current powers of the Victims' Commissioner (VC) in comparison to those of the other commissioners and the criminal justice inspectorates in England and Wales.[5]

It concluded that there are significant gaps in the powers of the VC in relation to the Victims' Code and that, at present, the Code is neither enforceable in law nor subject to effective review. It identified changes that could be made to close those gaps and enable the Commissioner to better fulfil her statutory duties, which are: to promote the interest of victims and witnesses; to encourage good practice in the treatment of victims and witnesses; to keep under review the operation of the Code (an obligation which cannot be fulfilled at all the moment); publish an annual report; and give advice to ministers on particular issues when asked to do so. In particular, the VC does not, at the moment, have the power in statute to undertake the review of the Code, and this needs to be addressed in the legislation.

Chapter 3 – Supporting victims of crime

Question 23: What legislative duties placed on local bodies to improve collaboration where multiple groups are involved (such as those set out above) have worked well, and why? What are the risks or potential downsides of such duties?

We recommend drawing on the positive elements of duties such as Prevent to ensure agencies are obligated to work together, with a statutory duty to provide community-based services for victims of VAWG and DA, accompanied by a non-legislative package which ensures adequate funding.

Though we recognise it has had many challenges, we note that the Prevent duty, enshrined in Section 26 of the Counter-Terrorism and Security Act 2015, is an example of a legislative mechanism designed to improve multi-agency working and join up. We would welcome a duty which would require bodies to work together to support adult and child victims of domestic abuse (or, indeed, other crimes) and to provide appropriate services to meet their needs, combined with a non-legislative funding package to ensure that support is made available and perpetrators are challenged to change.

The positive aspects of the Prevent duty include the limiting of the scope of any one statutory agency or local body to say that identifying extremism is 'not their job'.

[4] Victims' Commissioner (2022), *Victims' Law Briefings: Chapter 2, Question 13.* Available at: https://victimscommissioner.org.uk/our-work/briefings/victims-law/improving-oversight-and-driving-better-performance/

[5] Victims' Commissioner (2021), *Constitutional Powers of the Victims' Commissioner for England and Wales.* Available at: https://victimscommissioner.org.uk/document/constitutional-powers-of-the-victims-commissioner-for-england-and-wales/

The duty also creates a commonality between all geographic areas, including in areas where the Local Authority, police, schools, mental health services, universities, or others might claim that extremism is not a local problem. For example, the duty is just as relevant in rural settings as in major urban areas.

This clearly links to domestic abuse, where we frequently see statutory professionals in higher income and/or rural areas claiming that domestic abuse 'doesn't happen around here,' despite the fact that we know it does: in fact, rural victims of domestic abuse are half as likely to report their abuse and, on average, live with the abuse for 25% longer compared with those in urban areas.[6] Survivors of domestic abuse from higher income brackets do exist and need support – but they're less visible in agency data and so there is often a misconception that domestic abuse only happens behind a certain type of front door, linked to poverty.

Government and statutory agencies have given sustained attention to the Prevent duty and local bodies' adherence to it. The zero-tolerance approach to terrorism has ensured ongoing assessment and follow-up. Too often we see the imposition of new duties which do not receive that level of attention and, as such, do not have the intended effect.

The Prevent duty also came with high levels of investment to make sure that local professionals can accurately identify concerning behaviours and understand the referral pathways available to them.

We note that other duties on local bodies, such as those within the Care Act 2014, though welcomed and laudable, did not benefit from the same investment of time and energy. As a result, we have seen little change in local practice.

We want to see a duty to provide community-based services for VAWG implemented with the same urgency and attention as any counter-terrorism action, recognising the increased levels of harm caused, daily, to women and girls across the country. In England and Wales, there were 95 deaths in England and Wales from April 2003 to 31 March 2020 due to terrorism.[7] Over the last 10 years, around 80 women a year have died at the hands of a partner or ex-partner in England and Wales;[8] cases of domestic abuse at the highest risk of serious harm or murder as recorded by SafeLives in our Marac national dataset are up 31% since 2017 to over 116,000 cases, involving an estimated 144,500 children.[9]

Investment in counter terrorism extends far beyond the investment in tackling VAWG, which suffers both from short-term and wholly inadequate funding, and a lower profile and status in political discourse. Local bodies routinely have the opportunity to 'top up' their funding for counter terrorism, or benefit from ring-fenced counter terrorism policing budgets in order to fulfil the requirements imposed by a duty. The Government has made it impossible for a local partner to fail to implement the duty on the basis of a lack of funding.

We want to see the same level of commitment, backed by suitable funding, through a duty on local bodies to tackle and respond to VAWG and domestic abuse. We see daily the continued pressure on funding for frontline services. One frontline service manager commented: *"every year about this time everyone is on edge waiting to see if their job will continue, waiting to see if they need to inform victims that they can no longer receive support, it shouldn't be this way. Lives are far too important."*[10]

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[6] National Rural Crime Network (2019), *Captive & Controlled: Domestic Abuse in Rural Areas*. Available at: https://www.ruralabuse.co.uk/wp-content/uploads/2019/07/Domestic-Abuse-in-Rural-Areas-National-Rural-Crime-Network.pdf

[7] House of Commons Library (2021), *Terrorism in Great Britain: the statistics.* Available at: https://researchbriefings.files.parliament.uk/documents/CBP-7613/CBP-7613.pdf

[8] ONS (2020), *Homicide in England and Wales: year ending March 2020*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2020

[9] SafeLives (2022), *Latest Marac National Dataset.* Available at: https://safelives.org.uk/practice-support/resources-marac-meetings/latest-marac-data

[10] SafeLives (2020), *A Safe Fund: costing domestic abuse provision for the whole family*. Available at: https://safelives.org.uk/sites/default/files/A%20Safe%20Fund%20costing%20domestic%20abuse%20provision%20for%20the%20whole%20family%20in%20England%20and%20Wales_0.pdf

Another commented: *"initially the response is to remove the threat or the victim (in the case) to a place of safety. If appropriate referrals are submitted to the relevant agencies, then the whole family will be considered but unfortunately due to funding restrictions there are no current agencies who would be appropriate to support the family as a whole."*

Without adequate funding, adult and child victims of domestic abuse will fall through the gaps when they should be receiving help to get safe and recover, and perpetrators of domestic abuse will continue on to their next victim. We know that a quarter of high-risk perpetrators are repeat offenders. Some have at least six different victims.[11]

Without adequate coordination across Government, local agencies are not as engaged as they should be with DA and VAWG. By comparison, governance for counter-terrorism is strong and extensive.

Between Government departments, there is highly effective and cross-departmental work on the issue which is of major benefit when localising a duty. We know that only 4.3% of all Marac (Multi-Agency Risk Assessment Conference) referrals in the year to September 2021 came from primary and secondary care health agencies;[12] 65.9% of cases were referred by the police, yet only one in five victims of domestic abuse calls the police. Where local bodies are not actively engaging with VAWG, there are no structures in place to hold them to account. The Inter-Ministerial group on DA and VAWG meets very infrequently and has not demonstrated the focus, grip and action which has been the staple of counter-terrorism in Whitehall for many years.

We recognise that, although the highest rate of referral to Prevent interventions in recent years (and higher rates of arrest) has been linked to right-wing extremism, there is widespread public concern that the Prevent duty, and the counter-terrorism strategy from which is springs, leads to profiling on the basis of being Muslim, inappropriate scrutiny of a minority community, and ineffective methods of addressing and working through the risks of radicalisation. At times, this has been the reality as well as the perception. This clearly highlights the importance of doing the right work with key stakeholders, before *and* after a statutory duty is laid, to ensure that the true aims of the duty are achieved.

Current work by the National Police Chiefs Council and HSG in the Home Office on exploring the links between domestic abuse and radicalisation need to examine the roots of violent extremism in perversions of masculinity and masculine identity, rather than taking religious or cultural interpretations as the real root of either terrorism or interpersonal violence and abuse.

The creation through the DA Act 2021 of a duty to provide accommodation-based domestic abuse services was well intentioned but is already having the unintended consequences we warned about during the passage of the legislation. With the vast majority of adult and child domestic abuse survivors and victims, and their abusers, using community-based responses to their situation, we want to see a duty on local bodies to provide community-based services. This must be accompanied by an assurance that such a duty would take an equitable approach which ensures that those with protected characteristics receive specialist, tailored support, and do not find that discrimination bars their access to life-saving services.

Question 24: What works in terms of the current commissioning landscape, both nationally and locally, for support services for victims of domestic abuse?

Clear commissioning based on an effective assessment of local needs, and a good understanding of the full range of local provision and services available, with a long-term strategic view, can provide excellent quality support services to meet the needs of victims and survivors of domestic abuse, both accommodation based and community based, providing sufficient funding is made available.

[11] Robinson, A. et al. (2014), *Prevalence and Characteristics of Serial Domestic Abuse Perpetrators: Multi-Agency Evidence from Wales*. Available at: https://orca.cardiff.ac.uk/67542/1/Robinson%20Clancy%20%26%20Hanks%20%282014%29%20Serial%20perpetrators_Phase%202%20report_Final%20version.pdf

[12] SafeLives (2022), *Marac Data – Key Findings: October 2020 – September 2021*. Available at: https://safelives.org.uk/sites/default/files/resources/Marac%20Data%20Key%20Findings%20External%20October%2020%20to%20September%2021.pdf

The service provision can be statutory or voluntary sector provided, but what's important is its independence, a strong quality-assurance framework (through both practitioner training and service accreditation such as Respect, SafeLives Leading Lights[13] or Women's Aid's National Accredited Quality Standards) and the provision of tailored support which can meet the needs of all victims, particularly those with protected characteristics, whom we know are often not visible to services.

Sector collaboration is also valuable. As well as individual standards and quality assurance marks, in 2016, a number of specialist organisations came together to agree shared standards which should act as a baseline for good commissioning.[14]

We highlight, in particular, the valuable work of by-and-for services, often operating at a hyper local level, and want commissioners to explore and recognise their local landscape, rather than opting for a simpler-to-implement generic, non-specialist approach. We believe there is value in organisations of different sizes and specialisms operating effectively alongside universal services.

We know quality-assured provision delivers good outcomes for victims. For example, we know from our Insights datasets, the majority of survivors who receive support from an Idva report positive outcomes. At the point of case closure:

- 88% of Idva clients said they felt safer;
- 84% said their wellbeing had improved;
- 80% said their quality of life had improved;
- 80% were optimistic about the future;
- 79% said they felt more confident.[15]

Almost half (49%) did not experience any abuse following intake to the service.[16]

CEOs of services in different local areas who have positive relationships with commissioning teams report that good commissioning for frontline domestic abuse services looks like long-term funding, often "3+2" (year) contracts with the built-in opportunity to extend funding on the basis of positive outcomes.

In securing this sustainable long-term support, services have the time to develop referral pathways and close working relationships with statutory agencies, recruit great staff members and invest the time training them to a high standard. Moreover, staff are then freed from the cycle of bidding for and implementing short-term funding streams and can give extra focus to innovation and expansion to ensure they are meeting the needs of all victims of domestic abuse.

The Government must lead by example in providing longer-term funding, instead of short-term annual funding rounds with incredibly tight timeframes for spending the money.

One CEO told us about the honesty and trust they have built up with commissioners over time: when they are financially secure, they are open about that with commissioners which means that when the service tells Commissioners they *are* struggling to continue to fund a role or project after a different funding stream comes to an end, the Commissioners know to act in order to extend the role/project. This CEO is in regular contact with the team, and feels she and her staff are recognised as experts and peers, inviting the CEO to sit on the Adult Safeguarding Board for the area, and involving the frontline practitioners in the Local Authority training.

However, what we have heard time and time again, is that good commissioning relationships often relies on individuals and individual relationships. One service CEO told us that a recent pilot with police was initially extremely difficult, until officers with existing relationships with the service were moved into the pilot team. Now, the pilot is running much more smoothly, because those officers know the value and expertise of the service. Effective processes across the whole system must be embedded, rather

[13] SafeLives (Undated), *Leading Lights: Accreditation for domestic abuse services.* Available at: https://safelives.org.uk/practice-support/resources-domestic-abuse-and-idva-service-managers/leading-lights/

[14] https://safelives.org.uk/sites/default/files/resources/Shared%20Standards%20Whole%20Document%20FINAL.pdf

[15] SafeLives (2021), *Insights Idva dataset 2020-21 Adult Independent domestic violence advisor (Idva) services.* Available at: https://safelives.org.uk/sites/default/files/resources/Idva%20Insights%20Dataset%20202021.pdf

[16] SafeLives (2021), *Insights Idva dataset 2020-21 Adult Independent domestic violence advisor (Idva) services.* Available at: https://safelives.org.uk/sites/default/files/resources/Idva%20Insights%20Dataset%20202021.pdf

than relying on specific people, especially given the high staff turnover in statutory agencies such as CSC and the police.

One service provider told us that, in order to make commissioning work, there needs to be a recognition that specialist services add value, that they're there to work together and improve the experience of survivors of domestic abuse, rather than to criticise or hinder. Too often, agencies can be unwilling to recognise that expert input by third sector services will only serve to improve the service they provide victims. One CEO explained that their service will often identify an unmet need in the local area and will work to address it, even if they haven't received a commission for that specific piece of work, whereas generic providers will only work to the contract. Once that commissioning contract has come to an end, this CEO's experience is that the generic provider leaves the area and the knowledge, expertise, and positive relationships built during the contract are then lost to the communities in which local specialist services are fully embedded.

A case study showing effective commissioning is the ground-breaking work in our 'Beacon sites' in Norfolk and West Sussex which tailored responses to all family members whose safety was at risk, and individuals who posed a risk. The ambitious partnership brought together SafeLives, survivors, five specialist domestic abuse organisations, and local service commissioners, to develop a completely new way of working. The interventions wrapped around the needs of the whole family and work with children focused on very young children aged 0-5, in families staying together and where domestic abuse is impacting on parenting. 86% were supported with safety and understanding of safety, 52% with their mental health and 78% with their family relationships.

In terms of impact, exit reports for this whole family approach showed an 80% reduction in CYP witnessing abuse; a 42% reduction in CYP experiencing direct abuse and a 43% reduction in CYP demonstrating harmful behaviour, as well as 95% improved safety following safety support and 93% improved wellbeing following mental health support.[17] These findings were supported by an independent evaluation by UCLan.[18]

Interventions included 'Monkey Bob', resources and tools developed by one of the Beacons expert partners and My CWA for anyone working with Early Years children to deal with their emotions at difficult times in their lives.[19]

This holistic approach, which draws in the voice of survivors to co-create provision, builds on the risk-led approach and takes a systems-wide view, was developed to address the needs of a whole family, supported by the critical foundations of robust Idva-Marac provision in the area. Commissioning which recognises the critical links and integration of the lives of different family members is vital (and is also evident in some of the mini case studies we provide, above).

Colleagues in Government are familiar with the SafeLives 'genogram' approach – mapping harm to different family members who are intimately linked to each other, and pointing out how different provision, available at the right time, would reduce human harm and significant costs. We are also increasingly working with local commissioners to improve their partnership needs assessment process for their area, so they start from more robust assumptions about their local populations, and what provision is needed.

Question 25: How could the commissioning landscape be better brought together to encourage and improve partnership working and holistic delivery of victim services for: a) all victims of domestic abuse

We want to see services which meet the needs of the whole family, and commissioning which looks across the piece to assess and address these through a broad framework, underpinned by a statutory duty to provide community-based services. This must include commitments to support small specialist services as well as larger services, to ensure the needs of all victims,

[17] SafeLives (2020), *Connect CYP: at 2 years of service delivery*. Available at: https://safelives.org.uk/sites/default/files/resources/Beacon_Children_Young_People.pdf
[18] SafeLives (2021), *New research confirms support for ground-breaking approach to domestic abuse.* Available at: https://safelives.org.uk/uclan-evaluation-report-2021
[19] https://www.monkeybob.org.uk/

including people with protected characteristics and those who might be less visible to services, are fully met.

The commissioning landscape should be underpinned by some simple key principles:

- A transformation of systems, processes and responses;
- Better support for children and young people who live in fear;
- Creating long-term change, not short-term fixes;
- Disrupting those that abuse, perpetrators challenged and held to account;
- Engaging the 'whole family' means more opportunity to make people safe, sooner;
- Families do not operate in silos, and neither must we.

We want to see:

- **Survivor voice in commissioning – co-creating solutions and approaches;**
- **A duty to provide community based services, including sufficient Idvas to meet the needs of all victims at the highest risk of serious harm or murder, and sustainable funding to enable this;**
- **A public health approach to addressing DA;**
- **Appropriate services for children;**
- **Appropriate services for people with protected characteristics (see answer to Q26);**
- **Appropriate services for perpetrators;**
- **All quality assured and accredited where possible**
- **Effective consideration and appropriate action undertaken to improve collaboration between different agencies, so that the challenges of agency join-up are not experienced as disconnect (or even contradiction) by people using those services;**
- **Greater oversight by inspectorates, including more JTAIs which look at a joint plan for cross agency monitoring;**
- **Greater understanding of DA across all frontline responders, through cultural change training;**
- **The pooling – or, at minimum – coordination of local budgets (see below);**
- **Long-term, sustainable funding.**

Coordinating local budgets

SafeLives' work in local areas in the past has shown Local Authorities, PCCs and other partners sometimes operating with dozens of individual budget lines which relate to domestic abuse, without a joint understanding of what impact that cumulative funding should have or how it could go further if tiny, short-term budgets were built into more strategic pots of money.

In one area where we worked, we found that governance structures were not in place to effectively plan, commission and evaluate services for domestic abuse. This meant that the area was lacking a coherent commissioning framework which might foster wider participation. The result was that domestic abuse services were chronically underfunded:

- Comparative data from a number of local areas found that spending per police incident, at £120 per police incident, was the lowest we had seen and well below the range of £146 to £236 per police incident that we had found in other areas;
- Idva funding was at the lower end of the £27 to £102 per police incident rate that we had found elsewhere;
- The funding per service user for domestic abuse fell well short of that for other cross-cutting social issues at £820 per victim. The comparable figures for drug and alcohol services were £2,600 per service user, and mental health services at £17,000 per service user.

Moreover, there was very little funding or provision from public health, the CCGs or council services for children. This left providers patching together multiple insecure and fragmented funding stream. We found that there were too many small grants for individual posts or projects which were awarded in isolation, rather than planned within the context of the whole system, and the needs of the whole family.

In another area, we found a*lmost 50 separate and uncoordinated funding streams*, which we believe dilutes the potential impact of the funding. Additionally, there were marked variations in levels of expenditure for community-based domestic abuse services, from £31 per police incident in one borough to £79 in another. Local authority funding for refuge and some outreach services ranged from 100% of

the total spent in one borough, to 34% in another. The remaining funding for other domestic abuse services was piecemeal and insecure.

The Government should incentivise more coordination between the budgets of LAs, PCCs, local health and education bodies, and – importantly – role model this at the national level.

Survivor voice in commissioning

It is crucial that survivors and victims are heard in the commissioning process.
When we consulted SafeLives Pioneer survivors (experts by personal experience) for this response, they told us they want commissioners to listen to what survivors actually want and need, rather than taking a paternalistic approach and 'deciding for them'. One Pioneer who is a Victims' Representative in a local body explained that the commissioners should "want to build the services victims are asking for," and called for co-creation with survivors.

Where survivor voice is represented in the commissioning process, it too often depends on the personality of individuals who have the time and energy to fight for their voice to be heard. Instead, survivor voice should be built in, at the 'heart and start' of commissioning.

To avoid tokenism, there must be authenticity and a genuine will to listen to survivors and act on their ideas and feedback. Survivors must be believed and validated when they explain what they need from frontline services and statutory agencies. SafeLives' Beacon sites identified this as a priority early on, and survivor involvement at the earliest stage resulted in more effective service provision and outcomes for families.

"I just felt that I was being listened to and what I was saying was being acted on, so it was very much sort of led by me" (Adult survivor, Beacon site)[20]

A duty to provide community-based services

Throughout the passage of the Domestic Abuse Act 2021, we worked alongside other leading charities from the domestic abuse and Violence Against Women and Girls (VAWG), and Children's sectors, Police and Crime Commissioners, and a number of Royal Colleges. Collectively, we raised grave concerns regarding the Part 4 duty on local authorities to support victims of domestic abuse in accommodation-based services.

While we welcome the aims of the duty, Part 4 excluded community-based support services and, as such, we warned that it would create a two-tier system where services used by the majority of victims (around 70%), including child victims, risked losing support whilst accommodation-based support was prioritised.

Although too recent to have been fully evaluated, anecdotal data from frontline community-based services has highlighted that our fears of a two-tier system are coming to light. When asked in a call in October 2021, the majority (53%) of frontline practitioners disagreed that community-based services have parity with accommodation-based services in their local area; three quarters (75%) disagreed that funding is as secure and sustainable for community-based services as it is for accommodation-based services in their local areas.

By restricting the scope of the duty to only cover accommodation-based support alone, a crucial opportunity has been missed to provide a holistic response to VAWG which addresses the whole family.

The Victims' Bill is a key opportunity to rectify the current situation and ensure that all victims of domestic abuse and sexual violence can access the support they need to become safe and to recover.

Community based domestic abuse services are essential for supporting adults, children and young people who are experiencing domestic abuse at home or in their own relationships; and preventing abuse by working with those who are abusive in their relationships. Specialist support led 'by and for' Deaf and disabled, LGBT+, older, Black, Asian, and racially minoritised, and migrant and refugee

[20] SafeLives (2021) *What Does Good Look Like? Responding to domestic abuse*. Available at: https://safelives.org.uk/da-response-beacon-sites-blog

victims is also essential in responding to the additional barriers such groups face and to meeting their specific needs.

Community-based services also provide a critical pathway for victims who need to move into refuge, and long-term 'step down and recovery' support when women and children leave refuge and resettle into the community.

It is vital that community-based services are placed on the same statutory footing as accommodation-based services. We recommend the Victims' Bill places a duty on all relevant public authorities to commission specialist domestic abuse support services for all persons affected by domestic abuse, with an accompanying non-legislative package of appropriate funding.

This would:

- Provide support to all victims and survivors, including children, no matter where they live and regardless of their status, through community-based services alongside accommodation-based services, including 'by-and-for' services.
- Provide programmes to challenge perpetrator behaviour and prevent repeat victimisation.
- Apply to all relevant public authorities in line with the current commissioning landscape, including PCCs and Local Authorities.

A full spectrum of services allows women and their children to stay connected to their mortgage, job, friends, family, GP, school and wider life rather than having to relocate and leave all this behind.

In the 21st century, it can't be right that our aspiration only goes so far as to expect women to go and live behind locked doors in institutional accommodation with other traumatised families. We want the Government to support the right of someone who has experienced abuse to stay where they feel most 'at home', which may well be in their own surroundings, safely.

With the right provisions in this Bill, that is possible.

Even prior to the introduction of the Part 4 duty, refuges received around 85% of funding available at the local level to respond to domestic abuse, but most (conservatively estimated, 70%) victim/survivors who seek help access other kinds of services that are provided in the community. Community based support includes specialists such as Idvas, outreach workers, helplines, counselling services, and young people and children's workers. Last year alone, over 75,000 adults (96% women) and more than 95,000 children received support through dedicated multi-agency support via Maracs. Around 11,000 bed spaces were used in a refuge – it isn't clear how many individual women and children this represents.

Our most recent data highlights that there is only 66% of the required number of FTE Idvas in England and Wales to meet the needs of victims at the highest risk of serious harm or murder and this level has fallen for the first time since 2016.

Our practitioner survey from 2020-21 shows the number of Idvas is over 400 fewer than the minimum number required (at least 1,200) to meet the needs of victims and survivors at high risk of serious harm or murder. In 2016, there was 67% of the required coverage for Idva provision, and this rose to 74% in 2017 and remained stable at 74% in 2019.[21]

We welcome the MOJ's recent investment in Idvas and Isvas, with the ambition to recruit at least another 400, and look forward to seeing the impact of this additional funding, and confirmation that it has provided new *additional* posts, as opposed to funding existing provision as annual funding cycles concluded. We want to see Idva provision for victims at the highest risk maintained at a minimum number of 1200+ per year in England and Wales, alongside other forms of advocacy for other victims and survivors.

At the same time, there has been a 31% increase in the number of cases heard at Marac in 2021 compared to 2017 to 116,383. The increase in Marac cases across England and Wales means that the

[21] SafeLives (2021), *SafeLives' 2020/21 survey of domestic abuse practitioners in England and Wales*. Available at: https://www.safelivesresearch.org.uk/Comms/2020_21%20Practitioner%20Survey%20Final%202.pdf

recommended number of Idvas required to support victims at the highest-risk of serious harm or murder also needs to increase to meet the demand.

Our practitioner survey showed only three police force areas have the minimum required number of Idvas, while 14 have less than 50%. In 2019, ten force areas had 90% or more of the recommended coverage, so the number of areas with this better level of coverage has decreased. There are 14 police force areas with less than 50% of the recommended Idva coverage, four of which have less than a third. These numbers have increased since 2019, when nine police force areas had less than 50% and three had less than a third of the recommended Idva coverage. To note, Idvas are separate to any criminal justice agency or the criminal justice system; we use 'police force area' as an easy unit of currency.

We also estimate that a minimum of 7,000 outreach workers / Idvas working with victims at medium risk, holding a caseload of 100 per year, are needed to support victims and survivors below the high-risk threshold for Marac in England and Wales.[22] There are currently no reliable figures available for the number of frontline workers in this category.

Lack of sufficient and secure funding in the system remains an overriding concern. Funding constraints were a problem for many services long before the start of the Covid-19 pandemic. Our 2019 Practitioners Survey highlighted that it was necessary to increase long-term funding in order to improve this provision of support services.[23] In the same report, domestic abuse services were asked their views on the reasons behind the lack of services for perpetrators, and 60% of respondents said that lack of funding was the biggest barrier to implementing these services.

Domestic abuse funding has declined sharply in the last decade as national and local budget holders make savings to meet shortfalls.[24] Statutory services are thinly stretched, whether those are early intervention programmes for children in need or community mental health services, and the funding cycle continues to be short term and not sustainable. Meanwhile, the volume of reported domestic abuse cases is increasing year on year. Our 'A Safe Fund' report from September 2020 sets out a recommended funding picture.[25] Though we recognise the figures in there represent a best-case scenario, we welcome steps towards a fully funded response for adult and child victims and perpetrators.

A public health approach to addressing the needs of the whole family

The current system of support for domestic abuse victims is fragmented, complicated and inconsistent.

Our One Front Door pilot from 2016-2019 provided valuable evidence of some of the problems which exist in multi-agency working.[26] This included: structural differences between areas; a plethora of different multi-agency responses ranging from Marac, MASH, MAPPA and VRUs, with the same exhausted professionals going to multiple meetings; short-term, piecemeal commissioning for specialist services; lack of understanding of coercive and controlling behaviour; cases not managed collaboratively so no one joins the dots for families; services are siloed, with poor knowledge of one another's expertise; triage seen as child safeguarding process primarily; making decisions in isolation and only at a high threshold, and information not shared cumulatively. Typically, families had come to

[22] This calculation was done at the police force area level starting with the total number of domestic abuse victims. Using the Crime Survey for England and Wales prevalence data, we subtract the number of non-repeat cases heard at Marac from the total and then use those who told a support professional or organisation about partner abuse as a proxy for those who would wish to access support. This allowed us to determine the total number of people who should be 'visible' to services.

[23] SafeLives, (2019) *SafeLives' 2019 survey of domestic abuse practitioners in England and Wales*. Available at: https://safelives.org.uk/sites/default/files/resources/SafeLives%e2%80%99%202019%20survey%20of%20domestic%20abuse%20practitioners%20in%20England%20&%20Wales.pdf

[24] UK Women's Budget Group (2019), *Women and the Spending Review*. Available at: https://wbg.org.uk/wp-content/uploads/2019/04/spending-review-briefing-final-29- 08-19.pdf

[25] SafeLives (2020), *A Safe Fund: costing domestic abuse provision for the whole family*. Available at: https://safelives.org.uk/sites/default/files/A%20Safe%20Fund%20costing%20domestic%20abuse%20provision%20for%20the%20whole%20family%20in%20England%20and%20Wales_0.pdf

[26] SafeLives (2019), *Seeing the Whole Picture: An evaluation of SafeLives' One Front Door.* Available at: https://safelives.org.uk/sites/default/files/resources/Seeing%20the%20Whole%20Picture%20-%20An%20evaluation%20of%20SafeLives'%20One%20Front%20Door.pdf

Mash or CSC *four times before*, while multiple agencies were making interventions with families but not identifying domestic abuse.

The pilot brought agencies together to assess risks to people's safety and look at the needs of the whole family at the same time. Evaluation showed clear improvements in multi-agency working including:

- Multi-agency work became more collaborative and effective;
- There was an increase in parity of esteem between specialist agencies (often voluntary) and large statutory partners which deepened engagement between them;
- There was a shift from multi-agency teams administering information to them bringing specialist expertise and meaningful analysis to bear on all information.

In-depth analysis in individual sites found:

- Better information sharing resulted in 17% of risk assessments uprated, as agencies better understood the picture of risk an abusive individual posed;
- In the first four months of One Front Door implementation, 31% of police contacts progressed to social care assessments from 3% in previous year;[27]
- The number of contacts which were not closed with 'No Further Action' increased by 25% for the same time periods, indicating more meaningful action being taken by practitioners because they were able to see a fuller picture of what was happening for an individual or family.

In order to properly tackle domestic abuse, all parts of the issue need to be tackled, addressing the needs of the individual and the whole family – whatever 'family' means in that instance and including extended family members who are often drawn into abuse through contact with the primary perpetrator or primary victim. This entails:

- seeing and responding to the whole person, understanding linked adverse experiences and individual characteristics and situations;
- 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.

Since developing and delivering the One Front Door pilot, we have developed our approach to whole family working and adopted a public health approach with over 40 areas. The public health approach uses four simple steps to define and monitor the problem, identify risks to safety, and protective factors, develop and test responses that increase safety, early intervention and prevention strategies, then implement at scale.

It should involve effective multi-agency partnerships so organisations can work together to deliver effective support to a family, underpinned by long term funding. Commissioning should include intensive family support which allows for longer-term interventions with families, including step-up and step-down support. It should build on learning from existing programmes and initiatives such as the Supporting Families programme (formerly Troubled Families) and 'the Hertfordshire model' of family safeguarding (but both of which are primarily about outcomes for children), and allow support to take a more flexible approach, recognising that families will have spectrum of needs at different times.

A holistic approach to tackling domestic abuse is the most effective way of building stronger families and sustainable safety. Effective community-based domestic abuse services who work with the whole family - child, adult victim, perpetrator - already exist and we encourage the Government and commissioners to promote and replicate such models, investing for the *long* term, building an evidence base through appropriate data collection, iterating and continuing to listen to people with personal experience.

Appropriate services for children and young people

[27] It is not clear how much of this increase was as a result of having a better picture of the risks and needs within the family, and how much was due to the lack of alternative outcomes as it was not possible to track the outcome of these assessments.

Children are too often 'hidden victims' of domestic abuse, which has devastating effects on their wellbeing (mental and physical), educational outcomes, and likelihood of entering abusive relationships. SafeLives Insights dataset for children and young people shows material increased risks of other adverse experiences for children and young people living with abuse at an early age. Those risks include self-harm (including suicidality), risk-taking behaviours such as smoking, taking drugs, gang involvement and early pregnancy, and increased vulnerability to other crime types such as child sexual exploitation. Currently, these links are very poorly addressed by the siloed and minimal provision which is funded, and often funded outside the specialist domestic abuse sector, with children's and youth work charities. These charities have a crucial role to play, but some need a great deal more training and information, as well as closer links with specialist DA charities, to play an effective role.

With children explicitly referenced and recognised as victims in the DA Act, we want to see much greater provision of high quality services which meet their needs, both as children experiencing DA within families and as young people in their own intimate relationships.

And that need is significant. Analysis by the Children's Commissioner, pre-COVID-19, found that 831,000 children in England are living in households that report domestic abuse. Domestic abuse remains the most common factor amongst children assessed as 'in need' by local authorities in England. Radford et al. 2011 found that 26% of the 0 to 17-year-olds who had witnessed domestic abuse had witnessed one parent being kicked, choked or beaten up by the other parent.[28]
In 2021, SafeLives calculated the system actual 'cash costs' of dealing with the impact of domestic abuse for just the children associated with victims at the highest risk of serious harm or murder (144,000 children in 2020-21). This is around £500m pa, across police, healthcare, social services, education and youth crime.[29] These figures were presented to colleagues in Whitehall; unfortunately, they weren't used in CSR decisions by the Treasury but there is still time to use this data to develop progammes and policy.

Early intervention and support are essential to address the human harm and the extensive long term cost.

Current provision of specialist support for child and teenage victims of domestic abuse is threadbare and patchy. Action for Children found that children faced barriers to accessing support in two-thirds of the local authorities in England and Wales which took part in the research, and over 10% of these had no specialist support services available for children at all.

We want to see further investment in Young People's Violence Advisors (Ypvas) who work with young people experiencing abuse in their own intimate relationships, specialist children's workers and therapeutic support for those children who are visible to services. We know that establishing relationships over a longer period is necessary when working with children and young people, and Idva services usually only have capacity for short term support until the risks are reduced, which often isn't appropriate with young victims. As above, we also believe there needs to be dedicated training and guidance for those working in children's and youth work charities who might be in a position to form trusted relationships before domestic abuse has been explicitly recognised as an underlying problem in that young person's life. This combination is why the number of Ypvas we suggested below is relatively tiny.

The estimated costs of provision as shown in A Safe Fund are broken down as follows: [30]

Provision	Cost (per annum)
Ypvas x 50	£2.5m
Specialist children's workers x 4650	£232.2m
Specialist therapeutic support for children	£97m
TOTAL	**£331.7m**

[28] Radford, L. et al. (2011) Child abuse and neglect in the UK today. London: NSPCC.
[29] SafeLives (2021), *Investing to save: Domestic abuse and the CSR.* Available at: https://safelives.org.uk/sites/default/files/resources/SafeLivesSubmissiontotheCSR2021.pdf
[30] SafeLives (2020), *A Safe Fund: costing domestic abuse provision for the whole family.* Available at: https://safelives.org.uk/sites/default/files/A%20Safe%20Fund%20costing%20domestic%20abuse%20provision%20for%20the%20whole%20family%20in%20England%20and%20Wales_0.pdf

Joint Targeted Area Inspections

We want to see greater focus on oversight of cross-agency working.

The 2017 JTAI on domestic abuse was a fantastic piece of work: co-operation between Inspectorates meant that it was genuinely cross-agency, and SafeLives was grateful for the opportunity to be closely involved and to support the process. However, we are not confident that the excellent content and recommendations from the report have translated into practice and fully adopted by the relevant agencies.

With the next round of JTAIs underway, we recommend a joint plan for cross-agency monitoring and scrutiny. Failing such a plan, agencies are likely to revert to siloed ways of working without taking adequate notice of any new recommendations.

Frontline professionals, including Children's Social Care, frequently agree with recommendations around turning the focus on to perpetrators of domestic abuse, recognising their harmful behaviour as an active parenting choice, rather than holding victims of domestic abuse to account for the impact of the abuse.

However, even when they do agree, they tell us that they are left without the tools to tackle perpetrator behaviour. A key finding of the 2017 JTAI was that the workforce lacked the confidence and skills to work with perpetrators of abuse, and we know this is still a major blocker today, almost 5 years on from the JTAI. Our findings from our pilot Whole Picture Children's Social Care Training showed that only 40% of respondents before training felt confident in understanding the tactics perpetrators use to keep their victims within a relationship;[31] after training, this rose to 92%.

These professionals need cultural change training, guidance and advice, and genuine systems change to make the powerful JTAI recommendations a reality. In some cases, professionals have told us that the current tools available to them and the systems in which they work pull in the opposite direction. Strategic leads and those in middle management positions in CSC must fully buy in to this change and work to implement the recommendations.

Integrated Care Systems and the opportunity to improve commissioning

As the NHS begins to transition away from CCGs and to Integrated Care Systems (ICS), there is a key opportunity to ensure domestic abuse is addressed as part of a public health approach to violent crime. ICSs have the potential to embed a joined-up collaboration between health and social care alongside the commissioning of domestic abuse services. According to The King's Fund, this will create "better outcomes and a less fragmented experience for patients and users."[32]

Commissioning domestic abuse interventions falls squarely within Domain Five of the Commissioning Outcomes Framework, "treating and caring for people in a safe environment and protecting them from avoidable harm."[33]

We recommend that ICSs should invite health and social care partners to utilise commissioning that addresses the whole picture for victims of domestic abuse as a key tenet of their commissioning model. For some health authorities, this will mean they will be able to proactively plan service provision in order to support the whole family – adult, teen and child victims and perpetrators - in a preventative manner, as opposed to working in a solely reactive way, solving the various issues as they arise.

In order for this to happen, ICSs need to proactively support multi-agency partners, particularly VAWG third sector specialists, to help them understand the health system and identify key decision makers. This will allow both commissioners and practitioners to work in a more unified way, creating cross-agency initiatives rather than commissioning in silos. Domestic abuse professionals are experts in

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[31] SafeLives (2020), *Domestic Abuse: The Whole Picture – Pilot evaluation.* Available at: https://safelives.org.uk/sites/default/files/resources/Whole%20Picture%20Children%27s%20Social%20Care%20professionals%20cultural%20change%20evaluation.pdf

[32] The King's Fund (2020), *Integrated care systems explained: making sense of systems, places and neighbourhoods.* Available at: https://www.kingsfund.org.uk/publications/integrated-care-systems-explained

[33] NHS Digital (2020), *About the NHS Outcomes Framework (NHS OF).* Available at: https://digital.nhs.uk/data-and-information/publications/ci-hub/nhs-outcomes-framework [Accessed 04/03/21]

safeguarding, safety and understanding trauma, which could be of great value to NHS professionals if they only had the capacity and the opportunity to share it. We want to see NHS Trusts proactively reach out to their specialist community-based service delivery partners to create a system and services which work for all.

We also want to see health partners think creatively about the data they use to evidence their commissioning. If ICSs only consider data that is presented to them via criminal justice routes, they are likely to miss victims using their services without recourse to criminal justice agencies for example Black, Asian and racially minoritised victims. Instead, ICSs should be utilising the experiences of survivors to help drive and co-create the services in their area, as well as safeguarding data and that from local multi-agency partners, in the same way we recommended PCCs and LAs work with survivors to co-create change.

Question 26a: What can the Government do to ensure that commissioners are adequately responding and implementing the expertise of smaller, 'by and for' organisations in line with local need?

It is well established that victims and survivors of domestic abuse with protected characteristics are best served by specialist by-and-for services. As the Government's VAWG Commissioning Framework highlights, "investment in BME-led specialist organisations has been shown to deliver significant financial savings as well as a range of social benefits and outcomes for service users."[34] These services often provide additional support such as welfare advice, language interpreters, specialist counselling, and will work with victims and survivors for much longer periods of time.

These specialist, holistic services providers can incur higher running costs and, as a result, are disproportionately disadvantaged by the local commissioning and funding process. Too often local commissioners fail to commission multiple specialist services required to meet the needs of a diverse population with many favouring more generic providers who deliver larger, cheaper contracts, but are unable to deliver the same level of tailored support. When there is a lack of a critical mass of service users within a defined geographical area, the commissioning structure often discourages specialist services from applying. The commissioning of one single service often means that specialist by-and-for services are ineligible to apply.

The Domestic Abuse Commissioner has shared that initial findings from her mapping research found that community-based services provided by specialist by-and-for organisations were five times more likely to not be in receipt of any statutory funding compared to other types of organisations.

In order to ensure that by-and-for services are available for victims of domestic abuse and wider VAWG crimes, commissioners must be encouraged to see the value in commissioning culturally informed, specialist services and funding streams should be specifically established nationally and locally to ensure the often intersecting needs of victims with protected characteristics are met.

Galop's research, *Recognise & Respond*, suggests that among those accessing LGBT+ specialist services, at a minimum one in three discloses one form of disability or a health problem and around 40% identify as Black, Asian or racially minoritised. [35]

"I would think that, because it doesn't explicitly say they support LGBT people, then we're not welcome at that service". **LGBT young person, Voices Unheard Project at LGBT Scotland.[36]**

34 Home Office (2016), *Violence Against Women and Girls Services: Supporting Local Commissioning*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/576238/VAWG_Commissioning_Toolkit.pdf

35 Galop (2020), *Recognise and Respond: Strengthening advocacy for LGBT+ survivors of domestic abuse.* Available at: https://galop.org.uk/wp-content/uploads/2021/05/Galop_RR-v4a.pdf

36 SafeLives (2018) *Free To Be Safe: LGBT+ people experiencing domestic abuse.* Available at: https://safelives.org.uk/knowledge-hub/spotlights/spotlight-6-lgbt-people-and-domestic-abuse

Much research has been undertaken to assess the costs of domestic abuse to victims, the state and wider society.[37,38] What is less well understood is how much it would cost to provide specialist domestic abuse services for the whole family – adult and child victims of abuse, as well as people using abusive behaviours.

SafeLives' *A Safe Fund* costings exercise calculated the cost of providing specialist domestic abuse services to *all* victims in England and Wales – including adults, teenagers and children, alongside provision for perpetrators of abuse, and with significant investment in cultural change training programmes for frontline professionals. We also included costs for a public health campaign and funding for helplines/online support.

We estimate that £2.2bn of spend would be required to transform the response to domestic abuse in England and Wales.[39] In particular, we estimated a cost of £30m per annum to fund specialist regional by-and-for hubs with specific expertise to support Black, Asian and racially minoritised survivors, LGBT+ survivors, and Deaf and disabled survivors. Crucially, this is in addition to, not instead of, population-based provision which means that everyone with a need can get a service. In *A Safe Fund*, we suggested this baseline need for minoritised survivors should be met, *plus* additional regional hubs which would add further funding and capacity on top of the 'by and for' elements of frontline provision, securing specialist response even in parts of the country which might be struggling to provide fully representative provision for very small minority communities in their area.

Imkaan estimate the total cost of delivering specialist support services in the Black and minoritised women and girls sector to be £97,085,661, annually. This cost includes an inflationary increase of 3.20% and the funding shortfall of 39%. The annual cost of providing refuge services total £13,253,569. The annual cost of delivering trauma-informed wrap around holistic support services total £83,832,092.[40]

Specialist by-and-for regional hubs

There is an urgent need to develop provision in every region for specific groups of victims. However, more detailed work is still required to do justice to this area of provision. Having explored the issues with key by-and-for services, noted below, we have created the same nominal amount of £10m for each of the following characteristics – race (Black, Asian and racially minoritised survivors), LGBT+ survivors, and disabled survivors. £1m would be allocated per English region, plus Wales. As above, this is *as well as* localised frontline provision from by-and-for services, these hubs would be a means of securing specialist input even to parts of England and Wales where minority communities might be very small in number.

This figure has not been disaggregated on the basis of prevalence or regional population data. Instead, we have sought to provide baseline funding to reflect the need for regional hubs for these services, who would provide a frontline service for some clients who cannot access any other by-and-for service in their area. The hubs would also act as specialist centres providing training to other domestic abuse services and multi-agency partners in their region, ensuring that staff understand the needs of their survivor group and can respond appropriately. They could also act as representatives on commissioning and strategic groups and help to support other more local by-and-for services to set up their service and flourish and raise the profile of those specialist services. At the moment, by-and-for services are being asked to do all of these things, but without adequate recognition and remuneration.

We recommend that the specialists in these areas are funded to undertake further exploration of these costs and needs, and also that attention is paid to their existing research and analysis on this subject.

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[37] Walby, S. (2009), *The Cost of Domestic Violence: Up-date 2009*. Available at: https://eprints.lancs.ac.uk/id/eprint/88449/1/Cost_of_domestic_violence_update_4_.pdf

[38] Home Office (2019), *The economic and social costs of domestic abuse: Research report 107.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772180/horr107.pdf

[39] SafeLives (2020), *A Safe Fund: costing domestic abuse provision for the whole family*. Available at: https://safelives.org.uk/sites/default/files/A%20Safe%20Fund%20costing%20domestic%20abuse%20provision%20for%20the%20whole%20family%20in%20England%20and%20Wales_0.pdf

[40] Imkaan (2021), *Correspondence to the Chancellor of the Exchequer.* Available at: https://static1.squarespace.com/static/5f7d9f4addc689717e6ea200/t/616fd074665a2d2349bde2a2/1634717812655/Imkaan+CSR+Lttr+Representation_Signed+30.9.21.pdf

Question 26b: Should national commissioning play a role in the commissioning framework for smaller, 'by and for' organisations?

We recognise the challenges for local commissioners in identifying and funding small, hyperlocal or highly specialist services, **so recommend a national commissioning framework with ring-fenced funding to ensure these vital services are supported, with a grant fund allocated specifically to PCCs to commission for groups likely to be less visible to, or appropriately served by, larger or more mainstream services.**

Question 27: What can local commissioners (local authorities and PCCs) do to improve the commissioning of specialist 'by and for' services for their area?

SafeLives recently commissioned research to identify how we could be a better ally to small, specialist organisations. As part of that work, we conducted qualitative interviews with commissioners and funders. They observed that commissioning for small and/or specialist organisation is a very different style to other funding, focused more on relationship building compared to commissioning larger mainstream services and requiring more time to do this effectively. Funders wanted clear demonstrations from grassroots organisations that they are responding to the needs of their community and felt that this was more important than funding services with healthy finances or quality marks, so long as the service was providing quality support.

This view about quality marks was indicative of how they saw small and/or specialist services' policies and infrastructures, choosing to focus more on track record of delivery. The only exception to this was in relation to safeguarding, where commissioners and funders placed significant importance. In terms of monitoring, evaluation, and impact measuring, many of the interviewees volunteered that data collection by small services is not very rigorous and were eager to find a way to evidence the impact of their funding of these services without putting lots of pressure on the grantees.

Funders recognised the value of small and/or specialist services extends beyond the money into social value. The interviewees noted that there is a lot of additional work that extends outside of the specifications in the bids, such as education and awareness raising, which is critical in making sure social change is happening within the community. Understanding the true value of small and/or specialist services must take into account and consider the depth and breadth of services that they deliver.

However, funders also recognised that quality assurance processes for small specialist organisations aren't as robust as they would like and noted a role for organisations like SafeLives in helping to develop this. They would welcome a set of standards that would not burden front line services but provide key information to funders and commissioners. They would also welcome guidance around safeguarding, setting out specifications for bids, and training standards to help guide their decision making and monitoring. They also wanted to see collaboration within the sector to develop joint or complementary standards to ensure a consensus.

We support these findings and, along with other national organisations in the sector and the Domestic Abuse Commissioner, will continue develop further work to help both commissioners and services around training, research, evaluation, governance and policy development. **We do not see a legislative need here but welcome Government investment in support for effective quality assurance.**

Question 28: What challenges exist for victims in accessing integrated support across third sector and health service provisions? What and how could practical measures or referral mechanisms be put in place to address these?

Please note, these same questions have been answered by the domestic abuse sector (and academics like Gene Feder, University of Bristol) on many occasions. There is a substantial body of evidence from A Cry for Health, Health Pathfinder, Whole Health London, PATH, PRIMH, Reprovide, and other pieces of work dating back nearly a decade which have all been provided to the Dept of Health and Social

Care in the past. It is disappointing and frustrating to be asked to spend time answering these same questions, putting forward this same evidence, again.

Challenges

Our Pioneer survivors tell us that, too often, health services are missing from the conversation, and this is echoed in referral data: only 4.3% of all Marac (Multi-Agency Risk Assessment Conference) referrals in the year to September 2021 came from primary and secondary care health agencies;[41] our 2020/21 Insights datasets show that just 4.9% of referrals to Idva services and 3.9% of referrals to outreach services were made by health services.[42,43]

This is despite the fact that there is a strong body of evidence – not least from our *A Cry for Health* (2016) report and more recent Drive reports – to suggest that adult victim/survivors, and adult perpetrators of abuse, are *much* more willing to disclose their situation in a health setting than in a setting that's linked to criminal justice.[44]

We want to see much greater involvement of DHSC and NHSE / NHS Wales, nationally, and health services, regionally and locally, in identifying, supporting and referring victims to specialist support. Health bears some of the greatest costs of DA, but spends little on prevention and early intervention.[45] We recommend a whole-health approach to tackling DA, drawing on the ground-breaking work of programmes like A Cry for Health, Pathfinder, IRISi, Whole Health London, and Drive in identifying new approaches to adults using or experiencing domestic abuse. We don't know of similar work conducted with a focus on children, at this point, but this should be explored.

Domestic abuse has long been classified a public health issue which has a devastating impact on morbidity and mortality of victims. When the cumulative impacts on mortality and morbidity are assessed, the health burden is often higher than for other, more commonly accepted, public health priorities. Each year, more than 2.3 million people aged 16-74 experience some form of domestic abuse in England and Wales. It is endemic in the United Kingdom and should be approached with the same seriousness and resource accorded to other public health harms, such as obesity and smoking. The links between suicide (of both victims and perpetrators) and domestic abuse are only just starting to be explored, through the good work of AAFDA, Jane Monckton Smith, and a number of Local Authorities. The Drive programme's data shows clearly the links between perpetrators of high-risk abuse and suicide, and significant health needs amongst their adult and child victims.

In our *Psychological Violence* report (2019), survivors told us about having reached out to a GP or other healthcare professional before they realised they were experiencing abuse. [46] Many told the healthcare professional about feelings of unhappiness, and/or physical symptoms including migraines or weight loss, which they did not recognise as negative effects of the psychological violence they were experiencing.

"The deeper the abuse went, and it was very psychological – I didn't have scars as such, you know…so, for me, I started losing rapidly weight…just from the stress of it, just being ill. And it was through the GP that she said to me…you're living in domestic violence'. I couldn't even fathom that, you know? 'No, no-no…and then, she put the seed into my mind, and I was thinking 'Ok, if I go with… if I accept what she says, then things make sense' because I was very confused" (Survivor)

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[41] SafeLives (2022), *Marac Data – Key Findings: October 2020 – September 2021.* Available at: https://safelives.org.uk/sites/default/files/resources/Marac%20Data%20Key%20Findings%20External%20October%2020%20to%20September%2021.pdf

[42] SafeLives (2021), *Insights Idva dataset 2020-21 Adult Independent domestic violence advisor (Idva) services.* Available at: https://safelives.org.uk/sites/default/files/resources/Idva%20Insights%20Dataset%20202021.pdf

[43] SafeLives (2021), *Insights outreach dataset 2020-21: Adult outreach services.* Available at: https://safelives.org.uk/sites/default/files/resources/Outreach%20Insights%20Dataset%20202021.pdf

[44] 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

[45] SafeLives (2021), *Investing to save: Domestic abuse and the CSR.* Available at: https://safelives.org.uk/sites/default/files/resources/SafeLivesSubmissiontotheCSR2021.pdf

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

As we highlighted in *Psychological Violence*, many studies have shown that psychological violence is associated with poorer physical health.[47,48,49,50,51,52]

Domestic abuse and suicide (2018) found that almost a quarter (24%) of Refuge's clients had felt suicidal and almost a fifth (18%) had made plans to end their life. 3.1% had made at least one suicide attempt. 83% of clients had felt despair or hopeless, which are key determinants for suicidality.[53] SafeLives Insights data has been indicating for years that stronger more effective referral pathways are needed between mental health and domestic abuse services, in particular, but without strong leadership from the Department of Health and Social Care, this will never become operational practice.

We have never seen a public statement, speech or policy announcement from the Secretary of State for HSC on the topic of domestic abuse. The topic is – completely artificially – split off from sexual violence, which has for a long time been recognised as DHSC 'business'. This arbitrary divide has no evidential basis and must be addressed if the suicides and other physical and mental health harms already visible in the system are to be reduced. Until there is more national leadership on the issue, we will continue to respond to consultations like this one reflecting on pockets of good practice led by a small number of dedicated individuals – for example in East Lancashire and in West London.

Findings in London's 2018-21 VAWG Strategy highlighted restricted time slots with GPs as a key barrier to disclosure.[54] Survivors feel there is not enough time to ask questions sensitively or disclose information about their experiences. Survivors also raised issues regarding a lack of training, and a lack of awareness in recognising the signs of abuse. This is especially true for survivors with certain protected characteristics.

Health care professionals must be equipped with the knowledge to recognise when symptoms may be linked to domestic abuse, the ability to enquire sensitively, and the pathways to ensure the survivor can access holistic support.

Healthcare professionals can play an essential role in responding to and preventing domestic abuse. They have the opportunity to recognise risk and share necessary information, identify abuse, intervene early, provide treatment, and signpost and refer patients to specialist services. This is one of the reasons for which, in guidance on domestic violence and abuse published in 2016, NICE included a quality statement to ensure "people presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion".[55]

Though domestic abuse is a crime, the criminal justice route should not be the only one available to victims when seeking help. For many victims, the criminal justice system is not an obvious site for disclosure Only one in five people experiencing abuse ever calls the police but victims will be accessing every hospital, GP surgery and mental health setting every day, while children and their parents will be being supported every day in CAMHS, health visiting services and school nurses.

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[47] 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.
[48] 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.
[49] 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
[50] 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.
[51] 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
[52] 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.
[53] 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
[54] GLA (2018), *A Safer City for Women and Girls: The London Tackling Violence Against Women and Girls Strategy 2018-2021.* Available at: https://www.london.gov.uk/sites/default/files/vawg_strategy_2018-21.pdf
[55] NICE (2016), *Domestic violence and abuse: Quality standard [QS116].* Available at: https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse

Some groups are particularly reticent to involve the criminal justice system. Four in five lesbian, gay and bisexual victims of domestic abuse have never reported these incidents to the police and, of those who did report, more than half were unhappy with how the police dealt with the situation.[56] Furthermore, Black, Asian and racially minoritised survivors may not report abuse to the police for a range of reasons, including concerns about the impact of stigma on their wider family or community, and feelings of distrust of the police due to past negative experiences and ongoing discriminatory practices. This can include concerns around the rates of injury and death of Black, Asian and racially minoritised people in police custody, resulting in victims of domestic abuse fearing that reporting a perpetrator is, in reality, handing them a death sentence.

Migrant survivors may experience language difficulties, and the 'hostile environment' policies related to immigration (and the risk of deportation) have also contributed to the reason why these victims of domestic abuse may not come forward.[57] Survivor testimonies have highlighted that perpetrators will often use their insecure immigration status as a way of controlling and threatening the victim.[58] It is for this reason, we have developed advice with Southall Black Sisters and others, for Maracs on prioritising safeguarding above all else.[59]

Criminal justice responses are often only initiated at crisis point, and while the response to domestic abuse has improved in recent years through better training of frontline personnel, multi-agency safety planning and strengthened legislation, there is still a greater need for a public health approach which prioritises early intervention and prevention.

Solutions - the need for a whole-health approach

A whole-health approach can address the issues raised by survivors' experiences. This means that commissioners must recognise GPs and mental health services as key points of contact with survivors, as must A&E – survivors cannot continue to present at the Emergency department only to be told they can't access help for "that relationship, mental health stuff." We want to see co-located Idvas in hospitals, mental health Idvas, and IRIS AEs in GP surgeries with simple referral pathways in place to ensure survivors are identified and can access an appropriate response to the abuse.

Routine enquiry into domestic abuse, accompanied by the time and space to listen to patients' responses, must become the norm. Practitioners must know the right questions to ask as many survivors are not aware that the 'relationship problems' they are facing constitute domestic abuse so it is better to ask "is everything okay at home?" or "do you feel safe?". This is especially true of younger people, who more readily use the language of "toxic", "controlling" or "manipulative" relationships rather than "abusive" or "harmful" relationships and "domestic violence."[60]

Moreover, a better understanding of the dynamics of domestic abuse, and of common myths regarding those experiencing it is clearly necessary to ensure that health professionals are equipped to respond appropriately.

By-and-for organisations have also pointed out the need for healthcare professionals to avoid assumptions based on myths and stereotypes about what abusive relationships look like.

For example, LGBT+ survivors have told practitioners of experiences in which healthcare professionals have written off abuse in same-sex or same-gender relationships as a "catfight," or with problematic

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[56] Stonewall (Undated), *Protecting lesbian, gay and bisexual people: A practical guide for police forces*. Available at: https://www.stonewall.org.uk/sites/default/files/police_guide_web_final.pdf

[57] EVAW & Imkaan (2020), *Access to Justice for Women and Girls during Covid-19 Pandemic*. Available at: https://www.endviolenceagainstwomen.org.uk/wp-content/uploads/Access-to-Justice-for-Women-Girls-during-Covid-19-Pandemic.pdf

[58] LAWRS (2019), *The right to be believed: Migrant women facing Violence Against Women and Girls (VAWG) in the 'hostile immigration environment' in London.* Available at: https://stepupmigrantwomen.org/research-righttobebelieved/

[59] SafeLives (2021), *Guidance for Maracs on sharing of information in relation to victims who may have insecure immigration status*. Available at: https://safelives.org.uk/sites/default/files/resources/SafeLives%20guidance%20for%20Maracs%20on%20sharing%20immigration%20information_0.pdf

[60] 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

phrases, including “boys will be boys.” For many LGBT+ survivors, there will be a ‘double disclosure’ in which they not only need to tell their story about the abuse they are experiencing, but, for many, it will be the first time they have told their GP or other health professional about their sexuality or gender identity. This can potentially put them at risk of discrimination.

Similarly, a practitioner working with Black, Asian and racially minoritised survivors highlighted that signs and posters in healthcare settings regarding charging procedures for migrants, alongside fears of information sharing with the Home Office, create an intimidating space in which migrant survivors do not feel safe, welcomed, or comfortable disclosing their abuse or their immigration status.

It is important to build health professionals’ knowledge and confidence in dealing with the needs of all victims and survivors, ensuring good understanding of the issues they may face and confidence in using inclusive language.

Once a disclosure has been made, the pathways must be in place for multi-agency responses to ensure survivors are not burdened with or overwhelmed by the need to navigate difficult systems and retell their story to myriad professionals with differing levels of knowledge around abuse.

Domestic abuse and mental health

A key element of a whole-health approach is the need to see the ‘whole person’ and administer to the full spectrum of their needs. We know that many survivors experience some kind of mental health impact as a result of experiencing abuse. Therefore, supporting these survivors to go on to live a life free of harm will often involve some form of mental health intervention and a joined-up approach which l links health and mental health services is essential.

There is a clear relationship between experiencing domestic abuse and having mental ill health symptoms. Time and time again, survivors have told us about difficulties in accessing joined-up support. Despite the high co-occurrence, the vast majority of cases go undetected in mental health services: research estimates that just 10 to 30% of cases are identified.[61,62] According to Sylvia Walby the mental health costs to the NHS of domestic abuse victims equates to £176 million each year.[63]

There are higher rates of domestic abuse amongst people who have mental health problems compared to those who do not.[64] Research supports the existence of a bidirectional relationship: domestic abuse can lead to mental health difficulties, and having mental ill health can render people more vulnerable to domestic abuse.[65,66]

This high level of correlation is also visible in those who are using high-risk abusive behaviours, as evidenced over the last six years through the Drive programme. This is not to say that having a mental health issue is a driver or excuse for domestic abuse, but the links are prevalent. What is less visible to the system (and therefore in data) is those perpetrators whose lives appear to be fully functional, and who therefore don’t appear in data about the use of abusive behaviour or mental health concerns. This might include, for example, those in higher socio-economic categories – an issue that should be explored further.

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[61] Howard, L.M., Trevillion, K., & Agnew-Davies, R. (2010). Domestic violence and mental health. International Review of Psychiatry; 22(5): 525-34. DOI: 10.3109/09540261.2010.512283.
[62] Trevillion, K., Corker, E., Capron, L.E. & Oram S. (2016). Improving mental health service responses to domestic violence and abuse. International Review of Psychiatry, 28 (5): 423-432. DOI: 10.1080/09540261.2016.1201053.
[63] Walby, S. (2004), *The Cost of Domestic Violence.* Available at: https://eprints.lancs.ac.uk/id/eprint/55255/1/cost_of_dv_report_sept04.pdf
[64] Trevillion, K., Oram, S., Feder, G., & Howard, L.M. (2012). Experiences of domestic violence and mental disorders: a systematic review and meta-analysis. *PloS one*; 7(12): e51740. DOI: 10.1371/journal.pone.0051740
[65] Oram, S., Khalifeh, H., & Howard, L.M. (2016). Violence against women and mental health. *The Lancet Psychiatry*, 4 (2): 159-170. https://DOI.org/10.1016/S2215-0366(16)30261-9
[66] Devries, K.M., Mak, J.Y., Bacchus, L.J., Child, J.C., Falder, G., Petzold, M., & Watts, C.H. (2013). Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies. *PLoS Med* 10(5): e1001439. DOI:10.1371/journal.pmed.1001439

Despite mental health issues often being symptomatic of domestic abuse for women, research has shown than less than a third of domestic violence cases are detected by psychiatric services.[67]

Crucially, training and better join up between health agencies can improve the likelihood that domestic abuse is recognised in mental health settings and that survivors receive the sensitive response and the support they need.

Once again, having an identity which includes protected characteristics, such as being Black, Asian or racially minoritised, Deaf or disabled, or LGBT+, can increase survivors' barriers to mental health services, and intersections of those identities can further compound those barriers. As one agency put it a decade ago in *Safe and Sane* (2010), "if you are a woman in the mental health service: it's bad, if you are a lesbian woman in the service then it's worse, if you are a black lesbian in the service, then forget all positive chances within mental health service provision."[68]

Access is particularly crucial for these survivors: for example, according to our report, *Free to be Safe,* LGBT+ survivors of domestic abuse are almost twice as likely to have attempted suicide (28% compared with 15%) and more than twice as likely to have self-harmed (32% compared with 14%).[69]

In a survey of LGBT+ people, 72% of respondents who had accessed or tried to access mental health services in the 12 months prior to the survey reported that it had not been easy. Over half (51%) of those who had accessed or tried to access them said the wait had been too long, more than a quarter (27%) had been worried, anxious or embarrassed about going, and almost one in six (16%) said their GP had not been supportive.[70]

Several practitioners raised the Improving Access to Psychological Therapies (IAPT) programme, which was introduced in 2018 to transform the treatment of anxiety disorders and depression in adults in England. According to one, there is a lack of join up between IAPT and domestic abuse services which, ultimately, leaves survivors unable to fully address the causes of their mental health needs. Another told us that, for many survivors, six weeks of talking therapy is not enough for survivors of domestic abuse. For some, six weeks is enough time to bring up more complex issues, but not to address them, and they therefore need to be referred on to services after to continue the work, especially around adverse childhood experiences or ingrained concepts of shame and honour. This means they will need to go through the often retraumatising process of retelling their story, and frequently will experience a waiting period between services due to a lack of capacity among specialist third-sector organisations. One Pioneer survivor (expert by experience) was advised against accessing counselling on the NHS as accessing six weeks' worth of sessions would be like "pulling a plaster off and letting the wound bleed," which would only leave her retraumatised.

Pioneers (experts by experience working with SafeLives) raised concerns around the acknowledgement and position of mental health within the health sector, noting "mental health is the very poor cousin in all of this when it should actually be the number one priority." Pioneers noted that there is an expectation on survivors to understand the system while recovering from their traumatic experiences. Many do not know that it is possible to self-refer into mental health services without seeing a GP, and even once that is known, survivors are expected to know which type of mental health support they would best benefit from; one Pioneer told us that she was just presented with a drop-down menu on an online form which gave her the choice of services such as psychological talking therapy or online CBT (Cognitive Behavioural Therapy), without any useful information as to what might be most helpful to her.

Moreover, several Pioneers have highlighted that CBT is often the only option offered to them but that, often, it is not delivered in a trauma-informed way. CBT focusses on changing the survivors' behaviours rather than centring on recovering from their experiences; it's about moving forward and not looking at

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[67] Howard, L.M., Trevillion, K., & Agnew-Davies, R. (2010). Domestic violence and mental health. International Review of Psychiatry; 22(5): 525-34. DOI: 10.3109/09540261.2010.512283.
[68] Siddiqui, H., Patel, M. (2010), *Safe and Sane: A Model of Intervention on Domestic Violence and Mental Health, Suicide and Self-harm Amongst Black and Minority Ethnic Women*. Available at: https://southallblacksisters.org.uk/news/download-safe-and-sane-report/
[69] SafeLives (2018) *Free To Be Safe: LGBT+ people experiencing domestic abuse.* Available at: https://safelives.org.uk/knowledge-hub/spotlights/spotlight-6-lgbt-people-and-domestic-abuse
[70] Government Equalities Office (2018), *National LGBT Survey: Research report*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721704/LGBT-survey-research-report.pdf

what has happened to the survivor. One survivor told us that her psychologist explicitly stated that CBT could be actively harmful to this survivor given the abuse she had experienced, but that CBT was the only therapy available in the CCG area and, therefore, she could not be referred to a more suitable therapy. In addition, too often, therapy is available on a short-term basis, of six weeks, which doesn't allow for survivors to truly recover. **There must be greater flexibility and the ability for survivors of any trauma to access much longer-term counselling and therapy. As one Pioneer told us: "we deserve some investment – we've had our whole lives ripped apart."**

Hospital-based Idvas

Hospital-based Idvas are a key method to ensure 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.

SafeLives 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.[71]

According to the Office for National Statistics: "around a third (33.1%) 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%) doing so at a GP or doctor's surgery, 36.4% at a specialist mental health or psychiatric service and 12.2% had gone to a hospital's Accident and Emergency department."[72]

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% compared with 23%);
- 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% 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%) were related to the abuse they were experiencing: nearly two thirds (64%) of visits were due to injuries directly caused by the perpetrator.[73]

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.[74]

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[71] 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

[72] 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

[73] 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

[74] 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

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. This works particularly well in the Angelou Partnership which has an LGBT+ Case Worker provided by Galop and funded by three London boroughs, Hammersmith and Fulham, Kensington and Chelsea and Westminster.

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 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, while hospital cleaners and porters might oversee abusive behaviour by a perpetrator.

Lack of long-term, sustainable funding

A primary barrier to creating a whole-health approach to domestic abuse is the lack of long-term and sustainable funding available for health-based domestic abuse interventions, and community-based services. The domestic abuse sector has been historically underfunded, and Covid-19 has created ever more pressure in terms of demand on services and complexity of cases. One frontline service manager told us that the increase during Covid in complexity of cases including survivors' mental health needs had led to a 25% increase in the amount of resource required to safely support clients.

Many of the interventions outlined in our Whole Health London report, '*We Only Do Bones Here'*, such as IRIS programmes or hospital-based Idvas, have proven effectiveness both in outcomes and cost.[75]

[75] SafeLives (2021), *'We Only Do Bones Here:' Why London needs a whole-health approach to domestic abuse*. Available at:

However, they are either not commissioned at all or, if they are, only commissioned on one-year funding rounds and the insecurity which accompanies that. Services told us in our roundtable event that the constant cycle of rebidding swallows up their capacity and reduces their ability to roll-out their services further. When funding ends for 'innovative' interventions and they aren't recommissioned, much of the expertise and crucial areas of learning that is developed over the course of the intervention is lost.

A systematic, whole-health approach would mitigate the risk of losing time and expertise which could be better used identifying, responding to, and supporting survivors and victims of domestic abuse.

As Gwen Kennedy, Director of Nursing Leadership & Quality at NHS England & Improvement, told us in one of our roundtables on the barriers to a whole-health approach, there needs to be a recognition in the NHS that these services need to be sustainably funded, rather than commissioners taking a 'one-off', project-based approach. Only through longer-term funding will services be effectively embedded within mainstream functions. Moreover, losing funding can impact clinicians' trust in the intervention itself, as they may not understand who made the funding decision and on what basis.

The need for greater integration of health and domestic abuse commissioning

Integration is key in a trauma-informed approach which seeks to minimise the retraumatising effect experienced by survivors when they are required to tell their story multiple times to different professionals. A Pioneer told us that, if services were properly integrated, a survivor would be able to tell their local service and then not need to tell their doctor, healthcare professionals at the hospital, etc. A survivor could know that they had told their story once and would then receive the adjustments they need to access healthcare.

According to the NHS Confederation, "it is clear that there is near universal support for creating a system of integrated health and care, which will be focused on population health, with greater investment and focus on community, primary care and mental health services. It is seen as the only way of creating a sustainable future for the health and the care system in the face of rising demand."[76]

Survivors want to see change and have regularly raised the issue of having to navigate complex systems themselves while recovering from the trauma of their experiences, sharing their stories again and again to different professionals. Health-based advocates can help to improve this experience, acting as the victim's voice with multiple agencies.

Gwen Kennedy highlighted the need to avoid a narrow focus on the NHS and instead to ensure the full involvement of local government, alongside voluntary and community-sector organisations, if ICSs are to realise the goal of improving population health and wellbeing.

As our *Cry for Health* (2016) analysis found, survivors who present in health settings – in this case, specifically hospitals – are more likely to have complex needs:[77]

- Mental health difficulties: 57% hospital, 35% local Idva clients;
- Alcohol misuse: 18% hospital, 8% local Idva clients;
- Drug misuse: 11% hospital, 5% local Idva clients;
- Financial difficulties: 40% hospital, 30% local Idva clients;
- Physical disability (incl. hearing & sight) or learning difficulty:12% hospital, 8% local Idva clients;
- Any of the above complex needs: 74% hospital, 58% local Idva clients;
- The 'toxic trio' (domestic abuse, mental health difficulties and alcohol or drug misuse): 20% hospital, 7% local Idva clients.

Some of these may have arisen as a consequence of their experience of domestic abuse, while others may be used as a coping mechanism.

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https://safelives.org.uk/sites/default/files/resources/%27We%20Online%20Do%20Bones%20Here%27%20-%20Why%20London%20needs%20a%20whole-health%20approach%20to%20domestic%20abuse_0.pdf

[76] NHS Confederation (2019), *Unfinished business: the need to invest in the whole health and care system.* Available at: https://www.nhsconfed.org/resources/2019/06/unfinished-business-the-need-to-invest-in-the-whole-health-and-care-system

[77] 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

Not only does this mean they would greatly benefit from better join up between agencies, but they are also potentially less able to navigate the disjointed system as it is now in order to access the range of services and support they will need. A well-functioning multi-agency approach is critical to ensuring we see and respond to the whole person, rather than just seeing them as a collection of disparate needs.

Effective multi-agency working is a core principle of the transition towards ICSs as a model of commissioning, and therefore the move presents a key opportunity to overcome this barrier. Some local authorities and NHS Trusts have already embedded elements of this approach, for example in co-locating Idvas and other domestic abuse practitioners in settings which span local domestic abuse services and statutory agencies including housing or health settings.

The Pathfinder pilot project which ran between 2017 and 2020 is a good example of this. Led by Standing Together as part of a consortium of expert partners including SafeLives, Imkaan, AVA, and IRISi, the project engaged nine CCGs and 18 NHS Trusts across England to implement sustainable interventions in eight local areas, which included: Haringey and Enfield, Camden and Islington, and the so-called "super council" of Westminster, Hammersmith and Fulham, and Kensington and Chelsea. One mental health Idsva (Independent domestic and sexual violence advocate) was quoted as saying: "through the co-locations and developing partnerships with mental health services, we identified engagement with survivors [with whom] previously we were unable to establish contact."[78]

This style of working can not only streamline the system for survivors and victims, but also improve the levels of information sharing between settings and agencies, as is so clearly necessary. In 46% of the London Domestic Homicide Reviews (DHR) featuring interpersonal homicides included in a MOPAC and Standing Together report, there was a lack of information sharing between health agencies. For DHRs featuring adult family homicides, 40% lacked information sharing between specifically health agencies, and 48% included missed opportunities to share information across the board.[79]

Chapter 4 – Improving advocacy support

Question 31: How do Idvas fit into the wider network of support services available for victims of domestic abuse?

Independent Domestic Violence Advisor (Idva)

What is an Idva:
An Idva is a specialist professional who works with a victim of domestic abuse to develop a trusting relationship. They can help a victim with everything they need to become safe and rebuild their life, and represent their voice at a Multi-agency Risk Assessment Conference (Marac), as well as helping them to navigate the criminal justice process and working with the different statutory agencies to provide wraparound support.[80]

Idvas are an essential element of the domestic abuse response.

An Idva is a specialist professional who works with a victim of domestic abuse to develop a trusting relationship to help an adult victim with everything they need to become safe and rebuild their and their children's lives, and advocate for them at a Multi-agency Risk Assessment Conference (Marac).

They can help them to navigate criminal justice processes (NB: if the survivor chooses to go through the CJS – Idvas will support many survivors who choose not to do so) and work with the different statutory and other voluntary sector agencies to provide essential wraparound support.

The most crucial aspect of the Idva role is their independence. They are there to advocate for the victim's wishes and best interests. Their role in all multi-agency settings is to keep the client's

[78] Pathfinder (2020), *Pathfinder Key Findings Report.* Available at: https://safelives.org.uk/sites/default/files/resources/Pathfinder%20Key%20Findings%20Report_Final.pdf
[79] MOPAC (2019), *London Domestic Homicide Review (DHR): Case Analysis and Review of Local Authorities DHR Process*. Available at: https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5f633ee1e0e0be6ec5b858a1/1600339696014/Standing+Together+London+DHR+Review+Report.pdf
[80] SafeLives (Undated), *What is an Idva?* Available at: https://safelives.org.uk/what-is-an-idva [Accessed 13/01/22]

perspective and safety at the centre of proceedings, which may or may not include the criminal justice system.

Idvas are highly valued by both victims and agencies alike. And their support works.

"My initial contact with the Idva was earth-shattering. She asked very specific questions in exactly the right areas and I couldn't believe how much she understood my situation."
Jane*, survivor of domestic abuse

Studies have shown that when victims at high risk of serious harm or murder engage with an Idva, there are clear and measurable improvements in their safety.[81] This includes a reduction in the escalation and severity of the abuse, and a reduction in – or even cessation of – repeat incidents of abuse.

Originally, Idvas worked only with victims at high risk of serious harm or murder, according to the codified definition of the role as we first created it. Due to the huge success of the role, Idvas' independence, and their focus solely on the safety and wellbeing of their client, the role has been adopted into different settings to meet different survivors' needs. This includes health-based Idvas and Court Idvas, who work across risk levels. Across these different settings, in working with different victims of domestic abuse, the core of the role has consistently remained the same: the Idva is independent from other statutory agencies; their sole outcome focus is the survivors' safety and wellbeing.

Idvas receive specialist accredited training and hold a nationally recognised qualification. They are most effective as part of an Idva service and within a multi-agency framework, and play an essential role at Marac.

We need more of them – at the last count we were 400 Idvas short of the minimum number needed to support victims at the highest risk of serious harm or murder in England and Wales. SafeLives has trained over 3,200 Idvas since 2006 and almost 500 service managers since 2014. Our most recent Practitioner Survey from 2020/21[82] shows around 800 FTE Idvas working with victims at the highest risk of serious harm or murder in England and Wales. This had fallen by 4% over figures for the preceding year – the first time this has happened – and is only around 66% of the total number required (estimated at around 1200 FTE). We also note that demand for this support is increasing. Marac data shows cases rising 6% in the last year, and 31% over the last four years.

We welcome the additional funding provided by MOJ for Idvas and Isvas and recommend this is sustained over the longer term to ensure victims are assured an effective, high-quality response.

There is no 'typical' profile of an Idva client: Idvas work with clients across different communities and with a range of protected characteristics. We do not believe there is any fundamental dichotomy between by-and-for services and Idva services, and many 'by and for' organisations are proud to employ trained Idvas.

As a leading trainer and accreditor of Idvas, we know that many specialist by-and-for services are keen to ensure their frontline practitioners are trained to the same high standard as mainstream services – and, crucially, that the survivors they work with receive the same high-quality service as survivors accessing mainstream services.

Many by-and-for services employ Idvas, including Idvas working with Black, Asian and racially minoritised women, and LGBT+ Idvas / Trans+ Idvas. These services are incredibly proud of the life-saving work the Idvas do every day with marginalised survivors, and to suggest there is a separation between the two is to ignore the very real experience and expertise of these practitioners. As Idvas tailor the support and response provided to the individual needs of each client, there is no reason that a marginalised survivor of domestic abuse should not receive support in the way that works best for their specific needs and experiences.

[81] SafeLives (2009), Safety in Numbers: a multi-site evaluation of Independent Domestic Violence Advisors. Available at: https://safelives.org.uk/sites/default/files/resources/Safety_in_Numbers_full_report.pdf
[82] SafeLives (2021), *SafeLives' 2020/21 survey of domestic abuse practitioners in England and Wales*. Available at: https://www.safelivesresearch.org.uk/Comms/2020_21%20Practitioner%20Survey%20Final%202.pdf

Serving as a victim's primary point of contact, Idvas normally work with their clients to assess the level of risk, discuss the range of suitable options and develop safety plans.

Idvas are proactive in implementing these plans, which address immediate safety, including practical steps to protect themselves and their children, as well as longer-term solutions. If the case reaches the threshold for the local Multi-agency Risk Assessment Conference (Marac), this will include actions from the Marac as well as sanctions and remedies available through the criminal and civil courts, housing options and services available through other organisations. Idvas tend to support and work over the short- to medium-term to put survivors on the path to long-term safety.

According to our Insights 2020/21 Idva dataset, the average case length for an Idva service is 15 weeks, up from 14 weeks and 12 weeks in 2019/20 and 2018/19, respectively.[83] A quarter of cases (24%) lasted six months or more. On average, clients received 14 contacts from the Idva, with 18% receiving 35 or more.

At intake, 77% of cases had ten or more ticks on the Dash Checklist, denoting a victim at high risk of serious harm or murder. 18% had between six and nine ticks (medium risk) and 7% had one to five ticks (standard risk). 74% of cases had a lower number of ticks on the Dash at exit compared with intake**. While the majority of Idva clients are victims at high risk, Idvas can also work with clients across a variety of risk levels and settings, including healthcare settings and Civil, Family, and Criminal Courts.** Idvas will tailor their work to each survivor's needs, most frequently working to address safety, housing needs, and mental health needs.

Needs & Support matrix – Idva services 2020/1								
	Needs		Support		Impact			
	Clients identified with needs		Support provided		Improved safety		Improved wellbeing	
Areas of need	Count	%	Count	%	Count	%	Count	%
Safety			2264	96%	1811	80%	1727	76%
Housing	1271	54%	962	76%	630	65%	646	67%
Physical health	286	12%	122	43%	83	68%	95	78%
Mental health	1205	51%	741	61%	466	63%	527	71%
Drug misuse	212	9%	110	52%	69	63%	70	64%
Alcohol misuse	239	10%	109	46%	66	61%	69	63%
Children/parenting	573	24%	371	65%	239	64%	229	62%
Finance, benefits and debt	634	27%	365	58%	221	61%	248	68%
Employment, education and training	200	8%	66	33%	48	73%	56	85%
Social and community support	647	27%	311	48%	146	47%	202	65%
Immigration	62	3%	28	45%	17	61%	17	61%

In terms of the wider network of wraparound provision, Idva support is commonly delivered alongside outreach and other specialist interventions. For example, of the 178 Idva services in our 2019 Practitioner Survey, almost two thirds (65%) were also providing outreach support. However, only two in five (39%) were delivering refuge provision, and critically an Idva can support a victim/survivor to explore ways to stay safely in their *own* home, so a refuge place isn't required. They also play a referral role into refuge services and other housing and accommodation options. 10% of clients using Idva

[83] SafeLives (2021), *Insights Idva dataset 2020-21 Adult Independent domestic violence advisor (Idva) services.* Available at: https://safelives.org.uk/sites/default/files/resources/Idva%20Insights%20Dataset%20202021.pdf

support being supported into accessing refuge, 14% helped to access a sanctuary scheme and 9% supported to access statutory housing.[84]

Other support is delivered by Idva services. Two in five (39%) had a specialist children's support worker, more than a third (34%) were providing specialist support for young people (Ypvas), and almost a third (29%) employed Independent sexual violence advisors (Isvas).

One in ten services (10%) had an IRIS worker: a specialist role linked to GP services to deliver training to health professionals. Additionally, 37% of services provided other forms of provision, most commonly counselling, or a specialist advocate working with a particular group (such as those with substance misuse needs).

We know Idvas often work particularly well when they are co-located in other settings, such as such as children's services, housing departments and in adult social care. We often see improvements in information sharing and collaboration, though in these instances the Idva service may have to work harder to retain their independent status, which is so crucial to their role.

Although an Idva will work with clients experiencing sexual abuse, the role of an Idva is distinct from that of an Isva (Independent sexual violence advisor), as noted in the Home Office guidance on the 'Essential Elements' of the Isva role.[85]

Other forms of related advocacy support include outreach workers, court Idvas, hospital Idvas and young people's independent advisors – YPVAs. All can be accredited and qualitied and we welcome steps to ensure professional standards and quality assurance are maintained.

Outreach / Domestic Abuse Support Workers

An outreach worker is, similarly, a domestic abuse expert, working in a role designed to provide high-quality support to victims and survivors of domestic abuse. Like Idvas, outreach workers can work with victim/survivors who are still in their abusive relationship/situation, or who have 'left', though of course the abuse might still be happening through, for example, child contact, economic abuse, harassment and stalking.

Outreach workers provide one-to-one support for victims and survivors of domestic abuse. In theory, they will work with victims who are not assessed as at imminent risk of serious harm, but where there is the potential for serious harm if the situation changes. This may include those who have previously been at high risk of serious harm or murder, or those in a relationship that has not escalated into higher levels of risk. Outreach workers support these victims and survivors to manage safety, prevent escalation and repeat victimisation, and focus on wider needs, resilience and recovery. As such they are an essential part of early intervention and are mostly located in community-based domestic abuse services.

We estimate that around 7,000 outreach workers are required to support a caseload of 100 victims (per year) below the high-risk threshold for Marac. The cost of this is calculated at £350m split into £255m for approximately 500,000 women and £95m for 180,000 men.[86] Our latest estimates suggest that there are fewer outreach workers than Idvas, even though there ought to be far more. This might, however, be explained by i) less consistent understanding of what an outreach worker is - the role is not codified in the way the Idva role is and/or ii) less consistent reporting of outreach worker numbers into our surveys and other data collection processes.

[84] SafeLives (2021), *Insights IDVA dataset 2019-20: Adult Independent domestic violence advisor (Idva) services.* Available at: https://safelives.org.uk/sites/default/files/resources/Idva%20Insights%20Dataset%20201920.pdf
[85] Home Office (2017), The Role of the Independent Sexual Violence Adviser: Essential Elements. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/647112/The_Role_of_the_Independent_Sexual_Violence_Adviser_-_Essential_Elements_September_2017_Final.pdf
[86] SafeLives (2020), *A Safe Fund: costing domestic abuse provision for the whole family*, Available at: https://safelives.org.uk/sites/default/files/A%20Safe%20Fund%20costing%20domestic%20abuse%20provision%20for%20the%20whole%20family%20in%20England%20and%20Wales_0.pdf

In 2019, there was an increase in outreach workers, from 691 in 2017 to 813, though this provision was patchy across England and Wales. [87]

According to our Insights 2020/21 Outreach dataset, the average case length for an outreach service is 18 weeks, compared with 15 weeks for Idva cases.[88] Three in ten cases (31%) lasted six months or more, compared with 24% of Idva cases. On average, clients received 11 contacts from the outreach worker, with 16% receiving 35 or more.

At intake, 40% of cases had ten or more ticks on the Dash Checklist, denoting a victim at high risk of serious harm or murder, and 39% had between six and nine ticks (medium risk). 21% had one to five ticks (standard risk). At exit, the Dash score had reduced in 35% of cases. Outreach workers, therefore, are as likely to work with victims at high risk as those at medium risk of domestic abuse.

We know from our contact with frontline services that this is often linked to commissioning practice. Outreach workers are often advertised at lower salary rates than Idvas because of the lack of codified practice and standards, which means a commissioner who is trying to cut corners might fund outreach workers at a lower level but then expect them to carry out work which should be done by a qualified Idva.

We welcome further work to develop standards. In our Beacon sites in Norfolk and Wet Sussex, we have successfully piloted 'Outreach Idvas' as part of integrated, whole family provision. This role includes the framework, approach and expertise required to support people identified at medium risk of harm from domestic abuse.[89] Independent evaluation has evidenced its effectiveness.

Domestic abuse support should not be provided 'on the cheap' and it would be beneficial for the Government to set out the full spectrum of provision required in a local area, per our 'A Safe Fund' calculations. This would promote the value – social and financial – of multiple types of specialist, from Idva, outreach worker, young people's and children's workers, to perpetrator caseworkers.

Again, Outreach workers will tailor their response and work to a survivors' individual needs, most frequently working around safety, mental health, housing, and children and parenting needs.

Needs & Support matrix – Outreach services 2020/1								
	Needs		Support		Impact			
	Clients identified with needs		Support provided		Improved safety		Improved wellbeing	
Areas of need	Count	%	Count	%	Count	%	Count	%
Safety			1807	**84%**	1256	**70%**	1235	**68%**
Housing	746	**35%**	432	**58%**	298	**69%**	304	**70%**
Physical health	212	**10%**	63	**30%**	33	**52%**	44	**70%**
Mental health	1035	**48%**	591	**57%**	361	**61%**	417	**71%**
Drug misuse	108	**5%**	39	**36%**	21	**54%**	21	**54%**
Alcohol misuse	140	**7%**	43	**31%**	26	**60%**	30	**70%**
Children/parenting	706	**33%**	394	**56%**	242	**61%**	266	**68%**
Finance, benefits and debt	494	**23%**	262	**53%**	155	**59%**	182	**69%**

[87] SafeLives (2020), *A Safe Fund: costing domestic abuse provision for the whole family*, Available at: https://safelives.org.uk/sites/default/files/A%20Safe%20Fund%20costing%20domestic%20abuse%20provision%20for%20the%20whole%20family%20in%20England%20and%20Wales_0.pdf
[88] SafeLives (2021), *Insights outreach dataset 2020-21: Adult outreach services.* Available at: https://safelives.org.uk/sites/default/files/resources/Outreach%20Insights%20Dataset%20202021.pdf
[89] As with all the Beacon interventions, the Connect Principles are fundamental to the delivery of the Medium Risk intervention. These are: Flexible, consistent and reliable, Accessible, Strengths-based, Client involvement, Gender responsive, Working together, Trauma informed

Employment, education and training	256	**12%**	66	**26%**	35	**53%**	56	**85%**
Social and community support	768	**36%**	316	**41%**	179	**57%**	225	**71%**
Immigration	53	**2%**	28	**53%**	20	**71%**	20	**71%**

Dedicated Court Support (Court Idva)

Dedicated Court Support is usually a specifically commissioned resource to provide support for all victims and survivors of domestic abuse through the different court systems and processes. The role is usually referred to as a Court Idva.

Court Idvas should have the same training as an Idva but have advanced knowledge and experience of the justice process. They ensure victims and survivors have the right support needed to proceed through the justice process, advocating on their behalf where possible.

The Court Idva may be co-located within the court building or just spend the majority of their time within the courts. Their role includes explaining the court process and the multiple options that are available, arranging pre court visits, ensuring special measures are in place, attending court with victims and liaising with court officials.

The single most commonly cited intervention that improved survivors' experience of going through the courts was dedicated court domestic abuse support, yet there are still very few Idvas who specialise in the family or criminal justice system[90] and we remain concerned that Idvas are prevented from supporting their clients in the family courts. We urge change to allow them to be present, through a Practice Direction or similar.

Almost 90% of survivors of domestic abuse don't get any support through the family courts, and one in five Idvas is blocked from entering the courts. Our Practitioners Survey of frontline practitioners found that only one in twenty had an Idva providing specialised court support.[91]

Court Idvas can improve the experience of victims of domestic abuse in the justice system, but their most important role is that of independent advocate for the victim: their focus is representing the victim's voice and improving their safety across all aspects of their experience within and beyond the justice system. Their independence is key, no matter which agency has commissioned the role.

Hospital-based Idvas

Hospital-based Idvas are another form of co-located specialist domestic abuse support. They made be based across an Acute Trust or can be located in a specific department, for example Accident & Emergency, or Maternity. Our Practitioners Survey found that just one in ten services had an Idva who was based in a health setting.[92]

Though the evidence base for hospital-based Idvas is robust and longstanding (our Cry for Health report of 2016, the launch of which was supported by the Government Minister Nicola Blackwood, and many subsequent reports), where they do exist they are often on very short-term contracts and the service they provide is fragile.

In the Draft Domestic Abuse Bill (July 2019), Paragraph 167 noted that "From April 2020, NHS England are planning for Independent Domestic Violence Advisors (IDVAs) to be integral to every NHS Trust Domestic Violence and Abuse Action Plan, as part of the NHS Standard Contract." That commitment has yet to be achieved, and the wording was later removed from the Domestic Abuse Act.

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[90] SafeLives, Domestic Abuse Commissioner (2021), Understanding Court support for Victims of Domestic Abuse. Available at: https://safelives.org.uk/sites/default/files/resources/Court%20Support%20Mapping%20Report%20-%20DAC%20Office%20and%20SafeLives.pdf

[91] SafeLives (2021), SafeLives' 2020/21 survey of domestic abuse practitioners in England and Wales. Available at: https://www.safelivesresearch.org.uk/Comms/2020_21%20Practitioner%20Survey%20Final%202.pdf

[92] SafeLives (2021), SafeLives' 2020/21 survey of domestic abuse practitioners in England and Wales. Available at: https://www.safelivesresearch.org.uk/Comms/2020_21%20Practitioner%20Survey%20Final%202.pdf

We strongly recommend that the commitment to hospital-based Idvas be reaffirmed to ensure that more victims of domestic abuse can access support earlier, vital opportunities to identify risk and intervene aren't missed, and NHS staff feel supported to enquire about domestic abuse and refer patients on to the specialist support they need.

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. [93] 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.

Hospital-based Idvas act as a consistent space 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 victims at high-risk of serious harm and murder, and those with protected characteristics and intersecting identities who may have concerns about encountering racism, ableism, homo-, bi- or transphobia or other prejudiced attitudes.

Idvas in hospitals will often help with staff disclosures of domestic abuse, and staff are often an Idva's first referrals when a new service is established.

These Idvas tend to work with victims at all risk levels, and can often work with more diverse groups of clients than 'community' Idvas. In health settings, this includes higher rates of male victims,[94] pregnant victims, victims over 55, and victims with higher incomes, who may face extra barriers to accessing domestic abuse services.[95]

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.

Hospital-based Idvas can also work on a longer-term basis to challenge processes and ingrained views which present barriers to survivors presenting and to support staff disclosures of domestic abuse, alongside domestic abuse policies which support the needs of staff and patients.

Ypvas

We welcome the recognition of children as victims of abuse in their own right for the first time in the Domestic Abuse Act. This is a significant step forward in recognising that living with fear and control in a household at an early age is an abusive situation for that child. Specialist provision for children and young people experiencing abuse in families and in their own intimate relationships is vital.

Young People's Violence Advisors (Ypvas) are specialist advisors who work specifically with young people to help them rebuild their lives after experiences of abuse. One young survivor told us, "I feel more confident to get into new relationships as I can use the work with the Ypva Service to see if the relationship I am in is healthy or unhealthy."[96]

It is vital that support for young people is delivered in a way that is responsive to their needs, and that takes account of the differences in their circumstances, for example inclusive of those who live in rural, potentially more isolated communities, as well as those who live in larger towns and for whom there

[93] 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
[94] Mason, T., Elvey, R., Whittaker (2021), An evaluation of the Hospital-based Independent Domestic Violence Advisor service in Wrightington, Wigan and Leigh NHS Foundation Trust (Executive Summary). Available at: https://www.arc-gm.nihr.ac.uk/media/Resources/ARC/Organising%20Care/HIDVA%20Report%20Executive%20Summary-FINAL.pdf
[95] 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
[96] 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

might be higher levels of connected risk around exploitation, abuse and violence outside the home. They may not associate with the term 'victim' and need nuanced support about their own behaviour and the behaviour of the person harming them.

There is also a higher rate, amongst young people, of service users saying that they are using abusive behaviours as well as experiencing them.

Despite the 2013 change in the definition of domestic abuse to extend to 16- and 17-year-olds, and the efforts to embed this change in the response to domestic abuse, there are still huge gaps in the support for young people. While the Idva role was embedded in the Government's last strategy to end VAWG, there was no such formal support for the Ypva role.

Many young people must still rely on services designed for adult victims, or simply don't get a service that's suitable for them at all. Our Practitioners Survey reveals that the commissioning of Ypvas within adult Idva services is patchy across the country.[97] Many areas had only one Idva service with a specialist Ypva, and one area had none at all. While Ypvas may be based in other local services, such as specialist children's services, it is clear that there is no consistent pathway to specialist support for young people.

We want to see the inclusion of specialist services for young people, such as Ypvas, in the upcoming Domestic Abuse Strategy. We calculate the cost of providing Young People's Violence Advisors at just £2.5m.[98] Around 50 FTE Ypvas are required to meet the needs of young women (aged 12-15) who are victims of abuse in their own intimate relationships. This number is calculated at a relatively low level because young people are likely to use other services, such as youth workers.

As well as Ypva provision, there therefore also needs to be training and quality assurance for youth services. In our Safe Young Lives and our voices of men and boys work over the last two years, youth workers have consistently told us that they think abuse is prevalent for the young people they support, but they are not confident to address it.[99] We have provided bespoke materials for them to do that; **this needs concerted dissemination and integration with programmes the Government supports for young people.**

Our data reveals that 16- and 17-year-olds experienced abuse for an average of 1.5 years before accessing adult domestic abuse services, suggesting that in many cases the abuse began before they were able to access this support. Before the age of 16, young people must rely on support from limited specialist young people's domestic abuse services.

Legal remedies are also limited: protection through a non-molestation order is harder to obtain for those under the age of 16, who will need permission from the high court before they can apply. There are also gaps in effective support for those young people who cause harm towards a partner or family members. Traditional criminal justice remedies for domestic abuse perpetrators do not address the underlying behaviour, and specialist services are limited.

The identification of young people experiencing domestic abuse and the referral to specialist services should be aided by Local Authority Children's Services. Local Authorities have a duty (under the Children's Act 1989) to investigate the child's circumstances if they have reasonable cause to suspect that a child in their area is suffering, or is likely to suffer, significant harm. They must make such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

However, for example, our Children's Insights data shows that less than half (45%) of young people in an abusive intimate relationship were known to children's social services at intake to the service, with a

[97] SafeLives (2021), *SafeLives' 2020/21 survey of domestic abuse practitioners in England and Wales*. Available at: https://www.safelivesresearch.org.uk/Comms/2020_21%20Practitioner%20Survey%20Final%202.pdf
[98] SafeLives (2020), *A Safe Fund: costing domestic abuse provision for the whole family*, Available at: https://safelives.org.uk/sites/default/files/A%20Safe%20Fund%20costing%20domestic%20abuse%20provision%20for%20the%20whole%20family%20in%20England%20and%20Wales_0.pdf
[99] SafeLives (Undated), *The Voices of Men and Boys*. Available at: https://safelives.org.uk/voices-men-and-boys [Accessed 13/01/2022]

Common Assessment Framework completed in just 8% of cases.[100] In these cases, it is also possible that other concerns have brought these young people to the attention of social services. There is still more to be done to join up these two responses and ensure domestic abuse of young people is recognised as a child protection concern.

Specialist children's workers and therapeutic support

We estimate that approximately 371,000 children need support after experiencing abuse growing up. 41% of partner abuse victims in the Crime Survey for England and Wales also had children and we have used the same measure to calculate 'visibility' to services. Using the figure of £50,000 per worker and a case load of 80 cases (our Children's Insights data shows that children's cases are on average slightly longer than adult cases), we estimate that the cost of funding specialist children's workers across England and Wales for all children would amount to £232.2m.[101]

Specialist therapeutic support is also essential to ensuring children and young people are able to recover from their trauma. Using information provided by Barnardo's, we have estimated the cost of specialist therapeutic support for children as £97m, costed as £1,000 per child. As a proxy for the number of children who required this type of support, we used figures from Radford et al. 2011. They found that 26% of the 0- to 17-year-olds who had witnessed domestic abuse had witnessed one parent being kicked, choked or beaten up by the other parent.[102]

The figures for appropriate and sufficient support to children only seem large until they are set in the context of how much *not* supporting children costs. Please see our previous discussion of calculations submitted as part of the Comprehensive Spending Review in 2021.[103]

Question 32: How might defining the Idva role impact services, other sector workers and Idvas themselves?

We welcome the Government's intent to put the Idva role on a firmer footing. The CEO of a DA service in North-East England told us that a key challenge their Idvas face is the use of language: a definition of the Idva role would create a shared language across agencies and an acknowledgement of the vital and life-saving work that Idvas do. This would mirror the existing definition of an Isva. A high-level definition within statute should be supported by a non-legislative package of guidance, developed with the Domestic Abuse Commissioner in conjunction with the specialist domestic abuse sector.

At present, the codified definition of the Idva role as we first created it (see Question 31) is reasonably well understood and used. Where commissioning practice is sound, the use of this definition and the standards that accompany it work well. However, as noted above, poor commissioning practice can lead to a dilution or conflict with the definition we provide. Crucially, this definition is and must continue to be truly victim-centred and prioritise the Idva's independence, outside of any statutory agency.

The Idva role has evolved in the last ten to 15 years and will continue to evolve, so we welcome a definition, supported by guidance, which is flexible enough to allow for additions and expansions to the role of an Idva as it applies to different settings and the relationship to outreach workers, working outside the high-risk level. The expansion of the role, following the success of the original intervention, is about meeting victim/survivors of domestic abuse where they want to be: many victims, for example, will only ever seek help through healthcare settings, others might access the Civil or Family Courts but decide that going through the CJS is not an option they want to take.

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[100] 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
[101] SafeLives (2020), *A Safe Fund: costing domestic abuse provision for the whole family*, Available at: https://safelives.org.uk/sites/default/files/A%20Safe%20Fund%20costing%20domestic%20abuse%20provision%20for%20the%20whole%20family%20in%20England%20and%20Wales_0.pdf
[102] SafeLives (2020), *A Safe Fund: costing domestic abuse provision for the whole family*, Available at: https://safelives.org.uk/sites/default/files/A%20Safe%20Fund%20costing%20domestic%20abuse%20provision%20for%20the%20whole%20family%20in%20England%20and%20Wales_0.pdf
[103] SafeLives (2021), *Investing to save: Domestic abuse and the CSR*. Available at: https://safelives.org.uk/sites/default/files/resources/SafeLivesSubmissiontotheCSR2021.pdf

Reiterating and underlining Government commitment for the long-standing SafeLives definition of the role of the Idva would elevate the status of Idvas in local areas which currently undervalue or try to cut corners on the role.

It could also help Idvas to have more consistent access to multi-disciplinary teams and multi-agency forums, thereby improving the support available to victim/survivors of domestic abuse. Despite the longstanding existence of the role, Idvas do not always have a recognised seat at the table.

For example, currently, one in five Idvas are refused access to clients' court proceedings.[104] Defining the role could help to ensure more victims of domestic abuse have access to specialist domestic abuse support throughout the court process, thereby improving their experience of the courts.

More fundamentally, it needs to be clear through the justice system that access to a highly expert domestic abuse professional constitutes appropriate trauma-informed practice, to secure justice for some of the most vulnerable victims of crime. This approach should be emphasised in training and assurance processes for all agencies within the justice system, without false arguments being raised about independence.

We want to see a clear commitment to the Idva role, set in the context both of evolution of the role – without compromising standards – and also the place of Idvas alongside other specialist workers.

We strongly urge the Government not to see this as an either/or debate. Idvas play a vital role in the overall domestic abuse response landscape, and yet, despite their noted value, we still don't have sufficient provision to meet the needs of victims at the highest risk of serious harm or murder. We need Idvas *and* other advocacy provision.

We recognise that there's a mixed commissioning picture across the country, and that all advocacy workers, including Idvas, are too often under-valued, with commissioners using a lack of formal qualifications as a shortcut to lower wages for staff. The way to address this is through a clear national commissioning framework and a bigger funding envelope, rather than to try to pit one type of worker against another. Another frontline service CEO said there is a "postcode lottery on what Idvas deliver also because depending on capacity and what additional support commissioners demand dictates the breadth of Idva work and this may change per area and [the] funding available."

Safeguarding our definition of the Idva role, including what is and isn't an appropriate caseload, could be a step towards greater quality assurance and consistency across different local areas to ensure that victims of domestic abuse are getting the same high-quality care no matter where they live or who they are.

The most crucial tenet of the Idva role is their independence and this must be central to any definition. No matter who the role is commissioned by, the Idva acts in the best interests of their client, the victim/survivor of domestic abuse.

In order that any definition fully achieves the potential benefits outlined above, we would urge the Government to think about how it can support and bolster our existing definition of the Idva role, and make it realistic for commissioners to fund Idvas *and* the full spectrum of other specialist domestic abuse support, through sufficient, secure, funding.

Question 35: What are the challenges in accessing advocate services, and how can the Government support advocates to reach victims in all communities?

Across the board, victims of domestic abuse face barriers to accessing services. These can include: a lack of knowledge and awareness that what they are experiencing is domestic abuse, or a minimising of the situation and the belief that it is not 'bad enough' to warrant support; a lack of awareness of what

[104] SafeLives, Domestic Abuse Commissioner (2021), Understanding Court support for Victims of Domestic Abuse. Available at: https://safelives.org.uk/sites/default/files/resources/Court%20Support%20Mapping%20Report%20-%20DAC%20Office%20and%20SafeLives.pdf

help is available; a fear of reaching out in case it leads to unintended consequences (for example, the removal of children) or the perpetrator finds out; a fear that they will not be believed if they do disclose. Moreover, survivors may be reluctant to reach out for help if they are aware of the under-funded and over-stretched nature of voluntary-sector services and think they will encounter waiting lists or even be turned away.

Certain aspects of survivors' identities can increase the barriers they face to accessing support and advocate services. Below, we have detailed barriers that some with protected characteristics can face. However, it is crucial to recognise that no one is just one element of their identity at any one time, and individuals may be a member of several different groups and communities based on their background, experiences, or identity. This is why we must see the whole person and provide joined-up, multi-agency responses, instead of addressing an individual as a series of disparate experiences and identities. Crucially, the barriers are never the fault of the victim and their identity – they are the fault of systems. The social model of disability says that people are disabled not by their differences but by a society which is inaccessible.

If the abuser who poses a risk to one or more people is from a group that has historically been discriminated against (this may relate to minority status in terms of race, religion, sexuality, or disability, for example), this can act as a barrier to reporting that abuser to people in official positions. The victim or survivor may worry that the perpetrator of abuse will be treated disproportionately, subjected to discrimination, or even be exposed to physical violence or other adverse responses which a perpetrator from a majority group wouldn't. Olumide Adisa and Katherine Allen found that even the word 'perpetrator' can be problematic, in this context. Victim/survivors may also worry that speaking out about their abuser will be disapproved of by other community members, who may feel it will increase levels of discrimination and reinforce negative stereotypes and perceptions.

This is acting as a barrier to support for victims who need it, and may allow perpetrators of abuse to escape sanction for longer - possibly forever. Victim and survivors will need to see societal change, and reduced discrimination against minority groups, to feel more confident that official channels or disclosure more generally is something they can safely pursue.

Black, Asian, and racially minoritised people

These victims and survivors are often poorly represented by official datasets. These datasets may not disaggregate accurately to highlight the specific experiences of women of different racial and ethnic identities, and may be collected through methods and in forums which aren't trusted or used by those women at the same rate as by white women.

Despite being just as likely to experience abuse as any other ethnic group, research shows that the level of disclosure for these victims of domestic abuse is far lower than that of the general population.[105]

Similarly, there are no reliable data sources specifically around Black, Asian and other racially minoritised perpetrators. Recent work by Dr Olumide Adisa and Dr Katherine Allen is a rare example of research into this subject.[106] Again, this hinders efforts to improve services' and agencies' identification of and response to perpetrators.

This is acting as a barrier to support for victims who need it, and may allow perpetrators of abuse to escape sanction for longer - possibly forever. Victim and survivors will need to see societal change, and reduced discrimination against minority groups, to feel more confident that official channels or disclosure more generally is something they can safely pursue.

Disabled people

[105] Walby, S. and Allen, J. (2004), *Domestic violence, sexual assault and stalking: findings from the British Crime Survey.* Available at: http://openaccess.city.ac.uk/21697/

[106] Adisa, O. and Allen, K. (2020), *Increasing safety for those experiencing family and intimate relationship harm within black and minority ethnic communities by responding to those who harm.* Available at: https://www.uos.ac.uk/sites/www.uos.ac.uk/files/Family%20and%20intimate%20relationship%20harm%20within%20black%20and%20minority%20ethnic%20communitiesFINAL%20%281%29.pdf

Disabled people experience higher rates of domestic abuse than non-disabled people.[107] Our Spotlight report on disabled victims of domestic abuse found that they also suffer more severe and frequent abuse over longer periods of time than non-disabled victims. Our data reveals that disabled victims typically endure abuse for an average of 3.3 years before accessing support, compared to 2.3 years for non-disabled victims.[108] In 2014, the Care Act introduced a clear legal framework requiring local authorities to safeguard vulnerable adults. Despite this, our Insights national dataset shows that in 2015-2016 none of the 925 referrals of disabled victims to domestic abuse services were from adult safeguarding. Poor understanding of domestic abuse, limited ability to identify DA, and lack of knowledge around the support services available to disabled survivors are key barriers to disabled people accessing support.

Even after receiving support, disabled victims were 8% more likely than non-disabled victims to continue to experience abuse. For one in five, this ongoing abuse was physical, and for 7% it was sexual. Our research suggests that this may be attributed to a number of factors, either through poor commissioning, lack of awareness or understanding in practice, social stereotyping of victims of domestic abuse or services being inaccessible to disabled survivors. For instance, some services may offer only telephone support, which excludes those who cannot communicate on the phone.[109]

There is little to no research on disabled perpetrators of domestic abuse which leads to difficulties in recognising and responding to their harmful behaviours. Stay Safe East identified in their evidence to the VAWG Strategy focus group on Deaf and disabled survivors that, often, the perpetrators of clients they work with are also disabled. Perpetrators can use their own disability to convince professionals they were not capable of exerting power and control over their victim, or of abusing them physically. Moreover, Sign Health noted that perpetrator programmes do not regularly plan for interpreters for Deaf perpetrators and that they may find engaging with others on group programmes difficult culturally.

According to *Making the links: disabled women and domestic violence*, "the abuse experienced [by disabled women] was especially acute where the abusive partner was also the carer, making it impossible for women to get help. Neglect was a strong feature, and isolating women from other external carers had the effect of exacerbating the neglect, and was a direct strategy of abuse adopted by some perpetrators."[110] When a (non-disabled) perpetrator is also a carer for a disabled victim, this can result in an extra barrier to the victim/survivor regarding recognising the abuse, disclosing it, and seeking help, due to societal views of carers, the response of agencies, and internalised attitudes. One interviewee stated: "It's like… your heart goes out to your partner because they are doing all your care work. And I do appreciate that… because some it's quite physical and some of it's hard work."[111] The report also highlights how intersecting identities can further heighten these barriers, noting "interviewees who were in same sex relationships in particular had often been disbelieved and denied help."

LGBT+ people

Existing evidence, as well as Galop's practitioner experience, suggests that LGBT+ people face a range of distinct barriers on a personal and systemic level, which often prevent them from getting the support they need.[112] Personal barriers most often relate to LGBT+ people's perception of self and the abuse they experience, and their perception of the support system. In contrast, systemic barriers relate to the

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[107] Office for National Statistics (2020), *Domestic abuse in England and Wales overview: November 2020.* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwaleoverview/november2020

[108] SafeLives (2017*), Disabled Survivors Too: Disabled people and domestic abuse*. Available at: https://safelives.org.uk/sites/default/files/resources/Disabled%20Survivors%20Too%20CORRECTED.pdf

[109] SafeLives (2017), *Disabled Survivors Too: Disabled people and domestic abuse.* Available at: https://safelives.org.uk/sites/default/files/resources/Disabled%20Survivors%20Too%20CORRECTED.pdf

[110] Hague, G. (2008), *Making the links: Disabled women and domestic violence.* Available at: https://equation.org.uk/wp-content/uploads/2016/02/EQ-LIB-127.pdf

[111] Hague, G. (2008), *Making the links: Disabled women and domestic violence.* Available at: https://equation.org.uk/wp-content/uploads/2016/02/EQ-LIB-127.pdf

[112] Harvey, S. et al. (2014), *Barriers Faced by Lesbian, Gay, Bisexual and Transgender People in Accessing Domestic Abuse, Stalking and Harassment, and Sexual Violence Services.* Available at: https://gov.wales/sites/default/files/statistics-and-research/2019-07/140604-barriers-faced-lgbt-accessing-domestic-abuse-services-en.pdf

way services are designed and delivered that may result in them being less accessible and inclusive for LGBT people.

The most common portrayal of domestic abuse is that of a male perpetrator and female victim within a heterosexual relationship. The public narrative of domestic abuse therefore can exclude those whose experience of domestic abuse does not fit this representation. While domestic abuse is most often experienced by women and most often perpetrated by men, it can happen to anyone, and can be perpetrated by anyone. This includes people of all gender identities and sexual orientations, and in many types of relationship.

It is important to recognise the different experiences of LGBT+ survivors, who are not a homogenous group. For example, recent figures suggest that bisexual women experiences rates of domestic abuse almost three times as high as heterosexual women and 1.5 times as high as lesbian and gay women: 19.6% of bisexual women have experienced some form of domestic abuse, in comparison with 6.9% of heterosexual women and 12.2 percent of lesbian and gay women.[113]

According to our Spotlights Report on LGBT+ people, LGBT+ victims are more likely to be abused by multiple perpetrators (15% compared with 9%) than non-LGBT+ victims, and more than twice as likely to have experienced non-recent abuse by a family member (6% compared with 3%). They are almost twice as likely to have attempted suicide (28% compared with 15%) and more than twice as likely to have self-harmed (32% compared with 14%).

We know that those who identify as LGBT+ face additional barriers to accessing support that are unique to their sexual orientation and/or gender identity. Donovan and Hester's work (2014) found evidence of the impact of homo-, bi-, and transphobia on LGBT+ survivors' help-seeking.[114] Alongside others, they "found that survivors rarely seek help from formal agencies such as the police or specialist domestic violence services because of their fears of not being believed, their experiences being minimised, or because they feared experiencing homo/bi/transphobia from professionals/practitioners."[115]

Galop's report, *LGBT+ people's experiences of domestic abuse*, found that LGBT+ victims and survivors disclosing domestic abuse often report multiple vulnerabilities as a result of their sexual orientation, gender identity, physical or mental ill-health or substance abuse.[116]

With regards to LGBT+ perpetrators, "it is increasingly obvious that there remains a gap in knowledge, policy and practice with respect to those who are abusive in LGB and/or T relationships."[117] LGBT+ people using abuse appear only rarely in the criminal justice system, and there are few opportunities for them to engage with perpetrator interventions.

Information around perpetrator interventions for LGBT+ people using abuse is limited. Existing models, including Duluth and the Freedom Programme, work on a basis of heteronormativity, in which (cisgender and – implicitly – heterosexual) men perpetrate abuse against (cisgender and heterosexual) women. As stated in the ANROWS report, Developing LGBT+ programmes for perpetrators and victims/survivors of domestic and family violence, perpetrator programmes delivered primarily for cisgender and heterosexual men can result in the explicit and/or implicit exclusion of female LGBT+ clients, whether they are cisgender or transgender. It also potentially forces clients to make difficult decisions around 'coming out' and disclosing either their sexual orientation or their gender identity. "The

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[114] Donovan, C. and Hester, M. (2014), *Domestic Violence and Sexuality: What's Love Got to do with it?*
[115] Donovan, C. and Barnes, R. (2017), *Domestic violence and abuse in lesbian, gay, bisexual and/or transgender (LGB and/or T) relationships.* Available at: https://sure.sunderland.ac.uk/id/eprint/8352/1/SEX681491_rev1.pdf
[116] Magić, J. and Kelley, P. (2018), *LGBT+ people's experiences of domestic abuse: a report on Galop's domestic abuse advocacy service.* Available at: http://www.galop.org.uk/wp-content/uploads/Galop_domestic-abuse-03a-low-res-1.pdf
[117] Donovan, C., Barnes, R., and Nixon, C. (2014), *The Coral Project: Exploring Abusive Behaviours in Lesbian, Gay, Bisexual and/or Transgender Relationships.* Available at: https://www2.le.ac.uk/departments/criminology/documents/coral-project-interim-report

extent to which this occurs, or whether [these programmes achieve] any positive outcomes for LGBTQ clients, is currently unknown."[118]

Bisexual women were less likely to say that the police had made a difference to their safety and wellbeing (41% compared with 58%). Research by Stonewall shows that 81% of lesbians and bisexual women who have experienced domestic abuse never reported it to the police and, of those who did, only 49% were happy with how the police had responded to the situation.[119] While there is growing awareness within police forces that it is important for them to improve their relationships with LGBT+ communities, this research suggests that there is still a good deal of work to be done to ensure that they are giving these victims of abuse the support that they need.

With regards to transgender victims, research has suggested that up to 80% of transgender people have experienced emotionally, sexually, or physically abusive behaviour from a partner or ex-partner.[120] It is therefore important to look at this group in greater depth to better understand the abuse they are experiencing so that policies and services are better equipped to support their needs.
Transgender survivors also experience large numbers of additional needs, particularly in relation to mental health: according to our Insights data, 56% of transgender victims accessing domestic abuse services have mental health needs.

Trans survivors who access specialist domestic abuse services report that their experience of services has positive outcomes on their lives. However, only a small proportion of those with additional mental health needs are supported with these by specialist domestic abuse services. Given the large numbers of transgender victims and survivors who have mental health needs, it is vital that this issue be addressed.

Older people

Research by Age UK has found that older people are similarly likely to be killed by a partner/spouse (46%) as by their adult children or grandchildren (44%).[121] SafeLives' Spotlight on older people found that on average, nearly half (48%) have a disability.[122]

Many surveys and studies, such as the Crime Survey for England and Wales (CSEW), have historically excluded consideration for older victims, and awareness-raising campaigns have consistently focused on younger victims. We welcomed the extension of the CSEW to include those over 75, but the widespread exclusion still found in other datasets simply serves to reinforce the false assumption that abuse ceases to exist beyond a certain age.

The response to domestic abuse and VAWG must also be closely connected with adult safeguarding, health, and social care responses, alongside interventions for disability as people get older, given the prevalence of abuse of older people by adult children, as well as aging partners.

Men make up a larger proportion of older victims than they do in younger age groups. Our report on older victims, *Safe Later Lives*, highlighted that, for those aged 60 or under, men made up 4% of clients at domestic abuse services. For those aged 61 and over, that figure rose to 21%. [123] One of the reasons for this is the prevalence of perpetrators who are adult children of older abuse victims: for 41% of older

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[118] ANROWS (2020), *Developing LGBTQ programs for perpetrators and victims/survivors of domestic and family violence*. Available at: https://d2rn9gno7zhxqg.cloudfront.net/wp-content/uploads/2020/05/11093225/PI.17.09-Bear-RR.pdf
[119] Stonewall (2012), *Domestic abuse: Stonewall health briefing*. Available at: https://www.stonewall.org.uk/system/files/Domestic_Abuse_Stonewall_Health_Briefing__2012_.pdf
[120] Scottish Transgender Alliance (2010), *Out of Sight, Out of Mind? Transgender People's Experiences of Domestic Abuse*. Available at: https://www.scottishtrans.org/wp-content/uploads/2013/03/trans_domestic_abuse.pdf
[121] Age UK (2020), *No Age Limit: the blind spot of older victims and survivors in the Domestic Abuse Bill*. Available at: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/age_uk_no_age_limit_sept2020.pdf
[122] SafeLives (2016). *Safe Later Lives: Older people and domestic abuse*. Available at: https://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf
[123] *Ibid.*

clients, the perpetrator was an adult family member, in comparison with 6% for clients aged 60 and below.

Victims aged 61 and over are much more likely to experience abuse from a current intimate partner than those aged 60 and under (40% compared with 28%). They are less likely to attempt to leave their perpetrator in the year before accessing help (68% compared with 27%) and nearly four times more likely to be living with the perpetrator after getting support (32% compared with nine percent).

In instances of abuse of older people, criminal justice responses may be of more limited value if a victim or survivor is unwilling to see a long-term partner or adult child prosecuted for their actions and believe this is their only option to stop the abuse. This requires a more considered approach on the part of agencies to reassure older people that there are options available which will still help them be safe, but not result in family rupture, increased isolation, or financial hardship.

There is little direct research on older perpetrators of abuse, with regards to the profile of perpetrators or the specific behaviours they display. Perpetrators engaged with the Drive Project ranged in age from 17 to 81 years, though the mean average age was 32.[124] This knowledge gap hinders the ability of practitioners and agencies to recognise and respond to older perpetrators and must be addressed if we are to tackle VAWG across the board.

Children and Young People

Young people are disproportionately affected by domestic abuse, both through being directly subject to abuse in their intimate relationships, and through experiencing abuse in their household. According to the Crime Survey for England and Wales, 14% of women aged 16 to 19 reported experiencing some form of domestic abuse in the last year, as did 5.3% of men in the same age group. For women, this is 40% higher than the next age group (20-24).[125]

To seek support, victims of VAWG must recognise that what they are experiencing is just that. Evidence provided to the Women and Equalities Committee inquiry on sexual harassment and sexual violence in schools highlighted a 'normalisation' of sexual harassment and abuse among young people. The report concluded, "research with 13- to 18-year-olds suggests that young people trivialise and justify violence against women and girls, view some forms of sexual harassment as normal and even inevitable, and excuse rape."[126]

In order to address barriers to support services, we must empower children and young people to identify domestic abuse and sexual violence in their own relationships and those of their friends. 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 undertook interviews and focus groups with young people across the country, as well as a national survey, and gained frequent feedback from a Young Person's Steering Group.[127]

We found that:

- Young people do not use the term 'domestic abuse', instead using words such as 'toxic', 'controlling' and 'manipulative;'
- Young people want support in understanding what is and isn't acceptable in their relationships. In the Talk About Toxic national survey, more than half (51%) of respondents to our survey of

[124] Hester, M. (et al) (2019), *Evaluation of the Drive Project – A Three-year Pilot to Address High-risk, High-harm Perpetrators of Domestic Abuse.* Available at: http://driveproject.org.uk/wp-content/uploads/2020/03/DriveYear3_UoBEvaluationReport_Final.pdf

[125] Office for National Statistics (2020), Domestic abuse in England and Wales overview: November 2020. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwaleoverview/november2020

[126] House of Commons Women and Equalities Committee (2016), *Sexual harassment and sexual violence in schools.* Available at: https://www.publications.parliament.uk/pa/cm201617/cmselect/cmwomeq/91/91.pdf

[127] Currently unpublished

13- to 18-year-olds said they would most want support in that area, while one third (31%) said they wanted 'advice on getting out of a relationship that feels unsafe;'[128]
- Young people are unsure how to manage boundaries around technology;
- Unwanted sexual behaviour was a common feature in the stories young people shared with us;
- Friends and family are young people's main support mechanism for their relationships;
- Young people want content to be diverse and inclusive;
- Young people are happy to share their story, and see benefits in reading the stories of others, highlighting that we need to amplify young people's language and stories, rather than writing about them.

Out of this research, we developed and designed an online platform for mobile use called 'Draw the Line' which aims to empower young people to know how and where to reach out.[129]

Overall, the children of adult victims living with domestic abuse – including high-risk abuse – continue to be under-identified by Children's Social Care (CSC). While many adult victims don't want to have CSC involvement, which they can experience as coercive and threatening, there is clearly a gap in the knowledge CSC often have of children living in a household where there is a high risk of serious harm or homicide. Where they are aware, the signs of abuse also are often mischaracterised as 'neglect', which drives CSC down a specific route for intervention that may be ineffective in addressing abuse. Such an intervention can even make it worse, as it could trigger disguised compliance on the part of both parents, both the abused parent and the non-abusive parent.

Question 37: How useful is existing guidance, and how can this guidance be strengthened?

The National Statement of Expectations should have created appropriate guidance for the full spectrum of provision needed at the local level, but the document has not served this purpose. We know this document is being updated for re-release, but we would welcome further time to input to ensure it is comprehensive and robust. It will need some backing with clear monitoring and consequences for local areas who are not adhering to it.

The Shared Standards for frontline specialist domestic abuse response created by SafeLives, Imkaan, Rape Crisis, Respect and Women's Aid England form a baseline standard to which all frontline specialist services should be held.[130] **The Government could usefully support charities to more fully promote and embed these standards, and support the DA Commissioner and her office to monitor and create consequences for those who don't consistently reach them**.

Question 39: Is more action needed to define standards for Idvas and to ensure they are met? If yes, who is best placed to take this action?

Please see our answer to question 32.

Question 40: What are the advantages and disadvantages of the current qualifications and accreditation structures? Are there any changes that could improve it?

At SafeLives we know the importance of Idvas and other frontline professionals in helping to make victims of domestic abuse and their families safe. Over the last 16 years, we have trained over 3,000 Idvas (and Idaas in Scotland) to OCN-accredited Level 3 standards to provide a quality-assured professional independent service to victims of domestic abuse. Our established provision is highly regarded by participants, service managers and commissioners alike and its scale provides a nationwide confidence in quality assurance.

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[128] 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
[129] https://drawtheline.uk/
[130] Imkaan, Rape Crisis, Respect, SafeLives, Women's Aid (2016), *Sector Sustainability Shared Standards*. Available at: https://safelives.org.uk/sites/default/files/resources/Shared%20Standards%20Whole%20Document%20FINAL.pdf

We know that opening out training delivery has led in some cases to untested providers offering low-quality training, with worrying evidence of inappropriate trainers purporting to benchmark others. All victims need to feel confident they are receiving the best possible service and support, and proper training for frontline workers is essential.

SafeLives' Idva training courses are provided for Idvas, other domestic abuse practitioners and service managers who currently carry an active caseload or are about to start doing so. The course enhances practical knowledge, helping workers provide the best possible support for domestic abuse victims, survivors and their children.

The training is supported by relevant specialists from many different fields, including the criminal justice system, family law, child protection, sexual assault referral centres (Sarcs) and housing services. It includes modules on Multi-agency risk assessment conferences (Marac), anti-racist practice, and working with minoritised groups experiencing domestic abuse or harmful practices. The content is designed to give learners the depth and breadth needed to support domestic abuse victims, survivors and their children in a multi-agency context from a whole family perspective. We provide a whole range of support to ensure the training is fully accessible to all learners.

Learners are expected to complete four written assignments, attend 12 days of in-person or online training over 4 blocks, plus e-learning modules. The course expectations are for 120 hours of guided learning, 50 hours of worksheets, study of 130 hours, to a total time commitment of around 300 hours to achieve a Level 3 qualification. We do not compromise on these standards, or offer shortcuts.

98% of learners told us they felt more confident in their role after receiving our Idva training and our Idva Foundation training has an average NPS score of +64.3 since 2021 (on a scale of -100 to +100). Our learners report an increase in knowledge (out of a score of 5) from 3.15 at the beginning of the course to 4.69 at the end of the course. Our learners rate the content of the course a 4.71 out of 5 and the delivery of the course a 4.62 out of 5.

"It has widened my umbrella of thinking when risk assessing a client, for example new understanding of LGBT+ risks and lack of visibility" Learner on Idva Foundation Course

"Even though I am very meticulous in completing my Risk Assessments, the additional knowledge gained here has increased my skills and ability to make a comprehensive assessment. I have also gained additional knowledge on how to deal with challenges arising from inadequate assessment from partner organisations in a multi agency setting." Learner on Idva Foundation Course

"I feel so much more confident in my ability as a practitioner, the difference this has made is really amazing, I feel much more clued up on everything! I feel I can do more for my clients, which is what they deserve, and I have much more confidence in regard to working with other agencies too." Learner on Idva Foundation Course

Recognising that cost might be a barrier to access for some smaller services, we provide a sliding scale of fees with subsidies for registered charities with income of less than £1m and less than £500k. Responding to further feedback through a review with small, specialist services, we are developing further bursaries, free places and other access arrangements for very small services and CICs.

We also note it is important accreditation of Idvas exists alongside effective training for service managers and accreditation for services. SafeLives has trained 457 service managers since 2014, and now accredits over 50 frontline domestic abuse services to its Leading Lights standards. The programme offers services, partner agencies and commissioners a clear set of standards for supporting victims. The network of Leading Lights services also provides a valuable sounding board and support between services and a vital conduit for feeding back intelligence and evidence from the frontline to policy makers.

"Accreditation is vital for our service, and Leading Lights has been integral to Oasis' ability to focus on the development of young people's services. It has contributed to increased professionalism, skills and our reputation, and in combination with contract success has secured our ability to develop these other vital services." Deb Cartwright, Oasis.

Question 41: How can we ensure that all non-criminal justice agencies (such as schools,

doctors, emergency services) are victim aware, and what support do these agencies need in order to interact effectively with Idvas, Isvas or other support services?

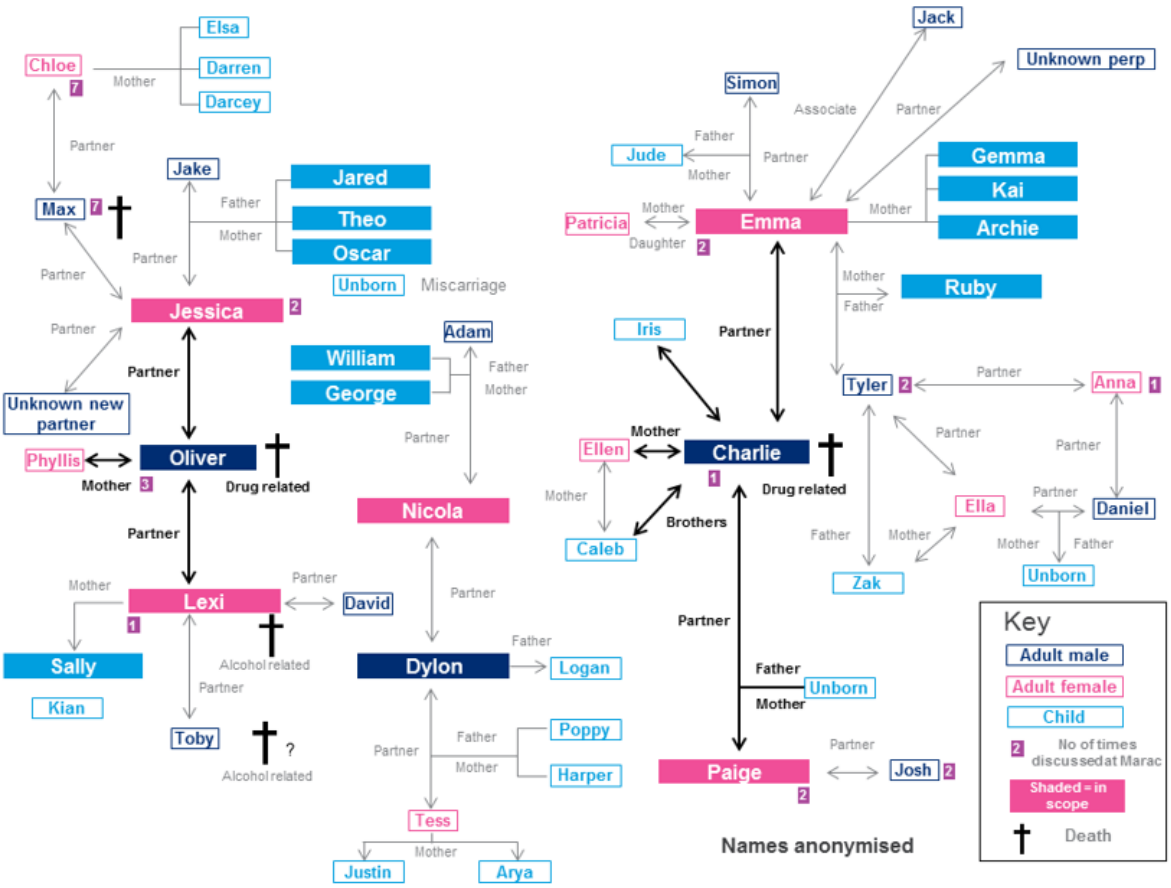
SafeLives' work over 15 years has highlighted repeated concerns that agencies are missing early opportunities to help a whole family in difficulty, costing lives and money.

Risks to children and adults are not routinely linked, so vulnerable people are missed. Domestic Homicide Reviews (DHRs) have highlighted these repeated failings, as has Ofsted's 2017 JTAI referred to previously, which clearly states that professionals were not working together to share information effectively.[131,132] A 2019 Serious Case Review stated: "these reviews highlight the consequences for children, young people and their families if professionals are unclear about their responsibilities in this area. More recent reviews have highlighted that information sharing is about more than just passing information from one agency to another. It is about each agency sharing its own analysis of the child and families' circumstances, and ensuring that those who know the child best communicate their understanding of the child's world."[133]

Without this understanding of the whole picture and a shift away from an incident focus, professionals are unable to provide a response that addresses all risks and needs for children and their families.[134] There are gaps in the local and national response, perpetrator responses are rare, as previously identified, and there is often poor knowledge of differing expertise between sectors.

Research has highlighted the complex and inter-linked nature of families affected by domestic abuse, as exemplified by our genogram below. The local authority we worked with to bring this picture together held all the relevant data but hadn't pieced together all the connections. Our further research highlighted that in addition to the two deceased adult men, there were six more adults and 11 linked children. The research also identified that one of the mothers of the men had called the ambulance service 22 times and, despite him being known to Marac, local authority adult social care had not identified him as the potential cause of the harm she was experiencing. This highlights the frailty of a current system which assumes one perpetrator is linked to one victim, rather than looking at a perpetrator in the round and assessing the risk he poses to multiple people in his surroundings.

[131] Sharp-Jeffs, N. and Kelly, L. (2016), *Domestic Homicide Review (DHR): Case Analysis*. Available at: https://coercivecontrol.ripfa.org.uk/wp-content/uploads/Standing_together_dom_homicide_review_analysis.pdf
[132] 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
[133] Gloucestershire Local Safeguarding Children Board (2016), *Serious Case Review: "Phillip, (and his siblings, John and Darren)".* Available at: https://www.gscb.org.uk/media/12924/philip-scr-version-10-301116-final.pdf
[134] SafeLives (2019), *How can we learn the lessons from Domestic Homicide Reviews?* Available at: https://safelives.org.uk/practice_blog/how-can-we-learn-lessons-domestic-homicide-reviews



<u>We need an approach which looks at the whole picture for the whole family</u>.
As referenced before, our One Front Door pilot from 2016-2019 provided valuable evidence of some of the problems which exist in multi-agency working.[135] This included: structural differences between areas; a plethora of different multi-agency responses ranging from Marac, MASH, MAPPA and VRUs, with the same exhausted professionals going to multiple meetings; short-term, piecemeal commissioning for specialist services; lack of understanding of coercive and controlling behaviour; cases not managed collaboratively so no one joins the dots for families; services are siloed, with poor knowledge of one another's expertise; triage seen as child safeguarding process primarily; making decisions in isolation and only at a high threshold, and information not shared cumulatively. Typically, families had come to Mash or CSC four times before, while multiple agencies were making interventions with families but not identifying domestic abuse.

The pilot, which brought together agencies to look at the whole family, showed improvements in multi-agency working including:

- Multi-agency work became more collaborative and effective;
- There was an increase in parity of esteem between specialist agencies (often voluntary) and large statutory partners which deepened engagement between them;
- There was a shift from multi-agency teams administering information to them bringing specialist expertise and meaningful analysis to bear on all information.

In depth analysis in individual sites found:

- Better information sharing resulted in 17% of risk assessments uprated;
- In the first four months of One Front Door implementation, 31% of police contacts progressed to social care assessments from 3% in previous year. It is not clear how much of this increase was as a result of having a better picture of the risks and needs within the family, and how much was

[135] SafeLives (2019), *Seeing the Whole Picture: An evaluation of SafeLives' One Front Door.* Available at: https://safelives.org.uk/sites/default/files/resources/Seeing%20the%20Whole%20Picture%20-%20An%20evaluation%20of%20SafeLives'%20One%20Front%20Door.pdf

due to the lack of alternative outcomes as it was not possible to track the outcome of these assessments;
- The number of contacts which were not closed with 'No Further Action' increased by 25% for the same time periods.

Question 43: What are the barriers faced by Idvas preventing effective cross-agency working, and what steps could the Government take to address these?

A key barrier is the lack of understanding and recognition given to the Idva role in certain areas. A former Pioneer (survivor of domestic abuse working with SafeLives) told us about her experience where, in one local area, the Idva was entirely disregarded and their professional judgement questioned and undermined. As a result, the multi-agency response the survivor received was very poor. After moving to a new area, the Idva was seen on a level with the statutory agencies, and the survivor received a much better response.

Idvas must be recognised across agencies as specialist domestic abuse practitioners. The CEO of one frontline service told us that their Idvas often experiences statutory agencies questioning their expertise, in a way that other professions do not experience.

In addition, please see our answers to Questions 31 and 32.

Question 44: What are the barriers facing specialist or 'by and for' services preventing cross-agency working, and what steps could the Government take to address these?

Please see our answer to Question 26.

Question 45: Please comment on the training required to support advocates for children and young people. How do these differ to adult advocate training, and are there barriers that exist to accessing this?

Our report, *Safe Young Lives,* highlighted the fact that the abuse that young people experience may look different to the abuse that adults experience.[136] It also found that existing adult domestic abuse support is not always equipped to meet the needs of young people. It is important that support for young people is delivered in a way that is responsive to their needs and their specific issues are expertly addressed.

Our Ypva training increases a practitioner's understanding of the dynamics of domestic abuse and how it is different for young people. It encourages frontline professionals to consider how adolescence impacts on a young person's behaviour, the key risk factors for serious harm, and how to safety plan in a multi-agency context. Young people commonly experience abuse through new technologies and social media, which can be used as a monitoring or harassment tool by the perpetrator. Our training helps the learner understand what technologies and apps are currently available and how to keep up to date as new ones emerge.
The course covers key areas for working with young people, including adolescent brain development, child sexual exploitation, and age-appropriate working. Moreover, learners are taught about the specifics of conducting risk assessments with young people. The course also covers content around young people affected by gangs, and working with young people who have additional needs. Feedback has been really positive, with learners telling us that the course builds their specialism in working with this particular group of victims and survivors of domestic abuse, and is crucial to tailoring their practice to the individual needs of each client.

"[The course] has highlighted the importance of the specialism in CYP support. It can feel isolating at times being a CYP worker, with little regard for knowledge, and this course has highlighted the need for CYP practitioners and the difference in skills that are utilised and required in this area." Learner on Ypva Foundation Course

[136] 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

On a scale of -100 to +100, our Ypva Foundation Courses has an average NPS score of +63.5 since moving online in 2021, and the Ypva Specialist Course has an average of +61.75. Learners on the Specialist Course report an increase in knowledge (out of a score of 10) from 5.81 at the beginning of the course to 8.7 at the end of the course. Learners consistently leave positive feedback regarding the high quality of the teaching and course content.

"My perception has changed with ways in which to contact young people and disengaging young people and how to provide more options whilst still promoting their independence."
Learner on Ypva Specialist Course

Question 46: What are the barriers to effective work with children and young people in this area, and what action could the Government take to address these?

Please see our answers to Questions 25, 31 and 35.

Question 47: What best practice is there on referral pathways for children and young people who are victims of crime looking for advocacy support, including interaction with statutory services? Are there barriers to these pathways?

SafeLives ground-breaking Beacon sites provide a valuable case study of the benefits of looking at the whole family. Our work identified key gaps in Local Authority provision for children and young people who are survivors of domestic abuse. These gaps include:

- A lack of adequate training on domestic abuse, and the trauma-informed approach for children and young people, for frontline professionals including social workers, police officers, early intervention practitioners, substance misuse practitioners and probation practitioners'
- Inadequate resources, including toolkits, to support practitioners who receive disclosures from children and young people;
- Programmes for pre-school age children (aged 0-5);
- Interventions for young people aged 13-17 demonstrating child-to-parent or adolescent-to-parent violence and abuse (APVA);
- A lack of specialist children and young people's practitioners;
- Services for young people experiencing abuse in their own intimate relationships and seeking peer support.

We also found examples of children and young people whose parents or guardians are receiving domestic abuse support programmes but who are not receiving support themselves. Moreover, we found that the multi-agency response was not evident when it came to the response to child and adolescent victims of domestic abuse, and information-sharing between agencies was poor.

Finally, we found that safety planning and the protection of children was frequently seen to be the responsibility of the non-abusive parent; the parent using abuse was rarely challenged and held to account for their parenting decisions to perpetrate abuse. This was particularly evident in Child Protection conferences and in strategic family meetings.

CYP interventions should support the local multi-agency response to safe-guard children and young people from the impact of domestic abuse and therefore should be part of a multi-disciplinary team, which works with each member of the family.

As part of the Beacons work, our West Sussex service provided support to over 300 children and young people (CYP). The majority of cases were new to the service (93%) with 7% repeat cases. Both the child and parent were supported in the majority of cases (64%).[184]

Outcomes for children in these families were overwhelmingly positive. Following safety interventions, almost all (97%) of the CYP had improved understanding of how to maintain their own safety. 96% of CYP with needs related to their family relationships and 93% of CYP with mental health needs had improved wellbeing after receiving support.

There was an 87% reduction in children and young people witnessing abuse from intake to exit. Reductions were evident across all forms of abuse, while the reduction was most significant for children

and young people who had witnessed physical abuse, and jealous, controlling and coercive behaviour. For over half of the CYP still witnessing abuse, this was due to child contact arrangements.

At exit, there was an overall 72% reduction in CYP experiencing direct abuse, especially among those who had been experiencing emotional abuse: 97% of children and young people were experiencing emotional abuse at intake, compared with 9% on leaving the service.

The service saw a 40% reduction overall in CYP demonstrating harmful behaviour, and there were significant reductions in CYP using physical harm and using jealous, controlling and coercive behaviours.

The majority of children and young people were referred to the service through internal domestic abuse and sexual violence services, children's social care, and external DA and SV services. Other services involved with the children and young people at intake included Police (almost one in ten), Cafcass and Children's centre. At exit from the service, there was a 37% decrease in social services involvement with the CYP.

Eight in ten CYP were experiencing ACEs in their household. Of those, the most common adverse experiences were domestic abuse exposure (57%), parental separation (56%) and verbal abuse (21%). The average number of ACEs experienced were 1.9 and 18 CYP had experience four or more ACEs.

Evidence from the pilot found that Children and Young People's interventions:

- strengthen referral pathways to improve how agencies work together to provide the right support at the right time, and with clear responsibility, to safeguard children and young people experiencing domestic abuse;
- equip practitioners with skills and tools to work creatively with children and young people, and their families, based on their individual needs and wishes;
- improve skills and confidence of local practitioners to better understand and support the needs and wishes of children and young people;
- support to deliver 1-1 and group programmes with evaluated toolkits that address the needs of children and young people and provide parallel support for mothers / families to build positive relationships;

Use online resources to increase awareness of domestic abuse and options to access support.

Question 48: Would providing clarity on the roles and functions of children and young people's advocates be helpful? In your experience, are these roles broad or do they focus on specific harms and crime types that children and young people have experienced?

We set out in earlier answers some of the benefits of codifying Government support for specialist domestic abuse response roles. However, we also comment on the methods through which this would happen – outside the tight timeframe and constraints of legislation.

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